



CMA Weekly Alert – June 2, 2005

PAY-FOR-PERFORMANCE IN MEDICARE: HOPES AND CAUTIONS

The Centers for Medicare and Medicaid Services (CMS) moved closer to implementing pay-for-performance in Medicare this past April with its new website, “Hospital Compare”. The site is geared toward consumers in hopes that they will use quality information to make more informed decisions about the hospitals they choose. Consumers are able to compare hospital quality by geographic area (state, county, city, or zip code). Hospitals are judged on seventeen different quality measures across three conditions: heart attack care (8 measures), heart failure care (4 measures), and pneumonia care (5 measures).

Though data reporting is voluntary, the Medicare Modernization Act of 2003 (MMA) made full Medicare reimbursement contingent on participation. Linking payment to quality in this way is called “pay-for-performance”, a system in which doctors and hospitals with the highest quality ratings are paid bonuses in addition to their base fee. Though largely untested, pay-for-performance has received support from many payers, researchers and advocates as a way to align the reimbursement system with quality care, rewarding those who give the best care, and giving incentives to poorer performers to make improvements. (See “Paying for Performance: Medicare Should Lead”, Open Letter, *Health Affairs*, Vol. 22, No. 6. November/December 2003.)

Pay-for-performance initiatives are an increasingly popular addition to the traditional fee-for-service reimbursement system, which does not differentiate between low and high quality care. Caution remains appropriate, however, as the viability of pay-for-performance has not been confirmed through rigorous and systemic evaluation. (Rosenthal, Meredith, Rushika Fernandopulle, HyunSook Ryu Song, and Bruce Landon. “Pay for Quality: Providers’ Incentives for Quality Improvement”, *Health Affairs*, Vol. 23, No. 2. March/April 2004). In an effort to bring validity and consistency to pay-for-performance, The Joint Commission for Accreditation of Healthcare Organizations has published a set of principles for pay-for-performance, available here (http://www.jcaho.org/about+us/public+policy+initiatives/pay_for_performance.htm).

As pay-for-performance evolves, advocates should be aware of the system’s limitations:

- **Standardized quality data.** Pay-for-performance attempts to measure performance through adherence to clinical standards. The problem is there is much disagreement on what those standards should be. This may lead to undue weight on the few measures that are accepted, and neglect for more complex conditions for which measures do not exist.
- **Quality of self-reported data.** There is currently no national quality reporting system. Pay-for-performance therefore relies on providers to record and submit

their own data. By making payment contingent on “good” data, providers may be inclined to inflate their numbers in order to receive payment.

- **Access.** Pay-for-performance provides a negative incentive to choose healthier patients to keep quality data artificially inflated. Providers who care for underserved and sicker populations may be unduly punished with pay-for-performance, making it even more difficult for them to provide care.
- **Cost-control.** Pay-for-performance, though initially promoted as a quality tool, is increasingly discussed as a tool for cost-containment. Many plans believe rising health care costs are the result of over-utilization. In their view, pay-for-performance provides an effective method to limit unnecessary services.

Although the Hospital Compare site is expanding, consumers and advocates should be aware of the limited scope of the data when choosing a hospital based on overall quality, and for a patient’s specific needs. Further, not all hospitals, or other care providers, participate in each of Medicare’s Medicare Advantage plans. Thus beneficiaries enrolled in such plans may be limited in their choice of hospital - and other healthcare providers. The Hospital Compare site does include a worksheet to help patients talk to their doctors about hospital quality and how to best choose a hospital. Advocates are encouraged to closely monitor developments and insist on comprehensive evaluations of existing programs. More information is available on the website at www.hospitalcompare.hhs.gov.

For more information on this topic, contact attorney Alfred Chiplin in the Center for Medicare Advocacy’s Washington, DC office at (202) 216-0028 or achiplin@medicareadvocacy.org.