



## Paying for Performance — Risks and Recommendations

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Free-for-service payment and a high degree of autonomy have long been defining characteristics of physician practice in the United States. And for the past 40 years, the Medicare program has protected

— and largely reinforced — this traditional professional model. But change appears to be imminent.

The past decade has brought compelling evidence of serious gaps in the quality of medical care. The increased availability of reliable measures of the technical quality of care in both hospital and ambulatory settings has proved that it is feasible to measure quality — and highlighted a remarkable variability in performance. Rising costs are threatening budgets in both the public and private sectors and the affordability of health insurance. Both public and private payers are demanding increased accountability. And many observers believe that financial incentives provide the best leverage for modifying providers' behavior.

As a result, private payers (under pressure from purchasers) and the Medicare program (under pressure from Congress) have been experimenting with approaches to rewarding improved performance. Congress recently called on the Centers for Medicare and Medicaid Services (CMS) to implement a pay-for-performance system for hospitals, and there is strong interest in expanding such programs to individual physicians.

The rush to adopt pay-for-performance programs, however, has raised a number of concerns among physicians and policy analysts. Foremost among these concerns are the following:

*What is the underlying goal?* Although the ostensible goal of pay-for-performance programs is to improve the quality of care, many

physicians fear that “efficiency” (i.e., the cost of care) will be the only focus — a fear exacerbated by the use of such measures to select physicians for inclusion in preferred provider networks.

*Are the measures adequate?* A closely related concern is that current performance measures (see table)<sup>1</sup> have serious limitations. Physicians recognize that good care — especially for the frail elderly and patients with multiple chronic illnesses — often requires a careful balancing of risks, benefits, and patients' preferences, not rigid adherence to clinical guidelines. Performance measurement at the level of the individual physician faces serious technical challenges, ranging from attribution (most patients with serious illnesses receive care from multiple physicians) to inadequate sample sizes (few physicians have enough patients for accurate measurement). And a measurement system that focuses on individual physicians or specific institutional sites (hospitals and

Selected Quality Measures for Ambulatory Care.*	
Measure	Definition
<b>Preventive services</b>	
Cervical cancer screening	Percentage of women who had one or more Pap tests during the measurement year or previous 2 years
Tobacco use	Percentage of patients who were queried about tobacco use one or more times during the 2-year measurement period
<b>Diabetes</b>	
Blood glucose testing	Percentage of patients with diabetes with one or more tests of glycated hemoglobin conducted during the measurement year
Blood glucose control	Percentage of patients with diabetes whose most recent level of glycated hemoglobin was greater than 9.0% (poor control)
<b>Depression</b>	
Acute-phase depression management	Percentage of adults who were diagnosed with a new episode of major depression and were treated with an antidepressant medication who continued to take an antidepressant during the entire 12-week acute treatment phase
Continuation-phase depression management	Percentage of adults who were diagnosed with a new episode of major depression and treated with an antidepressant medication who continued to take an antidepressant for at least 6 months
<b>Measures addressing overuse</b>	
Treatment of upper respiratory infection (URI)	Percentage of patients who were given a diagnosis of URI and were not dispensed an antibiotic prescription on the day of the episode or within 3 days
Testing of children with pharyngitis	Percentage of patients who were given a diagnosis of pharyngitis, were given a prescription for an antibiotic, and underwent a group A streptococcus test

\* Measures are from the 26-item starter set recommended by the Performance Measurement Workgroup of the Ambulatory Quality Alliance.<sup>1</sup> Pap denotes Papanicolaou.

nursing homes) risks reinforcing the fragmentation and lack of coordination that are perhaps the greatest failing of the current delivery system.

*Is implementation feasible?* Even for hospitals and large medical groups, the investments required to collect the measures for current public-reporting initiatives are substantial. Physicians in small-office practices — still the vast majority — will have to collect the data by hand through a review of medical records or make major investments in electronic health records. Audits will be required to ensure accuracy, and the costs will be high.

*Will rewards be sufficient?* Whether the potential bonuses will be sufficient to compensate for the costs of data collection or to motivate change is unknown. If the pool of funds for provider payments is fixed, then a policy that creates large rewards for some

could require substantial cuts in payments for others. If only physicians achieving a high level of performance receive payments, those for whom such a level is out of reach will not bother to try.

*Could there be unintended consequences?* Perhaps the greatest fear is that implementation of pay for performance could cause more harm than good. For instance, unless physicians are firmly convinced that risk adjustment is sufficient, they could decide that the easiest way to achieve high scores is to avoid sick or challenging patients (those who need them the most); systems serving the disadvantaged could see their revenues fall (undermining our tattered safety-net programs); and the emphasis on financial incentives could further undermine morale and the core professional value of altruism that is already threatened by the increasing commercialization of medicine.

These concerns, among others, are discussed in a report recently released by the Institute of Medicine (IOM) called “Rewarding Provider Performance: Aligning Incentives in Medicare.”<sup>2</sup> The IOM committee, on which I served, acknowledged these challenges but strongly recommended moving forward with pay for performance as one element of a comprehensive strategy to improve the quality of care. Each of the aforementioned concerns was addressed in our recommendations.

The committee pointed to the current payment system as an important cause of the fragmentation, complexity, unreliability, and waste of the current delivery system. We called on the CMS and Congress to begin implementing pay for performance as a means to learn how to modify the payment system to foster higher performance and encourage systemwide and comprehensive improvement.

We emphasized that measures and rewards of performance should target multiple dimensions of care, initially including measures of technical quality, patient-centered care, and efficiency but moving toward longitudinal and health-outcome measures as soon as it is feasible. Because most Medicare beneficiaries receive care from multiple physicians in diverse institutional settings, the committee highlighted the need for measures and rewards that foster shared accountability and coordination of care. Given the current threats to primary care, we recommended allowing Medicare beneficiaries to identify their regular care providers, and then rewarding such providers.

Although we called on the CMS to mandate that all Medicare institutional providers participate in pay-for-performance programs as soon as possible, we recognized the serious challenges faced by physicians in small-office practices and recommended that participation by physicians be voluntary at first. Special efforts will be required to assist providers in developing data-collection systems and adopting the electronic health records required to support quality improvement, performance measurement, and payment reform.

We recognized that substantial additional funding will not be forthcoming in the current fiscal environment and called for the

creation of modest funding pools derived from current payments. Annual changes in payment rates would be a likely source, so that some providers could see little or no increase in fees. All providers, however, should be able to receive performance rewards if payments are targeted to multiple dimensions of care and both improvement and achievement are rewarded.

Finally — and perhaps most important — the committee (recognizing that the evidence underlying pay for performance is weak and that unintended effects are possible) called on the federal government to implement pay for performance in the context of an effective monitoring and evaluation system that assesses early experiences (in order to identify potential harms and take corrective action), evaluates the approach's impact broadly (on all aspects of care), and identifies and disseminates information on how best to improve performance.

Unfortunately, much of the current work in performance measurement and pay for performance seems to ignore one or more of the commonsense principles outlined by the IOM committee. The technical quality measures still reflect a tiny segment of clinical practice. The efficiency measures used or under discussion target discrete diagnoses and episodes (which can make fragmented care

by multiple providers appear “efficient”), rather than the longitudinal costs and outcomes of care (which would reward comprehensive, coordinated care by single providers). Much of the focus appears to remain on the measurement of individual performance of physicians — a daunting technical and administrative challenge if implemented nationally. And little attention is being devoted to designing or building a comprehensive evaluation framework that would allow us to learn from our inevitable mistakes.

The shift from autonomy to accountability and from fee-for-service practice to new methods of payment appears inevitable. Accountability for performance on the basis of evidence is now the watchword for clinical services. We would be wise to apply a similar standard to the implementation of our health policy reforms.

**An interview with Dr. Fisher and Dr. Karen Davis on pay for performance, Medicare, and the IOM report can be heard at [www.nejm.org](http://www.nejm.org).**

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1. The Ambulatory Care Quality Alliance recommended starter set: clinical performance measures for ambulatory care. Rockville, MD: Agency for Healthcare Research and Quality, 2004. (Accessed October 12, 2006, at <http://www.ahrq.gov/qual/aqastart.htm>.)
2. Institute of Medicine. Rewarding provider performance: aligning incentives in Medicare. September 2006. (Accessed October 12, 2006, at <http://www.iom.edu/CMS/3809/19805/37232.aspx>.)

## Public Report Cards — Cardiac Surgery and Beyond

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The debate about public report cards for physicians and hospitals never seems to end.<sup>1</sup> Some praise report cards for their role in improving the quality of care, patient safety, and the choices

of patients, referring physicians, and organizations that purchase health care. Others argue that such reports can have negative consequences — for example, if physicians or hospitals, in order

to protect their rankings, avoid performing surgery on severely ill patients for whom surgical treatment might otherwise be recommended. Nonetheless, more and more data are being collected and