

'Pioneers' Outline Promise, Limitations of Pay-for-Performance to House Subcommittee

Speaking at a [recent hearing](#) of the House of Representatives' Education and Labor Subcommittee on Employer-Employee Relations, health care experts provided a primer on the relative maturity of performance-based payment systems (frequently referred to as "pay for performance" or "P4P") in the United States, including some limitations challenging the development of such incentive programs. Testimony included synopses of some of the more noteworthy P4P systems being used in the private sector, as well as demonstrations currently under way at the Centers for Medicare & Medicaid Services (CMS) intended to pave the way for performance-based payment in Medicare.

P4P has been recommended by the Medicare Payment Advisory Commission (MedPAC) for providers in general and also specifically for home health providers as a means by which the Medicare program can reward those delivering the most effective care. In its March report to Congress, MedPAC recommended authorizing CMS to develop P4P programs for hospitals, home health agencies, and physicians. CMS demonstration programs for P4P are in progress for inpatient hospital and physician services. The process is still in the development stage, however, and no model for a Medicare home health P4P system is anticipated before 2006 at the earliest.

Of particular interest at this subcommittee hearing were the comments of Meredith B. Rosenthal, PhD, a professor of health economics and policy at the Harvard School of Public Health. Rosenthal has conducted research on P4P over the last several years under contract with the Agency for Healthcare Research and Quality, the Commonwealth Fund, and the Robert Wood Johnson Foundation. While highlighting the potential for performance-based payment to realign incentives in the health care system -- that is, to place the focus on payment for the best patient outcomes -- **Rosenthal issued several cautions:**

- There is little guidance at this time to help payers develop P4P programs;
- The positive effects of P4P stand to be diminished if the effort is not standardized, i.e., if the areas measured for determining incentives vary from payer to payer or if few payers use P4P systems;
- Current P4P programs are not designed to save money, since they focus primarily on correcting underuse of services, although programs are beginning to be "reoriented" toward cost savings. Continuing work in this area is essential to progress along these lines, Rosenthal stated.

Rosenthal views P4P as one of several strategies that might be employed to improve the "value of health care spending and make insurance coverage more affordable." Others include (1) public reporting of quality and cost information, (2) tiered benefit designs, (3) shared-risk payment models, and (4) disease management, she noted at the hearing.

In her analysis, Rosenthal noted that most current P4P models reward the highest-ranking providers but fail to differentiate between high-ranking providers that have improved their performance and those that historically rank high. She also noted that under P4P programs, the gains (incentive payments) that health care providers reap from providing high-quality care or meeting other eligibility requirements for incentive payments must balance the costs they incur -- otherwise, providers could be discouraged from trying to meet set standards.

P4P 'Gaming'

In her research, Rosenthal said she has found little evidence to solidly quantify the effectiveness of P4P in health care. She has seen, however, documented cases of P4P programs yielding unintended consequences, including "gaming" by doctors and hospitals through selection of healthier patients (typically referred to as "cherry picking").

Rosenthal advocates for continuing evaluation and dissemination of findings from private and public P4P projects to help guide the development and formation of future pay arrangements. Finally, Rosenthal said she believes that government efforts, such as those being undertaken by CMS to develop P4P demonstration projects, will play a "decisive role" in the speed at which P4P approaches are adopted by health care payers.

Several CMS P4P demonstration programs are in operation; most notable among these is one covering inpatient hospital services and another that was launched recently under CMS's "Provider Group Practice" demonstration. The hospital demonstration was initiated in July 2003 in collaboration with Premier, a nationwide nonprofit hospital chain, and **focuses on five clinical areas:**

- Heart attack,
- Heart failure,
- Pneumonia,
- Coronary artery bypass surgery, and
- Hip and knee replacements.

Hospitals ranking in the top 10 percent for select measures in any of these clinical areas receive a 2 percent bonus payment under the demonstration, and hospitals ranking in the next highest 10 percent receive a 1 percent bonus. In its

final year of the demonstration the initiative will take a further step: Financial penalties will be assessed to hospitals ranking in the lowest levels for performance. According to CMS, "substantial improvement" already has occurred at the hospitals in clinical areas measured by the program.

Additional testimony provided at the hearing will be the subject of a future article in NAHC Report. For more information about the hearing, "[Examining Pay-for-Performance Measures and Other Trends in Employer-Sponsored Health Care](#)," visit the House subcommittee's website at <http://edworkforce.house.gov>.