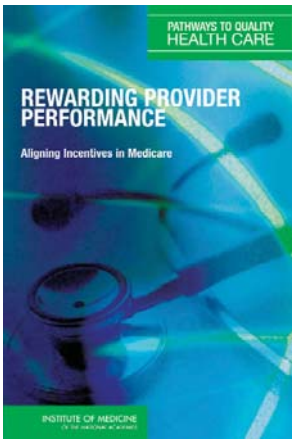
REPORT BRIEF • SEPTEMBER 2006

# Rewarding Provider Performance: Aligning Incentives in Medicare




The health of senior citizens in the United States is not as good as it should be, given the billions of dollars spent on health care each year. This raises concerns that Medicare is not getting the best value for the services it purchases. Medicare's current payment system places no emphasis on whether the care delivered is of high or low clinical quality or is appropriate. The system provides few disincentives for overuse of often high cost medical services and does little to encourage coordinated, preventive, and primary care that could save money and produce better health outcomes.

The Medicare payment system needs to align its incentives to ensure that care meets professionally recommended quality standards, is centered on individual patients' needs, and is delivered efficiently. Pay-for-performance incentives, which reward providers for delivering high quality care, could speed the process of implementing best practices. The Institute of Medicine's study, *Rewarding Provider Performance: Aligning Incentives in Medicare*, is the third report in a series of studies requested by Congress and sponsored by the Centers for Medicare and Medicaid Services on accelerating the pace of quality improvement. Previous reports recommend specific measures for public reporting of health care provider performance and ways to strengthen Medicare's Quality Improvement Organizations' technical assistance function so all providers are ready to deliver the best quality care.

**Medicare needs to revise its incentives to promote both better health and better value.**

## FOSTERING HIGH PERFORMANCE THROUGH PAYMENT INCENTIVES

The current payment system creates many incentives for a high volume of services, yet few for better health. Pay for performance is one mechanism that can help transform the payment system into one that rewards both higher value and better outcomes. However, care must be given to the design of a pay-for-performance system because it could influence far more than just payment rates. This design should:

- encourage the most rapid, feasible performance improvement by all providers,
- support innovative change throughout the health care system, and
- promote better outcomes of care, especially through coordination of care.

Figure 1 (page 2) outlines some of the major design principles to be considered in the development of a pay-for-performance system.

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

*Advising the Nation. Improving Health.*

## SELECTING PERFORMANCE MEASURES FOR ALL PROVIDERS

**Pay-for-performance measures should shift rewards from service use to patient outcomes.**

While efforts to develop measures that will provide more comprehensive assessments of provider and system performance should continue, an adequate set of starter measures is now available, as delineated in the first report of this series, *Performance Measurement: Accelerating Improvement*.

Initially, performance measures that relate to Medicare's spending patterns within each care setting should be emphasized. For example, 61% of payments under the physician fee schedule are associated with the 32% of Medicare patients who have the following conditions: chronic heart failure, coronary artery disease, diabetes, or a combination of the three.

**FIGURE 1. Design Principles for Pay for Performance and its Implementation**

- Use performance measures that reliably define good care and optimal health outcomes.
- Reward care that is of high clinical quality, patient-centered, and efficient.
- Reward significant provider improvement as well as achievement of excellence.
- Foster care coordination among providers.
- Reward data collection and reporting functions and encourage adoption of improved information technologies.
- Report provider achievement in ways that are both meaningful and understandable to consumers.
- Develop performance measures and structure rewards to maximize participation of all providers over time.
- Be fiscally responsible.
- Implement in deliberately planned phases, evaluate progress, and learn from experience in each phase.

## ENSURING COORDINATION OF CARE AMONG PROVIDERS

**Care coordination is needed. Medicare beneficiaries see, on average, five physicians a year; those with chronic heart failure, coronary artery disease, and diabetes see an average of 13.**

The health care Medicare beneficiaries receive is often fragmented as patients move among different physicians and across different care settings (e.g., hospital to home care). As a result, patients do not always receive timely care best suited to their needs. Fragmentation is reinforced by the failure of the current payment system to recognize and pay for care coordination.

Pay-for-performance mechanisms should recognize, promote, and reward improved coordination of care among a patient's multiple providers and during entire episodes of illness. Beneficiaries and their providers need to work together to identify an accountable caregiver who could be rewarded for successful coordination of a patient's care.

## COLLECTING AND REPORTING PERFORMANCE INFORMATION PUBLICLY

The pay-for-performance system should offer incentives to providers to collect and submit data, thus allowing assessment of how they are performing compared to their peers and to professionally recommended standards of care. Public reporting can powerfully motivate improved provider behavior and give consumers information on which to base their decisions.

Pay-for-performance rewards should make it more attractive for providers to invest in systems that help track quality of care more quickly and consistently. Because only about one-third of physicians currently use electronic health records in their practices, however, pay for performance cannot be contingent on advanced information technologies being available in each provider setting.

**Public reporting is integral to improving performance.**

## ENSURING PARTICIPATION BY ALL PROVIDERS AS SOON AS POSSIBLE

It will be more difficult to implement pay for performance in some provider settings than in others. For many institutional settings, pay for performance can and should begin immediately. For physicians, a voluntary approach should be pursued initially, relying on financial incentives sufficient to ensure broad participation. The initial set of measures and the pace of expanding required measures will need to be sensitive to the operational challenges confronted by providers in small practices.

Within three years, the Secretary of the U.S. Department of Health and Human Services should determine whether progress toward universal participation by physicians is sufficient under the voluntary approach or whether stronger actions—such as mandating provider participation—are required.

## USING EXISTING SOURCES OF REVENUE FOR REWARDS

Funding might be obtained from existing funds, generated savings, or new investments. Over the next three to five years, funding for a pay-for-performance program should largely come from existing funds, with provider-specific pools derived from reductions in Medicare's base payments. Once feasible, the separate pools should be consolidated into one pool to be distributed to all qualified providers.

**Better quality can be obtained at a sustainable and socially acceptable cost.**

Provider reward pools must be large enough to create adequate motivation for improvement, yet be at least budget conscious. New investment dollars may be necessary to create adequate resources to effect change for certain provider groups. The feasibility of using additional funding sources, such as those realized from improved efficiency, should be evaluated.

## PHASING IN IMPLEMENTATION WITHIN A LEARNING SYSTEM

The committee proposes phasing in Medicare's pay-for-performance program within a learning system that has the capacity to monitor and assess early experiences, adjust for unintended consequences, and evaluate impact. The phased implementation recognizes the need to improve health system quality as soon as possible, but at the same time, to derive insights from each stage for ongoing improvement.

## REFORMING PAYMENT SYSTEMS OVER TIME

Pay for performance constitutes one key component needed for the transformation of the health care payment system, but cannot achieve this transformation alone. Pay for performance appears, however, to offer significant promise and Medicare can begin now by building off other strategies for improvement such as public reporting of performance measures and technical assistance.

The implication of this report goes well beyond Medicare and its beneficiaries. The Medicare program should encourage and coordinate with other purchasers' and payers' similar efforts to raise the quality of care all Americans receive.

## FOR MORE INFORMATION...

Copies of *Rewarding Provider Performance: Aligning Incentives in Medicare* are available from the National Academies Press, 500 Fifth Street, N.W., Lockbox 285, Washington, DC 20055; (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area); Internet, http://www.nap.edu. The full text of this report is available at http://www.nap.edu.

This study was supported by funds from the U.S. Department of Health and Human Services through the Centers for Medicare and Medicaid Services. Any opinions, findings, conclusions, or recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the organizations or agencies that provided support for the project.

The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public. For more information about the Institute of Medicine, visit the IOM home page at www.iom.edu.



## COMMITTEE ON REDESIGNING HEALTH INSURANCE PERFORMANCE MEASURES, PAYMENT, AND PERFORMANCE IMPROVEMENT PROGRAMS

**STEVEN A. SCHROEDER (Chair),** Distinguished Professor of Health and Health Care, University of California, San Francisco, CA; **BOBBIE BERKOWITZ,** Alumni Endowed Professor of Nursing, Psychosocial and Community Health, University of Washington, Seattle, WA; **DONALD M. BERWICK,** President and Chief Executive Officer, Institute for Healthcare Improvement, Cambridge, MA; **BRUCE E. BRADLEY,** Director Health Care Plan Strategy and Public Policy, Health Care Initiatives, General Motors Corporation, Pontiac, MI; **JANET M. CORRIGAN,** President and Chief Executive Officer, National Quality Forum, Washington, DC; **KAREN DAVIS,** President, The Commonwealth Fund, New York, NY; **NANCY-ANN MIN DEPARLE,** Senior Advisor, JPMorgan Partners, LLC, Washington, DC; **ELLIOTT S. FISHER,** Professor of Medicine and Community Family Medicine, Dartmouth Medical School, Hanover, NH; **RICHARD G. FRANK,** Margaret T. Morris Professor of Health Economics, Harvard Medical School, Boston, MA; **ROBERT S. GALVIN,** Director, Global Health Care, General Electric Company, Fairfield, CT; **DAVID H. GUSTAFSON,** Research Professor of Industrial Engineering, University of Wisconsin, Madison, WI; **MARY ANNE KODA-KIMBLE,** Professor and Dean, School of Pharmacy, University of California, San Francisco, CA; **ALAN R. NELSON,** Special Advisor to the Executive Vice President, American College of Physicians, Fairfax, VA; **NORMAN C. PAYSON,** President, NCP, Inc., Concord, NH; **WILLIAM A. PECK,** Director, Center for Health Policy, Washington University School of Medicine, St. Louis, MO; **NEIL R. POWE,** Professor of Medicine, Epidemiology and Health Policyand Management, Johns Hopkins University School of Medicine and Johns Hopkins Bloomberg School of Public Health, Baltimore, MD; **CHRISTOPHER QUERAM,** President and Chief Executive Officer, Wisconsin Collaborative for Healthcare Quality, Madison, WI; **ROBERT D. REISCHAUER,** President, The Urban Institute, Washington, DC; **WILLIAM C. RICHARDSON,** President Emeritus, Johns Hopkins University and W.K. Kellogg Foundation, Hickory Corners, MI; **CHERYL M. SCOTT,** Chief Operating Officer, Bill and Melinda Gates Foundation, Seattle, WA; **STEPHEN M. SHORTELL,** Blue Cross of California Distinguished Professor of Health Policy and Management and Dean, School of Public Health, University of California Berkeley, CA; **SAMUEL O. THIER,** Professor of Medicine and Professor of Health Care Policy, Harvard Medical School, Massachusetts General Hospital, Boston, MA; **GAIL R. WILENSKY,** Senior Fellow, Project HOPE, Bethesda, MD

## STUDY STAFF

**ROSEMARY A. CHALK,** Project Director; **KAREN ADAMS,** Senior Program Officer, Lead Staff for the Subcommittee on Performance Measurement Evaluation; **DIANNE MILLER WOLMAN,** Senior Program Officer, Lead Staff on Quality Improvement Organization Program Evaluation; **TRACY HARRIS,** Program Officer; **SAMANTHA CHAO,** Senior Health Policy Associate; **DANITZA VALDIVIA,** Program Associate; **MICHELLE BAZEMORE,** Senior Program Assistant