



NOVEMBER 2004

Issue Brief

Paying for Performance

PATRICIA SELIGER KEENAN,
JOHN F. KENNEDY SCHOOL OF GOVERNMENT
AND
JANET KLINE, HEALTH POLICY SPECIALIST

For more information,
please contact:

Mary Mahon
Public Information Officer
The Commonwealth Fund
One East 75th Street
New York, NY 10021-2692

Tel 212.606.3853

Fax 212.606.3500

E-mail mm@cmwf.org

Introduction

Studies show that current provider payment systems tend to discourage quality improvement in the health care system.¹ A frequently suggested solution is “paying for performance,” a reference to a range of strategies to reorient payment incentives by rewarding efforts to improve quality. Quality problems have been documented for decades, both in fee-for-service and managed care delivery systems. Paying for performance is a relatively new approach to address longstanding quality problems, by rewarding providers for delivering care that is clinically effective and results in improved health.

Recent Activities in Quality of Care

Evidence of Quality of Care Problems

Research continues to document problems with quality of care throughout the health care system.² Figure 1 documents the problem of “underuse” of services among Medicare beneficiaries for acute, preventive, and chronic care. According to the data, more than 1 in 5 elderly heart attack patients did not receive aspirin or beta blockers when discharged from the hospital, 45 percent did not receive recommended vaccinations, and more than 1 in 4 diabetics did not receive needed tests. “Overuse,” or treatments received when there is little likelihood of medical benefit also affects quality of care. A recent study found that approximately 11 percent of patients received care that was not recommended and could cause harm.³ Care delivered with medical errors, referred to as misuse, also occurs. Estimates suggest that medical errors in hospitals may account for as many as 44,000 to 98,000 unnecessary deaths each year.⁴

Increased quality efforts may be particularly effective in certain areas, such as treatment for chronic illness. Individuals with chronic conditions account for a disproportionate share of private and Medicare spending, overall and for prescription drugs.⁵ Treatment for chronic illness is important for Medicare beneficiaries and program spending. Two-thirds of Medicare beneficiaries have multiple chronic conditions and account for 96 percent of Medicare spending.

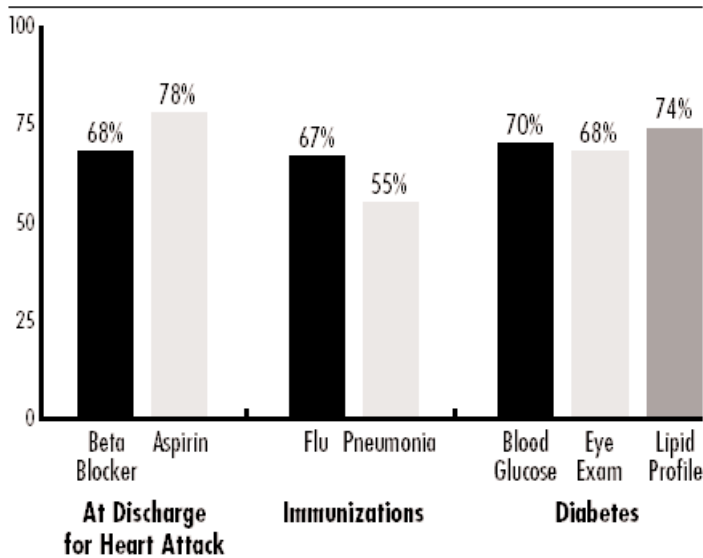
Individuals with multiple chronic conditions are more likely to experience problems with care coordination and quality of care. They see a greater number of

Additional copies of this (#708) and other Commonwealth Fund publications are available online at www.cmwf.org

To learn about new Fund publications when they appear, visit the Fund's Web site and [register to receive e-mail alerts](#).

This *Issue Brief* was prepared for The Commonwealth Fund/John F. Kennedy School of Government Bipartisan Congressional Health Policy Conference, January 15–17, 2004.

Figure 1
Share of Medicare Beneficiaries Receiving
Medically Indicated Services, 2000–2001



Source: Jancks et al., *Journal of the American Medical Association*, 2003.
A rate of 100% means that all patients received medically appropriate care.

specialists and to require more prescriptions than those with fewer or no chronic conditions. As their number of chronic conditions increases, individuals are increasingly likely to receive a conflicting prescription, and to be subjected to duplicate tests or procedures. They also are more likely to be admitted to a hospital for an ambulatory sensitive condition that could have been prevented with outpatient treatment, to experience complications during a hospital admission, and are at risk for rehospitalization.⁶ Health insurance programs, particularly Medicare, traditionally have not covered services that may promote chronic care management, such as nurse education programs and support for patient self-management.⁷

Availability of Performance Data

The growing availability of performance data contributes to the call for pay-for-performance incentives. Efforts to collect and report data on quality of care are rapidly expanding. Quality of care measures are used to provide information to consumers and purchasers to help inform their health care choices. These measures also can be used to reward performance. One major reporting effort, the Health Plan Employer Data and Information Set (HEDIS), collects and reports data on a set of quality performance indicators from health plans, for individuals with private and public insurance coverage.⁸ In addition, consumer assessments of care are collected in commercial health plans, Medicare managed care and fee-for-

service, and Medicaid, using the CAHPS (formerly the Consumer Assessment of Health Plans) survey.⁹

Hospitals also are a focus of data collection efforts. The Centers for Medicare and Medicaid Services (CMS) has begun a voluntary hospital reporting effort of 10 quality measures that focus on acute myocardial infarction, heart failure, and pneumonia.¹⁰ The National Quality Forum, an organization designed to promote a national strategy for reporting performance measures, has developed a separate set of 31 hospital performance measures.¹¹ The Department of Health and Human Services is working to create a consumer survey for hospitals, referred to as “H-CAHPS.”¹² CMS already reports quality data for nursing home and home health agencies, available at www.medicare.gov. The new Medicare bill contains an incentive for hospitals to report quality information (see below).

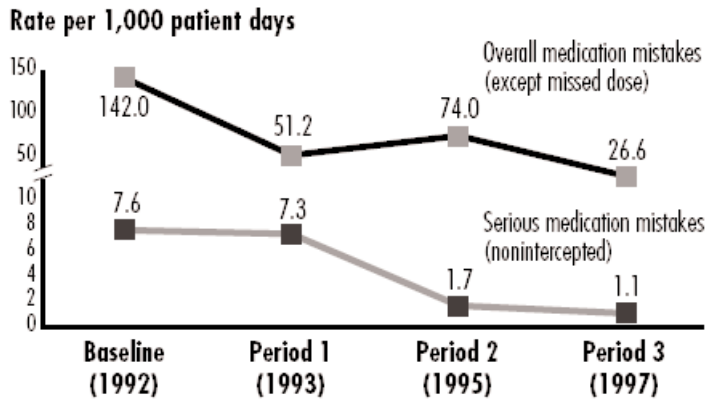
Financial Barriers to Quality Improvement

More information is becoming available about effective quality improvement models. Investments in information technology may increase patient safety, resulting in cost savings.¹³ Figure 2 shows an example of reduced medication errors following adoption of a computerized physician order entry system in a large teaching hospital. Studies show that across a variety of settings, changes can be implemented that improve patient care.¹⁴ These studies examined the “business case” for quality improvement—defined as whether the organization that invests in quality improvement realizes a financial return.¹⁵ The case studies highlight a key problem in expanding such efforts: Even when the programs lowered overall costs, the providers that invested in implementing changes did not financially benefit from the savings. Based on these and other examples, many have concluded that the “business case” for quality improvement is low.¹⁶

Some providers point to instances in which they are punished, rather than rewarded, for providing high quality care. Incentives often reward those that provide more technologically intensive care relative to preventive care.¹⁷ Under fee-for-service (FFS) incentives, physicians are paid per visit. Thus, a physician group that invests time to develop a diabetes management program that reduces the need for office visits will lose money.¹⁸ Hospitals receive a separate payment for each person who is admitted to the hospital, with higher payments when intensity of treatment increases. Thus, hospitals that implement quality improvement programs to reduce complications that lead to readmissions lose revenue from reduced admissions. In managed care, capitation payments are typically based on average sickness levels across a broad population rather than on sickness of plan enrollees. A health plan will lose money if it is

Figure 2
Preventing Medication Mistakes

Over 80 percent of medication mistakes (other than missed doses) were prevented by a computerized physician order entry system once it was fully developed at a teaching hospital. Medication mistakes that caused patient injury or had the potential to cause injury (and were not intercepted before reaching the patient) were reduced by 86 percent.



Source: Adapted with permission from Bates et al., 1999.

known for having the most extensive network of specialists or an effective program to treat chronically ill patients, resulting in a sicker and more costly group of enrollees.

Varying Approaches to Pay for Performance

Generally, pay for performance refers to a range of policies that reward quality improvement with higher payments.¹⁹ The basic idea is simple: provider payments should reward care that improves health. Linking payment to quality would provide higher reimbursement to providers with improved care or outcomes. Under this approach, providers would have incentives to devise ways to deliver care that results in better health outcomes. For example, a hospital might invest in a computerized order entry system and barcoding to reduce medication errors.²⁰ A large physician group might hire a nurse to help diabetic or hypertensive patients monitor blood glucose levels or blood pressure.

There is no single type of pay for performance; these approaches are taking different forms. Quality can be measured in multiple ways, such as by processes of care, health outcomes, or consumer satisfaction. An example of a process of care is whether diabetics receive blood glucose screenings at appropriate time intervals, while an outcome would be whether blood glucose levels are controlled. Other approaches would provide higher payments to entities that make infrastructure investments, such as implementing electronic medical records systems. Creating new payment categories to

compensate actions that typically cannot be billed for, such as care coordination or time spent on e-mail communication with patients, is another approach.²¹

The decision to reward high levels of quality, improvements in quality, or both raises other issues. Rewarding top performers creates incentives to compete to be in the top category, and is likely to direct resources to providers with initially high quality. Rewarding improvements in quality may offer stronger incentives to lower-performing providers, even if they are less likely to reach the top performing level. In either event, how many providers receive some reward and how much that reward is are issues that must be settled. Because it is not clear yet which approaches will lead to the best results, multiple approaches may be necessary.

Current Efforts

Pay-for-performance programs operated by Integrated Healthcare Association Initiative, the Bridges to Excellence Initiative, and the Leapfrog Group are examples of private-sector efforts under way to reward providers based on their performance. The Integrated Healthcare Association in California began a pay-for-performance initiative in 2002, in which six health plans evaluate and reward performance of their contracting physician groups.²² Bridges to Excellence, a nonprofit organization, has implemented programs that provide rewards to physicians who meet selected care standards in treating patients who work for participating employers.²³

IHA and Bridges to Excellence are part of the \$8.8 million Rewarding Results program. Rewarding Results was established to align financial and nonfinancial incentives toward improved quality, through funding from the Robert Wood Johnson Foundation (RWJF) and the California Healthcare Foundation, with additional funding from The Commonwealth Fund. In September 2002, the Rewarding Results program announced six grants for \$4.9 million, to pilot projects that will run for three years.²⁴ The Agency for Healthcare Research and Quality and RWJF are funding an evaluation of the program.

The Leapfrog Group, an organization focused on improving patient safety, encourages participating employers to reward hospitals that implement three selected hospital safety measures: computer physician order entry, evidence-based hospital referral, and intensive care unit physician staffing.²⁵

The Centers for Medicare and Medicaid Services is conducting a pay-for-performance demonstration project with Premier, Inc., a health care alliance that includes nearly 1,500 hospitals. The 278 participating hospitals report data on 34 measures in five clinical areas: heart attack, heart failure, pneumonia, coronary artery

bypass surgery, and hip and knee replacements.²⁶ Hospitals in the top 10 percent of performance in any of five clinical areas receive a 2 percent bonus. Those in the next 10 percent of performance receive a 1 percent bonus. Demonstration funding totals \$7 million per year, for three years.

Other countries are also linking payments to quality. The United Kingdom has adopted and is working to implement a new general practitioner contract with that includes rewards for delivering quality care.²⁷

Several analyses catalog pay-for-performance efforts.²⁸ A recent review identified 37 programs to reward hospitals and physicians currently under way, based on newspaper and other reports.²⁹ Programs identified in the review focused more on rewarding top performers or all providers that reached a performance goal, with virtually no programs rewarding quality improvement. Very little is known of the effects of current pay-for-performance programs, however.³⁰

Challenges

Pay-for-performance efforts face a number of challenges, including extent of purchasing power, data collection, and selection incentives.³¹ First, efforts by individual purchasers may not have sufficient purchasing power to create meaningful incentives for quality improvement when providers are paid by multiple insurers. The Medicare program has greater purchasing power because it accounts for a greater share of provider revenues, resulting in a strong opportunity for pay-for-performance efforts to affect provider behavior.

Also, data collection efforts may be challenging, in several respects. Lack of standardized reporting measures means that there are multiple sets of performance measures in operation, increasing the amount of data that providers must report, and that purchasers must sort through.³² All data used for payment must be audited to ensure accuracy. Focusing on a select set of quality indicators may shift resources away from other aspects of quality health care, particularly those that are more difficult to measure.

A further challenge is that patient characteristics can affect performance. Some patients may respond better to treatments than others; and some patients may be less likely than others to follow physicians' recommendations. Rewarding care processes and outcomes can create incentives for providers to avoid patients who are sicker, less likely to respond to treatment, or those who are perceived to be less likely to adhere to a treatment regimen.

Quality Changes in Recent Medicare Law

Medicare has the potential to lead in efforts to change payment incentives to reward quality.³³ The new Medicare

legislation signed on December 8, 2003 (P.L. 108-173), includes a number of provisions that address quality improvement and chronic care treatment.³⁴ Select provisions are briefly summarized below.

Payment and Quality

- For each year between 2005 and 2007, payment updates for hospitals under the inpatient prospective payment system will be reduced by 0.4 percentage points if the hospitals do not submit data on 10 quality indicators.³⁵
- The law requires the Institute of Medicine to examine existing performance measures and pay for performance programs, and to identify ways to align performance with payment for Medicare.
- The law requires CMS to operate a "care management performance" demonstration that would provide extra payments to providers that meet established performance goals.

Chronic Care Improvement

- The law requires HHS to implement chronic care improvement programs under fee-for-service Medicare to improve clinical quality and beneficiary satisfaction and to achieve spending targets for Medicare for beneficiaries with certain chronic health conditions. Participation is voluntary.
- The law requires HHS to develop a plan to improve quality of care and to reduce the cost of care for chronically ill Medicare beneficiaries. The plan must use existing data, identify data gaps, develop research initiatives, and propose intervention demonstration programs to provide better health care for chronically ill Medicare beneficiaries.

Safety and Outcomes

- The Medicare law authorizes \$50 million to the Agency for Healthcare Research and Quality for FY 2004 to develop an initial list of research priorities and to conduct research on outcomes of health care services, including prescription drugs. It also requires CMS to conduct Medicare quality demonstration programs to improve safety and outcomes.

Prescription Drug Plans

- The law requires prescription drug plans—the plans that will deliver the Medicare drug benefit to fee-for-service beneficiaries—to have in place efforts to reduce medication errors, and to have medication therapy management programs for individuals with multiple chronic conditions, prescriptions, or high drug costs.

Conclusion

Pay-for-performance attempts to address longstanding quality of care problems by directly rewarding providers for delivering care that promotes patients' health. Questions of whether such approaches will produce intended results are largely unanswered. Recent changes to Medicare law direct new attention to studies and demonstrations of quality improvement efforts, including pay for performance. Policymakers must consider whether to wait for the results of this research or to take further action based on what is already known.

REFERENCES

- ¹ Coye M. 2001. No Toyotas in Health Care: Why Medical Care Has Not Evolved to Meet Patients' Needs. *Health Affairs* 20 (6): 44–56; Leatherman S., Berwick D., Iles D. et al. 2003. The Business Case for Quality: Case Studies and an Analysis. *Health Affairs* 22 (2): 17–30.
- ² U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. *National Healthcare Quality Report*. Prepublication Copy, Rockville, Md. December 2003. Available at: <http://www.qualitytools.ahrq.gov/qualityreport>; Institute of Medicine. 2000. *To Err Is Human: Building a Safer Health System*. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (eds.). Washington, D.C.: National Academies Press; Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academies Press; Davis K. et al. 2002. [Room for Improvement: Patients Report on the Quality of Their Health Care](#). New York: Commonwealth Fund; Cubanski J. and Kline J. 2002. *Improving Health Care Quality: Can Federal Efforts Lead the Way?*; Leatherman S. and McCarthy D. 2002. [Quality of Health Care in the United States: A Chartbook](#). New York: Commonwealth Fund; McGlynn E. et al. 2003. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine* 348 (26): 2635–45.
- ³ McGlynn E., et al. 2003. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine* 348 (26): 2635–45.
- ⁴ Institute of Medicine. 2000. *To Err Is Human: Building a Safer Health System*. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (eds.). Washington, D.C.: National Academies Press.
- ⁵ Boccuti C., Moon M., and Dowling K. 2003. [Chronic Conditions and Disabilities: Trends and Issues for Private Drug Plans](#). New York: Commonwealth Fund.
- ⁶ Partnership for Solutions. 2002. *Chronic Conditions: Making the Case for Ongoing Care*. Chartbook. Baltimore: Johns Hopkins University. Data cited on p. 32; Wolff J.L., Starfield B., and Anderson G. 2002. Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly. *Archives of Internal Medicine* 162: 2269–76.
- ⁷ Berenson R., and Horvath J. Confronting the Barriers to Chronic Care Management in Medicare. *Health Affairs* Web Exclusive W3–37–W3–53.
- ⁸ See <http://www.ncqa.org/Programs/HEDIS>.
- ⁹ See <http://www.ahcpr.gov/qual/cahpfact.htm>.
- ¹⁰ See <http://www.cms.hhs.gov/quality/hospital/TQIFactSheet.pdf>.
- ¹¹ See <http://www.qualityforum.org/txhospGrp1publicweb.pdf>.
- ¹² See <http://www.cms.gov/quality/hospital/HCAHPSqanda3.pdf>.
- ¹³ See, for example, *Patient Safety: Achieving a New Standard for Care*. Aspden P., Corrigan J.M., Wolcott J., and Erickson S.M., eds. Washington, D.C.: National Academies Press; Blumenthal D. How Information Technology Can Improve Health Care Quality: Core Lessons. Alliance for Health Reform/Commonwealth Fund Roundtable. Washington, D.C., November 14, 2003; GAO. Information Technology: Selected Benefits Realized for Health Care Functions. GAO 04–224; Bates D. and Gawande A., 2003. Improving Safety with Information Technology. *New England Journal of Medicine* 348 (25) :2526–34.
- ¹⁴ Leatherman S., Berwick D., Iles D. et al. 2003. The Business Case for Quality: Case Studies and an Analysis. *Health Affairs* 22 (2): 17–30.
- ¹⁵ Ibid.
- ¹⁶ Coye M. 2001. No Toyotas in Health Care: Why Medical Care Has Not Evolved to Meet Patients' Needs. *Health Affairs* 20 (6): 44–56; Leatherman S., Berwick D., Iles D. et al. 2003. The Business Case for Quality: Case Studies and an Analysis. *Health Affairs* 22 (2): 17–30. See also individual case studies, all available from The Commonwealth Fund Web site at: <http://www.cmwf.org/>.
- ¹⁷ Davis K. 2001. President's Message. [The Quality of American Health Care: Can We Do Better?](#) New York: Commonwealth Fund; Cutler D.M. *Your Money or Your Life: Strong Medicine for America's Health Care System*. New York: Oxford University Press.
- ¹⁸ Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academies Press.
- ¹⁹ Cutler D.M. *Your Money or Your Life: Strong Medicine for America's Health Care System*. New York: Oxford University Press; Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academies Press.
- ²⁰ See, for example, *Patient Safety: Achieving a New Standard for Care*. Aspden P., Corrigan J.M., Wolcott J., and Erickson S.M., eds. Washington, D.C.: National Academies Press; Blumenthal D. How Information Technology Can Improve Health Care Quality: Core Lessons. Alliance for Health Reform/Commonwealth Fund Roundtable. Washington, D.C., November 14, 2003; GAO. Information Technology: Selected Benefits Realized for Health Care Functions. GAO 04–224; Bates D. and Gawande A., 2003. Improving Safety with Information Technology. *New England Journal of Medicine* 348 (25): 2526–34.
- ²¹ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C.: National Academies Press.
- ²² See <http://www.iha.org/Ihaproj.htm>.
- ²³ See information available at http://www.bridgestoexcellence.com/bte/bte_overview.htm and http://www.bridgestoexcellence.com/bte/diabetescarelink/gty_physicians.htm#scoring.
- ²⁴ See <http://www.leapfroggroup.org/RewardingResults/index.htm> and <http://www.leapfroggroup.org/RewardingResults/grantees.htm>.
- ²⁵ Rosenthal M., Fernandopulle R., Song H. et al. 2003. Paying for Quality: An Assessment of Recent Efforts to Align Provider Incentives with the Quality Improvement Agenda. Forthcoming, *Health Affairs*.

-
- ²⁶ See <http://www.cms.hhs.gov/quality/hospital/PremierFactSheet.pdf> for overview information and <http://www.cms.hhs.gov/quality/hospital/PremierMeasures.pdf> for a list of quality measures.
- ²⁷ See <http://www.doh.gov.uk/gmscontract/background.htm> and <http://www.nhsconfed.org/gmscontract>.
- ²⁸ For examples of efforts under way, see Maio V., Goldfarb N., Carter C., and Nash D. 2003. *Value-Based Purchasing: A Review of the Literature*. New York: Commonwealth Fund.
- ²⁹ Rosenthal M., Fernandopulle R., Song H. et al. 2003. Paying for Quality: An Assessment of Recent Efforts to Align Provider Incentives with the Quality Improvement Agenda. Forthcoming, *Health Affairs*.
- ³⁰ Maio V., Goldfarb N., Carter C., and Nash D. 2003. *Value-Based Purchasing: A Review of the Literature*. New York: Commonwealth Fund.
- ³¹ Information on challenges draws from Newhouse J. 2002. *Pricing the Priceless*. New York: Oxford University Press; Rosenthal M., Fernandopulle R., Song H. et al. 2003. Paying for Quality: An Assessment of Recent Efforts to Align Provider Incentives with the Quality Improvement Agenda. Forthcoming, *Health Affairs*; McGlynn E. 1997. Six Challenges in Measuring the Quality of Health Care. *Health Affairs* 16 (3): 7–21; Cutler D.M. *Your Money or Your Life: Strong Medicine for America's Health Care System*. New York: Oxford University Press.
- ³² Maio V., Goldfarb N., Carter C., and Nash D. 2003. *Value-Based Purchasing: A Review of the Literature*. New York: Commonwealth Fund.
- ³³ Open Letter. Paying for Performance: Medicare Should Lead. *Health Affairs* 22 (6): 8–10; Institute of Medicine. 2003. *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*. Corrigan J., Eden J., and Smith B., eds. Washington, D.C.: National Academies Press; Institute of Medicine. 2003. *Priority Areas for National Action: Transforming Health Care Quality*. Adams K. and Corrigan J., eds. Washington, D.C.: National Academies Press; Schoenbaum S., Audet A.-M., and Davis K. 2003. *Obtaining Greater Value from Health Care: The Roles of the U.S. Government*. *Health Affairs* 22 (6): 183–90.
- ³⁴ Summary of provisions taken from legislation, available at <http://www.house.gov/medicarerx/hr1-conflegtext.pdf>, and from Congressional Research Service. Overview of the Medicare Prescription Drug and Reform Conference Agreement, H.R. 1. Updated December 4, 2003.
- ³⁵ Hospital quality indicators are those already in use by CMS as a voluntary data collection initiative. See <http://www.cms.gov/quality/hospital/TQIFactSheet.pdf>.

Other Issue Briefs produced for The Commonwealth Fund/John F. Kennedy School of Government 2004 Bipartisan Congressional Health Policy Conference

What's Driving Health Care Costs? Patricia Seliger Keenan

Addressing Unequal Treatment: Disparities in Health Care, Gillian K. SteelFisher

Continuing Policy Issues in Medicare Prescription Drug Coverage, Juliette Cubanski

Is Incremental Change Working? Or Is It Time to Reconsider Universal Coverage? Juliette Cubanski

Trends in Mental Health Care, Colleen L. Barry

The Obesity Epidemic in the United States: Causes and Extent, Risks and Solutions, Erin Strumpf

The Commonwealth Fund is a private foundation supporting independent research on health and social issues. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff.

