



## **Pay for Performance – An Excellent Idea that Simply Needs Implementation**

While paying for clinical performance has become the latest cost control mantra, implementation is seriously deficient. This is due, in large part, to the fact that pay for performance cannot consist of a one-size fit all approach. Although variation in quality and cost of care is best measured using standardized concepts and metrics, homogenizing the assessment tool does not allow for flexibility across the many diverse systems that constitute the American health care marketplace. Participants in the health care market need to build consensus regarding an overall pay for performance approach together with a tool-box (not an approved list) of scientifically validated tools from which payers, providers and consumers can choose to build the incentives needed for pay for performance.

### **The key attributes of a successful pay for performance system**

An effective pay for performance reward system requires that providers be at financial risk for quality improvement. The specifics of such a system include the development of a single cost score (a measure of resource consumption, complexity, and illness burden of the population) and a single quality score (a measure of structure, process and outcomes in patient care) that can be integrated into a global measure of value (cost plus quality). These scores should be directly attributable to specific providers, be available for public scrutiny in the decision making process and offer flexibility in implementation. Standardization should occur at the conceptual level allowing measurement activity to reflect the values and goals of the evaluating entity.

This pay for performance philosophy mandates that financial incentives for the quality score “strongly encourage” the provider to focus its resources on quality improvement. The scores should not include within the cost score, to the extent possible, costs or services that are potentially preventable. The minimum financial incentive needed for quality varies from market to market and there is limited scientific research to document the appropriate percentage. The authors propose, however, that the incentive not be made on top of current payments but rather be included as part of the current levels of payment and overall health care expenditure. Without such a dramatic incentive, the American health care system will continue down its current path of shifting costs onto individual American consumers and increasing the number of uninsured/underinsured.

### **Current Hospital Payment Methodologies Need to be Reconsidered**

Traditional payment methods for both hospitals and individual outpatient practitioners need to be reconsidered. Current approaches to tiering, a current mantra for pay for performance, need to be completely revamped. Tiered hospital contracting typically places hospitals into two or more categories primarily based on the cost of services but which might incorporate in a minor way (from a decision-making point of view) aspects of quality of care. The tiered approach as currently implemented is both too crude a stick and does not provide incentives for improvement. Rather than two tiers, a point system should be utilized incenting institutions to pursue quality improvement/ six sigma and thus move into one of many higher tiers. In

addition, currently available tiering systems are based on tools that have little relevance for significant quality improvement, patient empowerment, or most importantly, hospital cost control over a sustained period of time.

We advocate the use of tools that measure severity of illness and quality of care. These tools combine well-validated case mix measures for each type of health care encounter such as severity adjusted Diagnosis Related Groups or DRGs together with quality measures endorsed by national organizations such as the Agency for Health Care Research and Quality. Payers need to use these tools as the underpinning of a pay for performance system that, in turn, could relentlessly control costs and narrow variations in care.

With respect to hospitals, payers (governmental or private) have used CMS/ Medicare DRGs and/or per diems in an effort to control hospital costs. The Medicare DRGs are not severity adjusted thus continuing to provide a perverse incentive for hospitals to select, for example, “healthier” or lower risk patients for procedures and encouraging the “complicated” individuals to go elsewhere. In addition, where disease management has taken hold, the hospitalized patients will be “sicker” than average. The Medicare DRGs also pay extra for potentially preventable complications. Health services researchers have realized for years that the Medicare system has built into its DRG payment formula a disincentive for performance.

Per diems, the other popular form of hospital payment provide virtually no information (let alone incentives) to either payers or hospital management on improvement opportunities. In summary, neither DRGs as they are currently constructed nor per diems, in any form, provide an appropriate pay for performance incentive for hospitals or payers. Put differently, if 90 plus percent of a hospital’s payment comes from data derived from payment tools (i.e. DRGs, per diems or tiering as currently constructed) there is little incentive for quality improvement. None of the current pay for performance schemes can be considered a significant attempt on the part of payers to constrain health care costs within a framework of quality (pay for performance).

## **Challenges with Traditional Physician Payment and Pay for Performance**

Over the past five years, medical groups have been largely able to jettison the managed care industry’s approach to capitation that contained the toxic combination of nonexistent financial incentives to coordinate care together with inadequate and lack of timely and useful information on patients that could be used for quality improvement. In order to link cost and quality effectively, however, the ideal form of payment for primary care physicians is capitation. The next generation of capitation systems need to incorporate information that will allow medical groups to “disassemble” the payment rate into its component parts (ambulatory visits and episodes of illness, hospitalizations, ambulatory procedures, and, if needed, pharmaceuticals) and be able to assign the components to individual physicians. Only in this manner, will physician leadership be able to identify opportunities for improving results from pay for performance incentives.

In order for the physician community to take serious interest in capitation and pay for performance, the implementation of well validated risk adjustment methodologies is critical. There are a number of case mix tools that measure episodes of illness. The authors of this report advocate for the use of Clinical Risk Groups (CRGs). CRGs are a classification system for risk adjustment that quantifies the impact of the health status of a population on the future need for health care services. The CRGs are a clinical model in which each enrollee is assigned to a single mutually exclusive risk group which relates the historical clinical and demographic characteristics of the enrollee to the amount and type of healthcare resources that enrollee will consume in the future. The key to tying quality and cost is using a tool that is both case mix adjusted at a broad level but that can, at the same time, be unbundled into its components parts. Such a report cannot produce reliable information on a prospective basis for an individual primary care physician or even a small group of primary care physicians. However, this same report can be displayed for all physicians/ disease management companies on a retrospective basis on a large number of variables, including rates of hospitalizations (preventable and non), outpatient pharmacy costs, emergency room visits and patient satisfaction. CRG reporting also allows for viewing the cost of the individuals with chronic illnesses served in the medical group. It provides feedback to health professionals on the projected future costs of patients with diabetes chronic illnesses. Reporting can also examine hospitalizations, average pharmacy use, emergency room visits and other process/ outcome variables or cost issues.

## **Improving Specialists Care – A critical area of cost and quality improvement**

Much research and effort currently is focused on managing patients in the primary care setting, or in managing patients in broad networks which cover the spectrum of care. This current focus on primary care and large populations in networks of care fails to align the level of analysis with the level of resource intensity. Patients seeing specialists utilize a disproportionate percentage of the health care dollars expended. Equally important, some specialists' patient panels (e.g. orthopedists) are more homogenous, thereby facilitating analysis of financial and quality factors. Others such as medical oncologists are not homogenous but consume significant resources particularly pharmaceuticals for which there are significant cost increases.

Specialty medical groups will want to examine the performance on a cost/quality basis of individual ambulatory visits. Two tools are available that provide case mix adjusted information on ambulatory visits – Ambulatory Patient Group

### **Conclusions**

By examining the variation in quality of care and variation in cost underuse and cost overuse of health care services, the opportunities for cost reduction and quality improvement can be identified. Economic incentives must be significant enough to focus the provider's attention on these activities. Today we have the necessary tools to measure the component parts of the sources of variation for all health care encounters. More importantly, today we have the necessary tools to significantly improve the overall "value" of health care (quality/cost) using the quality and cost measures described in this article. Unfortunately, the tools are neither fully understood nor effectively deployed by payers or providers.

Pay for performance cannot consist of a one-size fit all approach. However, there should be common agreement on the overall conceptual approach together with a tool box of approved techniques from which payers, providers and consumers can choose to build the incentives needed to implement pay for performance. The Agency for Health Care Research and Quality and private organizations such as Leapfrog, National Committee for Quality Assurance and the National Quality Forum can serve as independent evaluators and place their stamp of approval on the range of tools that can be used for cost/quality evaluations. The tools are ready for serious pay for performance. Without pay for performance approaches that take these three words to heart, we will only

continue down the path the American health care system has taken – continuing the delivery of inefficient, uneven quality care for a shrinking population of insured Americans. Thus, health care is at a crossroads. It either will become increasingly effective, or it will become increasingly cruel. The choice is ours to make, and will be dependent largely on what results the system rewards.



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