



In the Literature

REWARDING EXCELLENCE AND EFFICIENCY IN MEDICARE PAYMENTS

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Milbank Quarterly
September 2007
85(3)449–68

An abstract is available at:
<http://www.blackwell-synergy.com/doi/abs/10.1111/j.1468-0009.2007.00495.x>

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Commonwealth Fund Pub. 1063
August 2007

In the Literature presents brief
summaries of Commonwealth Fund-
supported research recently pub-
lished in professional journals.

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As the single largest payer for health services in the United States, Medicare is in a unique position to provide a model of innovation for the nation. In addition, as the baby boom population ages and health care costs continue to grow, Medicare faces enormous budgetary pressures. To best serve elderly and disabled beneficiaries and prove itself as a leader in achieving high performance, Medicare must align financial incentives with the dual goals of improving health care quality and efficiency.

In “[Rewarding Excellence and Efficiency in Medicare Payments](#)” (*Milbank Quarterly*, Sept. 2007), Commonwealth Fund President Karen Davis, Ph.D., and Stuart Guterman, senior program director for the Fund’s Program on Medicare’s Future, propose a new, blended payment strategy that would combine fee-for-service payments with payments based on episodes of care. Such a system, they argue, would create incentives for providers to deliver both high-quality and efficient care.

Flaws in Current System

Medicare currently pays fixed rates for services, with prospective payments for hospital care and fees for physician services. Although the system rewards providers for efficiency in the provision of individual services—since they can profit from delivering care for less than the fixed prices—it also rewards delivering more services, rather than the provision of appropriate, coordinated care.

Paying for care over an episode of treatment, or a set period of time for patients

with particular chronic conditions, could be a more efficient way of paying for care, the authors say. In addition, such a system could support the goals of care coordination and chronic care management.

Building a New Payment System

Laying the groundwork for fundamental payment reform will require several changes. First, there is the issue of how to define an episode of payment. For example, an “episode” for a chronic condition such as diabetes might entail all the care for diabetic patients in a given year. For an acute condition like acute myocardial infarction (AMI), the episode could be defined as the beginning to the end of treatment.

In addition, if a patient’s care is shared by multiple providers—hospitals, primary care physicians, specialists, physical therapists, etc.—there is an issue of how to best reward higher performance. This is most easily resolved, say the authors, when providers belong to an integrated delivery system or large multispecialty-group practice. Other options include creating new entities, such as physician-hospital organizations or networks of independent physician practices; basing rewards on the performance of all providers in a geographic region; or setting rules for responsibility, such as the proportion of a provider’s total contribution to the patient’s care.

Another way to improve performance and guide future payment reforms is by learning from top-performing providers. Across the nation, there is great variation in the costs and quality of care provided by

Medicare. This is troubling, say the authors, as it indicates how much worse performance is in some areas than others. But these variations also provide benchmarks for improvement because the data show that areas with the highest quality and best outcomes are generally not those with the highest costs. Quality improvement and greater efficiency, say the authors, need not be a trade-off.

The authors point to the analysis of *Dartmouth Atlas* data on 306 U.S. hospital referral regions that found wide differences in costs and risk-adjusted mortality rates for patients with three acute conditions: AMI, colon cancer, and hip fracture. Using these data to identify the regions with the lowest costs and best outcomes, the analysis revealed that Medicare could save almost \$900 million per year by paying a maximum global fee for all the care for patients with these conditions equal to the average standardized costs for the highest-performing regions. Emulating the highest-performing regions also could save almost 8,500 lives.

Medicare has begun testing models for rewarding quality and efficiency. Two current experiments are the Hospital Quality Incentive Demonstration, which is rewarding hospitals for their performance on 34 process and outcome measures for inpatients with one of five conditions (AMI, heart failure, pneumonia, coronary artery bypass graft surgery, and hip and knee replacement); and the Physician Group Practice Demonstration, which aims to coordinate and improve care and enhance information technology among multispecialty group practices. Preliminary studies have shown positive results in terms of both quality and costs. These

demonstrations and others will be closely watched for insight that could yield lessons for redesigning Medicare payments to produce a better, more efficient health care system.

Rewarding Quality and Efficiency

Support for fundamental payment reform is growing, as signaled by medical professional organizations' support for the concept of per-patient payments for providers serving as "medical homes," and by efforts led by the National Quality Forum to assess value across episodes of care. In addition, the authors note that a September 2006 Institute of Medicine report recommended further experiment and refinement of pay-for-performance incentives.

Conclusions

Ultimately, the authors suggest that payment reform could take place in two stages: a pay-for-performance payment system with bonuses for excellence of care and efficiency, followed by a blended fee-for-service and capitated case-rate payment system for managing patients with chronic conditions and case rates for episodes of acute care.

"A blended payment system based on both fee-for-service, which rewards productivity, and population or episode case-rate payments, which reward the prudent use of resources, would go a long way to rewarding the results we would like to achieve and narrow the current wide, and unacceptable, variations in both quality and efficiency," the authors conclude. "The difficult work will not just be realigning financial incentives but restructuring the delivery of care and organizing health care services in a way that best capitalizes on these incentives."