
NHPF Forum Session
Meeting Announcement

**NATIONAL
HEALTH
POLICY
FORUM**

**Paying for Performance in Health
Care: Getting a Better Deal?**

A DISCUSSION FEATURING:

Thomas H. Lee, MD
Network President
Partners Healthcare System,
Boston

Mark E. Miller, PhD
Executive Director
Medicare Payment Advisory
Commission

Robert Galvin, MD
Director of Global Health Care
General Electric

**Friday,
July 9, 2004**

11:45 am — *Lunch*

12:15–2:00 pm — *Discussion*

**Reserve Officers Association
of the United States**

Congressional Hall of Honor—
Fifth Floor
(Across from the Dirksen Senate
Office Building)

To register:

Please call Tiombé Diggs at
202/872-1392 as soon as
possible. Space is limited.

**For additional information
on this topic:**

See “Paying Physicians for
High-Quality Care”; available
at [http://content.nejm.org/cgi/
content/full/350/4/406?ijkey=
oWgVRge.MbxA&keytype=
ref&siteid=nejm](http://content.nejm.org/cgi/content/full/350/4/406?ijkey=/oWgVRge.MbxA&keytype=ref&siteid=nejm).

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Paying for Performance in Health Care: Getting a Better Deal?

Paying for quality is not a novel concept, as Rolex or Porsche purveyors might attest. Even in medicine, an eminent specialist may command fees beyond those of a neighborhood general practice physician, at least partly on the basis of perceived quality. For some time, health plans have used payment policy to influence provider behavior, often with the aim of controlling service volume. Only recently has payment been wielded as a strategy aimed at improving clinical outcomes and population health. With a goal of increasing the value of the health care dollar, performance incentive programs for physicians are now being tested across the country.

Cost and quality themes converge in the pay-for-performance approach to health care management. Discussion of clinical quality has waxed over the past several years, and the ability to measure it—at least for some conditions and procedures, where an evidence base exists—has improved. During the same period, unpopular managed-care cost-containment strategies were overthrown in much of the country. As networks broadened and utilization controls were relaxed, premium increases began to climb. Some employers and health plans, seeking to boost quality and to check costs, have experimented with linking the two objectives through performance incentives.

The “business case” for quality is anchored in a belief that high-quality care means more efficient care. Providing the right care in the right setting at the right time obviates duplication, error, and unnecessary

SESSION OVERVIEW

This meeting will examine the idea of rewarding physicians and other health care providers for delivering health care services that meet specified standards or achieve defined levels of quality. Speakers will review the issues involved in designing incentives, encouraging provider participation, and measuring performance. The strategies and attainments of the private-sector initiative Bridges to Excellence will be discussed, as will recent recommendations by the Medicare Payment Advisory Commission to link payment and quality in Medicare.

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services, thus saving money—or so the theory goes. In practice, there has been little success to date in documenting such savings. Other proponents of performance incentive strategies suggest that paying more for better care has a chance of narrowing practice variation and improving health outcomes across a population, thus giving health plans and plan sponsors better value for their health care dollar.

While pay-for-performance conceptually applies across a variety of care settings and levels, private sector initiatives often focus on the physician or physician group—and often meet a discernable lack of enthusiasm. Some of the difficulties physicians point to are purely practical; for example, some fear that quality data might be used as evidence in malpractice actions. The additional staff or personal time necessary to report quality data is viewed by many as a burden.

Other objections relate more to professionalism and autonomy. Physicians as a class bristle at the inference that “a professional paid 2x will perform significantly better than if he is paid x.”¹ An American Medical Association Board member, stating in a recent article that “[e]very physician knows that he or she would not even consider practicing anything but the best or highest quality of medicine possible,” explained that linking compensation and quality could only be a “scam” designed to “reduce payments to the vast majority of physicians.”² The corresponding view from the payer side might be, why pay someone extra to do what he or she is supposed to do in the first place?

Yet some physicians do participate in pay-for-performance programs, by choice as well as by mandate. The number of patients in a physician’s practice who would be involved in a particular program is clearly a factor. Other determinants of willingness seem to be the magnitude of the incentive offered, the degree to which conflicting quality metrics are imposed by different health plans or payers, and the degree to which perceived autonomy can be preserved. (A comment that could serve as a refrain is, “Just tell me the outcome you want. Don’t tell me how to get there.”) Analysts have also pointed out that, in order to be effective in changing behavior, performance incentives must be congruent with basic compensation policy; that is, if the bulk of a physician’s compensation rests on doing procedures, a marginal incentive to emphasize prevention is unlikely to have much impact.

Varying strategies have been used to gain provider cooperation, including the following:

- A common approach is an incentive to adhere to defined clinical guidelines or attain a target score on defined quality measures, sometimes in combination with reaching certain levels of patient satisfaction. Such programs are likely to be instituted

across a network rather than being voluntary. For example, Independence Blue Cross's **Practice Quality Assessment Score** offers physicians a payment premium for achieving target scores based on member satisfaction and clinical guidelines derived from HEDIS (Health Plan Employer Data and Information Set) measures.

■ **Bridges to Excellence (BTE)**, spearheaded by General Electric, actively woos physician participation for its three components, Diabetes Care Link, Cardiac Care Link, and Physician Office Link. BTE coordinators solicit the support of physician opinion leaders in the communities where the program operates. In Diabetes Care Link, physicians are required to qualify for participation on the basis of patient volume (specifically, patients employed by a BTE employer, or their family members) and then to demonstrate superior performance on the basis of measures developed by the American Diabetes Association and administered by the National Committee for Quality Assurance. Those who succeed receive bonuses of \$100 per eligible diabetes patient. Participating employers let their employees know which physicians have been recognized as high-quality providers. Cardiac Care Link is similar, whereas Physician Office Link rewards the implementation of specific processes to reduce error and improve quality in daily practice.

■ California's Integrated Health Association (IHA) sponsors **Pay for Performance**, under which six of the state's largest health plans use a common set of performance measures to evaluate and reward physician groups under their own plan-designed pay-for-performance programs. All plans will implement a quality scorecard comprising clinical quality, patient satisfaction, and information technology investment. IHA has estimated that approximately \$100 million will be available for bonus awards, the first distribution of which will occur in late 2004.

■ Empire Blue Cross and Blue Shield, in partnership with four of its national accounts (IBM, PepsiCo, Verizon, and Xerox), established an incentive program that offers payment to hospitals in New York City and the eastern part of New York for being early adopters of two measures championed by the Leapfrog Group: use of computerized physician order entry systems and use of "intensivist" specialists in critical and intensive care units. Payments, based on the volume of patient-employees treated in a particular institution, amounted to \$195,000 distributed among 29 hospitals in 2003.

■ The Centers for Medicare and Medicaid Services in 2003 launched the **Premier Hospital Quality Incentive Demonstration**, a three-year project to reward participating hospitals that demonstrate high-quality performance in specified aspects of acute care with higher payments for Medicare patients. Hospitals

in the top-performing decile for a given diagnosis will receive a 2 percent bonus and the next-best decile will receive 1 percent, for an expected total of about \$21 million over three years. In year three, hospitals in the two lowest-performing deciles will receive diminished diagnosis-related group (DRG) payments.

Other Medicare demonstrations also have pay-for-performance elements. The Medicare Payment Advisory Commission (MedPAC) has recommended that payment be linked to quality in Medicare.³ The Commission's March 2004 report to Congress suggested that Medicare, as a first step, base a portion of payment on performance for Medicare Advantage plans and dialysis physicians and facilities.

This forum session will look at the theory and practice of pay-for-performance programs. **Thomas H. Lee, MD**, co-author of a pay-for-performance analysis that appeared in the *New England Journal of Medicine* earlier this year,⁴ will discuss the promises and challenges of this strategy and highlight some lessons learned along the way. Lee is an internist and cardiologist who is network president for Partners Healthcare System in Boston, bringing both provider and payer perspectives to his consideration of paying for quality. **Robert Galvin, MD**, director of global health care for General Electric, will give an update on the design, objectives, and progress of Bridges to Excellence. **Mark Miller, PhD**, executive director of the MedPac, will review the Commission's recent recommendations to link quality and payment in Medicare.

KEY QUESTIONS

- Should rewards be based on an absolute or percentage improvement in performance? What are the advantages and disadvantages to each approach? Are assessments typically based on clinical outcomes, physician adherence to evidence-based guidelines, or other criteria?
- Do current programs rely on physicians to report the quality information or is analysis based on data available through claims?
- To whom should performance scores or ratings be reported? At what point does public disclosure to consumers become feasible and advisable?
- In constructing performance incentives, is there a place for the stick as well as the carrot?
- What is the role of consumers in the evolution of payment for quality?
- Does pay-for-performance contracting have the potential to address what some experts have estimated as the 30 percent waste in the health care system?

- To what extent are performance incentive plans able to build in a mechanism to evolve with clinical evidence, new technology, and new practice patterns?
- Are private sector models applicable in the Medicare context?

ENDNOTES

1. Bruce Vladeck, "If Paying for Quality Is Such a Bad Idea, Why Is Everyone For It?" *Washington and Lee Law Review*, 60, no. 4 (Fall 2003): 1371.
2. William G. Plested III, "Fair Pay a Sounder Approach than 'Pay for Quality,'" *American Medical News* (March 1, 2004): 21.
3. Medicare Payment Advisory Commission, "Using incentives to improve the quality of care in Medicare," chap. 7 of *Report to the Congress: Variation and Innovation in Medicare*, June 2003; available at http://www.medpac.gov/publications/congressional_reports/June03_Ch7.pdf.
4. Arnold M. Epstein, Thomas H. Lee, and Mary Beth Hamel, "Paying Physicians for High-Quality Care," *New England Journal of Medicine*, 350 (January 22, 2004): 406; available at <http://content.nejm.org/cgi/content/full/350/4/406?ijkey=/oWgVRge.MbxA&keytype=ref&siteid=nejm>.