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Rick Mayes
University of Richmond, bmayes@richmond.edu

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Rick Mayes

Abstract

"Pay for performance," a reimbursement method under which some physicians and hospitals are paid more than others for the same services because they have been deemed to deliver better quality care and their patients appear to have better outcomes, is enormously controversial. Disputes invariably arise over how "quality" should (or even can) be measured. Nevertheless, differentiating between medical providers, financially, lies at the heart of this new reimbursement innovation developed by insurance companies and employers. Its two main objectives are: (1) to increase the overall quality of health care that patients receive, and (2) to encourage behavioral change on the part of physicians and hospitals that leads to increased efficiency. This article attempts to explain where the momentum for "pay for performance" reimbursement has come from, why its advocates consider it an improvement upon existing payment systems, and how it can both positively and negatively affect medical providers.

The majority of health care spending in the U.S., argues health economist David Cutler, is good. Rather than pay less, he maintains that we as a nation should pay for more medical care, albeit wisely.[1] Unfortunately, getting additional value from increased medical spending is difficult under the current models of reimbursement. The three worst payment mechanisms for rewarding quality and performance, jokes health economist Jamie Robinson, are: (a) fee-for-service, (b) capitation, and (c) salary.[2] What all three of these models have in common is that, financially, they generally treat most physicians and hospitals the same regardless of their patients' outcomes.[3] "Pay for performance," then, is principally an effort by a growing number of employers and insurers to find new ways to pay medical providers that increases the value and quality of the health care that they purchase, as well as the efficiency with which it is provided.[4] Two landmark reports by the Institute of Medicine [IOM]—*To Err is Human* (2000) and *Crossing the Quality Chasm* (2001)—put health care quality and patient safety issues squarely on the public policy agenda.[5] The 2000 report estimated that as many as 98,000 patients die annually in U.S. hospitals due to preventable medical errors. The statistic was made more visceral when the report's authors noted that this was equivalent to a 300-passenger airplane crashing almost daily in the U.S.[6]

The IOM reports raised the profile of an initiative closely related to "pay for performance" reimbursement, which goes far beyond just improving hospital safety. It is critical for medical providers to understand what this initiative is and how accumulating evidence over the last three decades have shaped its development. The initiative is to reduce *unwarranted* geographic variation in both the volume and variety of medical care provided, while at the same time increasing the kinds of care that clearly work and improve patients' health.[7]

Economic & Epidemiological Origins

Key to understanding why efforts to reduce unwarranted medical variation and "pay for performance" reimbursement are closely inter-connected is to recognize that there is no one single American health care system. There are, instead, hundreds of regional health care systems across the country; and each one has its own unique approache to patient care and medical spending. Where you live has a significant effect on which (and how many) physicians you see, how many days you spend in the hospital (if any), and what drugs you are (or are not) prescribed.[8] The realization of this fact, like so many other discoveries in the field of medicine, had a serendipitous quality to it. In rural Vermont in the early 1970s, a Dartmouth physician by the name of John Wennberg discovered a medical peculiarity. In a very homogenous part of the country, doctors in two nearby towns with similar characteristics appeared to have adopted wildly different practice styles. In one town, 70 percent of the children had had their tonsils removed by age 12; in the other, the figure was only 20 percent.[9]

Intrigued, Wennberg and many of his colleagues at Dartmouth and elsewhere have spent the better part of the last three decades documenting similarly dramatic geographic variations in far more serious cases: mastectomies, coronary-bypass surgeries, and radical prostatectomies, to name a few.[10] Other "small-area large-variation" studies have found that the number of cesarean sections is often much higher in low birth-rate counties than in high birth-rate counties, even after controlling for a variety of factors (such as differences in local prices or rates of illness) that could explain this disparity.[11] Medicare administrators have discovered that the program pays twice as much per patient in Miami as it does in Minneapolis, yet the Miami patients do not live longer than the Minneapolis patients, nor are they healthier.[12]

Researchers and insurers have deduced two things from these and other similar findings. First, physician practice styles are often influenced nearly as much by local factors—such as collaboration, referral and the number of competitors—as they are by what medical treatments have been scientifically validated ("evidence-based").[13] And, second, when it comes to medicine, supply generally creates its own demand, which runs counter to the ordinary competitive forces in our economy.[14] In short, the substantial differences in health care spending that exist across the country are disproportionately related to the number of specialists, hospital beds and technology available.[15]

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While most physicians exemplify the professional and altruistic virtues that the general public both expects and deeply admires, they are also humans who respond rationally to existing financial incentives.[16] Moreover, they usually have significant medical education debt, at least early in their careers, and/or sizeable practice expenses that they must finance.[17] Therefore, if an area of the country has many specialists, patients tend to see them more often.[18] If hospitals in an area have a surplus of beds, more patients invariably tend to spend more time in them.[19] There are so many Medicare patients in New York City and parts of Florida, for example, that doctors (particularly specialists) have always had a strong incentive to locate there.[20] Once established in these types of locations, they would be going against their own self-interest if they did not try to keep themselves busy. Essentially, supply creates its own demand, because physicians are rational economic agents and—given the structure of current healthcare financing—they ordinarily act rationally to maximize their revenue.[21] And ensuring that patients receive properly integrated and managed care with an abundance of proven preventative care is ordinarily not lucrative for medical providers in terms of their reimbursement from private or public payers (health insurers, Medicare, Medicaid).[22]

In an effort to improve patient outcomes, "pay for performance" schemes often try to increase the amount of high quality preventative care.[23] Ten to twenty years ago, there was no widely agreed-upon methodology for measuring the quality of health care.[24] It used to be assumed that differences among hospitals or doctors in a particular specialty were generally insignificant.[25] If one plotted a graph showing the patient outcomes of all the centers that treated diabetes or heart disease—or most any other condition for that matter—people expected that the curve would look something like a *shark fin*, with most places clustered around the very best patient outcomes.[26] But mounting evidence has begun to indicate otherwise. What one tends to find instead is a *bell curve*: a number of medical providers with shockingly poor outcomes for their patients, a roughly equal number on the other side of the curve with extraordinarily good results, and a large "average" middle.[27]

The growing ability to measure patients' outcomes, and the subsequent discovery that they vary more than previously assumed, has contributed to the popularity of "pay for performance" reimbursement because it would allow health plans and employers to do three things simultaneously: (a) pay more to medical providers with the best patient outcomes, (b) encourage the majority of medical providers with average outcomes to find ways of improving, and (c) pay less to medical providers with the worst patient outcomes—or perhaps not pay them at all. If publishing K-12 educational test scores and "on-time arrival" statistics is considered a good idea for encouraging local schools and airlines to improve their performance, the argument goes, how bad of an idea could it be for medical providers?

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Policy and Legal Implications

"Pay for performance" could be problematic for a couple of reasons, observers contend, particularly for small physician practices and hospitals.[28] First, it could encourage *gaming* on the part of hospitals and physicians, whereby they consciously or unconsciously favor taking healthier, more educated and affluent patients with the highest probability of successful outcomes.[29] Under this "rich get richer, while the poor get poorer" scenario, "pay for performance" might unfairly penalize physicians who care for sicker and less affluent patients.[30] Donald Berwick, founder of the Institute for Healthcare Improvement and one of the leading voices for raising standards of medical quality, supports performance-based models for hospitals and health systems, but he is skeptical of their value at the individual physician-level.[31] Second, many older patients have multiple chronic conditions with different clinical practice guidelines [CPGs], which complicates assigning them to any one "pay for performance" quality or outcome-based measure.[32]

Fortunately for hospitals, physicians, and practice managers, existing "pay for performance" models tend to only pay more for the best providers: all those either above a specific threshold or percentile ranking in terms of their patients' care and outcomes.[33] They currently do not single out any specific minority of providers for lower payment. Furthermore, physicians and hospitals that already meet a standard (e.g., an 80 percent childhood immunization rate or a 100 percent administration of aspirin to patients who present with myocardial infarction), usually need only maintain their status quo to receive performance-related bonus payments.[34] Finally, the percent of a physician's overall revenue that is at stake is rarely more than 10 percent, which can complicate matters because any stake less than 10 percent is seldom worth medical providers' time and effort. Again, though, current "pay for performance" models are not intended to punish physicians, but rather to change existing payment incentives and encourage redesigned systems and large investments in IT (e.g., electronic medical records). So for physicians and hospitals already looking for extra capital to make these investments, "pay for performance" may present a one-time opportunity to have someone else finance it.

The legal underpinnings of existing "pay for performance" programs are similar to those of the predominant financial contracts that determine risks and rewards between medical providers and medical purchasers (employers and health plans). The most common programs provide a pure bonus to those providers that meet performance targets.[35] Some "pay for performance" programs, however, are more aggressive and withhold—thereby putting at risk—a proportion of contracted payments to medical providers unless they meet performance targets.[36] Key to the design and implementation of any "pay for performance" program is health plans' contractual bargaining with medical providers over performance or quality criteria and bonus structures. The U.S. Department of Justice and the Federal Trade Commission regulate the extent to which physicians and hospitals can form networks to collectively bargain with health plans without violating U.S. antitrust laws.[37] Yet these regulations, which allow providers to form networks as long as they represent no more than approximately a quarter of all the providers in their relevant geographic market, only provide protection from federal investigation.[38] Private parties and state regulators are free to initiate their own antitrust claims.

The prevalence of "pay for performance" reimbursement is growing,[39] largely as a result of employers' intense efforts to limit their health care cost inflation.[40] Most of the areas that it targets are primary care and, thus, are likely to improve patient outcomes,[41] although early experience with "pay for performance" has been less than impressive in terms of dramatically improving health care quality.[42] The majority of measures that "pay for performance" models use to determine bonus payments target the *under*use of care. As a result, when adopted, they usually increase health spending.[43] "Pay for performance" also appears to be well-suited for treating patients with chronic conditions, such as diabetes, heart disease, and hypertension.[44] As a dominant reimbursement model, though, it is still years away.

Yet if Medicare eventually shifts the bulk of its reimbursement to various forms of "pay for performance," as many of its current leaders want to do,[45] the medical landscape would change rapidly. Medicare is the "800-pound gorilla" of American medicine. When it moves, virtually all other stakeholders in the U.S. health care system are forced to adjust their behavior to varying degrees.[46] Several senior Medicare officials are particularly enthusiastic about "pay for performance," because upwards of 80 percent of the program's beneficiaries have at least 1 chronic condition, and 30 percent have 4 or more. The latter group drives almost 80 percent of Medicare's total spending.[47] Any new reimbursement system that can improve the health of these patients with multiple chronic conditions creates the potential for significant cost savings. Medicare is currently experimenting with a number of hospitals that have voluntarily agreed to participate in a program that rewards top performing hospitals by increasing their payment for Medicare patients.[48]

Ultimately, the medical community should prepare to play a very proactive role in determining precisely how "performance" and "quality" will be measured and, thus, how this new form of reimbursement can best improve both patient safety and health care delivery (not health plans' financial well-being). It is an old cliché, but when it comes to "pay for performance" reimbursement, the "devil will most certainly be in the details."

Rick Mayes, Assistant Professor of Public Policy, University of Richmond, Richmond, Virginia, and Faculty Research Fellow, Petris Center on Healthcare Markets, University of California Berkeley School of Public Health.

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