
A Lesson in Pay for Performance

Joanne Kaldy

Few concepts in recent years have generated as much conversation and controversy as pay for performance. Lauded by legislators and insurers and raising questions by physicians and other practitioners, pay for performance has been implemented in a variety of settings and pilot programs. Yet, many people still don't really understand pay for performance, what it is, and what it means to health care practitioners and patients. By taking a closer look at the basic issues surrounding pay for performance, physicians and others can have a better understanding of what this concept means to them and how it will impact their patients and practices in the months and years ahead.

Defining Pay for Performance

The term “pay for performance” generally is used to describe incentive programs that provide financial bonuses or rewards to physician groups or other entities (such as hospitals or health plans) that achieve or meet specific quality and/or efficiency benchmarks set by a particular program (such as Medicare).

Broadly, pay for performance programs are designed to reward quality by creating financial incentives that promote excellent patient care and structural change. Pay for performance also aims to encourage physicians to broaden their delivery of patient care beyond office visits. Proponents of the concept suggest that health care will improve and costs will go down as quality increases.

According to the American Medical Association (AMA), pay for performance has 2 core requirements. It:

- employs a common set of metrics to measure physician group performance, and
- commits significant funding to reward this performance.

The majority of physician pay for performance programs are sponsored by major health plans that have a substantial market share. However, some large employer groups/coalitions have begun to offer incentives directly to the physicians who care for their employees. Additionally, some physician groups have implemented their own pay for performance programs.

Pay for performance bonuses tend to be fairly modest. They generally amount to about 1% to 5%

of the physician practice's total revenue from a particular health plan.

Origins of Pay for Performance

Pay for performance is part of the “health care quality movement” that has evolved in recent years as efforts to contain costs led to concerns about the quality of care and outcomes of interventions and treatments. Several issues drive the move toward pay for performance:

- current reimbursement systems do not effectively or consistently reward quality or performance;
- performance report cards generally focus on health plans and not providers; and
- individual health plans often issue their own report cards, resulting in mixed messages, inconsistent data, and confusion for patients and others.

The Pacific Business Group on Health (PBGH) first attempted to launch a pay for performance-type initiative back in 1998. However, the concept was still too new and the program failed. Two years later, the Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*, suggested that accountability had a key role in promoting quality and safety.¹ This concept evolved into a more

widely accepted version of pay for performance, and the first pilots began appearing sporadically.

In September 2001, the Integrated Healthcare Association (IHA) convinced 6 major California health plans—Aetna, Blue Cross of California, Blue Shield of California, CIGNA, Health Net, and PacifiCare—to support a common set of performance measures for physician groups and financial incentives based on the set performance measures. Also in 2001, the IOM released its report, *Crossing the Quality Chasm, A New Health System for the 21st Century*, which stated:

“Even among health professionals motivated to provide the best care possible, the structure of payment incentives may not facilitate the actions needed to systematically improve the quality of care, and may even prevent such actions. For example, re-designing care processes to improve follow-up for chronically ill patients through electronic communication may reduce office visits and decrease revenues for a medical group under some payment methods. Current payment policies are complex and contradictory, and although incremental improvements are possible, more fundamental reform will be needed over the long run. The goal of any payment method should be to reward high-quality care and to permit the development of more effective ways of delivering care to improve the value obtained for the resources expended.”²²

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Created in response to the *Crossing the Quality Chasm, A New Health System for the 21st Century* report, Bridges to Excellence (BTE) encouraged more patient involvement in pay for performance efforts. The organization, a nonprofit group involving employers, providers, and health plans, recommended a redesign of the way providers are paid that encourages quality improvement. Bridges to Excellence also has developed several pay for performance programs in collaboration with the National Coalition on Quality Assurance (NCQA), which pay physicians’ offices up to \$50 per year for each patient covered by a participating employer or plan.

More recently, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress establish a quality-incentive payment policy for Medicare physicians. The Commission made

several specific recommendations geared toward establishing a pay for performance system across health care settings and systems. These recommendations included using information technology in Medicare initiatives to reward physicians financially on the basis of quality.

At the same time, members of the Practicing Physicians Advisory Council (PPAC) have urged the Centers for Medicare and Medicaid Services (CMS) to exercise caution in any efforts to promote pay for performance. Nonetheless, CMS is making plans to implement pay for performance into physician reimbursement, and the agency has begun demonstration projects with hospital and physician practices. In fact, last January, the agency announced a 3-year pay for performance pilot project, involving 10 large physician practices.

Under the pilot program, CMS will continue to pay physicians on a fee for performance basis, but the agency will add payments based on quality and outcome measures for patients with certain chronic illnesses, such as congestive heart failure, coronary artery disease, diabetes, and hypertension. At the same time, CMS will look at physician practices’ use of preventive interventions, such as influenza vaccinations, and preventive measures to limit or prevent complications in patients with chronic illnesses.

At the local level, states such as Connecticut, Florida, Kentucky, North Carolina, Tennessee, Texas, and Michigan have enacted or are considering legislation creating programs to study quality or promote

best-practice measures. Although these don't necessarily address pay for performance in detail, they suggest that this concept is spreading in its acceptance on the state level, as well as the national and regional levels.

How Pay for Performance Works...One Story

Under the IHA plan, the payments made under a pay for performance system will be made to the physician groups involved. The physician groups then can use the money to improve management systems, upgrade information technology, and/or offer bonus payments to individual physicians. The set of measures used to evaluate and reward physician group performance includes clinical performance, patient experience, and information technology investment. The clinical component includes 3 preventive health measures (childhood immunizations, breast cancer screening, and cervical cancer screening) and 3 chronic care measures (relating to asthma, diabetes, and heart disease). The patient experience takes into account 4 issues: communication with the physician, specialty care received, timely care and service, and overall rating of care. Finally, the information technology measure assesses the physician group's ability to integrate data and/or provide physicians with data at the point of care.

Health plans—and, in some cases, physician groups—supply audited data to an independent entity that compiles the scorecard. The patient experience data come from a statewide vendor that man-

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ages a consumer assessment survey. Performance ratings are made public via print and Web-based sources.

Of course, each pay for performance pilot or program is unique to its setting and stakeholders. In general, however, pay for performance programs have a few key features. These include a balanced scorecard that incorporates patient satisfaction and clinical measures, public reporting of results, and an opportunity for all physician groups to benefit via rewards for performance improvements.

One study suggests that an effective pay for performance program also must include³:

- trust between physicians and the organization that determines/manages the incentives;
- recognized need for change;
- confidence in the data on which the rewards are based;
- perceived fairness and value of incentives; and
- support of medical leadership.

Pay for Performance: Where Do We Stand?

Although many organizations are considering or planning pay for performance programs and there are relatively few fully realized initiatives, the numbers are growing by leaps and bounds. As of September 2004, fewer than 40 health plans had some type of pay for performance program. One year later, there were nearly twice that number.⁴

While there is concern among physicians and others about pay for performance programs and how they will work, physicians groups increasingly are realizing that such programs will move forward with or without them. As a result, many organizations are planning ahead and developing pay for performance programs to ensure that their input and concerns are represented. National organizations, such as the American Academy of Family Physicians (AAFP), the American Medical Association (AMA), and the American College of Cardiology (ACC) have drafted or approved guidelines that address standards for pay for performance programs. Documents developed by the AMA and the AAFP stress the need to focus on quality instead of cost cutting, involve physicians in program design, employ evidence-based and statistically valid performance measures, and reward performance improvement, as well as the achievement of set targets.

Elsewhere, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has developed key principles that payers can

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Take-Away Message

- Pay for performance is a reimbursement system that rewards performance.
- CMS has introduced a voluntary program to report evidence-based quality measures.
- Besides clinical performance measures, practices will be measured on patient experience and information technology investment.

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- Practices would be wise to develop quality improvement programs and begin measuring certain chronic illnesses, such as congestive heart failure, coronary artery disease, diabetes, and hypertension.
- This will require an investment in technology systems and other resources to gain from a pay for performance system.

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use to structure their pay for performance programs.

In the beginning, most pay for performance programs targeted primary care physicians. However, other specialists increasingly are involved in pay for performance initiatives. In fact, some large insurers have started new specialty physician networks for this purpose. Physicians may be chosen to participate in these networks on the basis of measures, such as volume of work, quality outcomes, and practice efficiencies.

What Will the Future Bring?

While there still are many questions and concerns about pay for performance, the handwriting on the wall is bold and clear: pay for performance is here to stay. Advocates and optimists hope that pay for performance will change physician and system behaviors in ways that improve both quality and patient safety. These individuals and organizations also hope that financial incentives will facilitate improved population management—ie, care for an entire practice, instead of just individual patients.

Despite high expectations, the future road for pay for performance is not without some bumps. There are still questions about what measures will be most effective and how to assess various measures. In addition, there are many more uncertainties and concerns. Nonetheless, the presence of major players, such as CMS, on the pay for performance bandwagon makes it clear that this is a concept that physicians and other health care providers need to accept as an inevitable part of the future. MPM

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Medicare Prescription Drug Coverage

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www.ssa.gov or www.shiptalk.org
The Social Security Office and the Commonwealth of Pennsylvania's Supplemental Health Insurance Program (SHIP) are available to answer questions and enroll residents in the different plans.

www.medicarerxeducation.org

A Key Dates Calendar posted by the nonprofit MedicareRx Education Network, which includes a printable chart of important dates regarding implementation of the new Medicare drug benefit, is available on this site.

www.americangeriatrics.org

The American Geriatrics Society has information and resources of particular importance to health care providers whose practices focus on seniors. MPM

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