Pay for Performance: *GREAT IDEA.* But Can it Deliver *GREAT RESULTS?*

BY DEXTER W. BRAFF

For years, although health care providers understood how valuable it could be to be able to differentiate themselves on the basis of quality, absent uniformity regarding the "right" data to collect and the technology for providers with varying platforms to efficiently and consistently collect said data, developing – and most importantly – comparing measures of quality was highly elusive. But with a growing number of government and private initiatives mandating the collection of uniform data sets, coupled with improvements in information technology, it is becoming increasingly possible to capture, analyze, compare, and report health care measures that reasonably reflect the outcomes that characterize quality.

In an effort to improve the care given to patients, the "natural" progression is for payers to reward those providers that deliver the best results. And so we have the rationale behind pay-for-performance (P4P), a program that makes all the sense in the world, but may be extremely difficult to implement, and will face formidable challenges in achieving the intended results.

Disaggregation and Competing Agendas of Patient, Referral Source, and Payer

Perhaps the most significant problem stems from the fact that until patients truly act as consumers – making their own health care decisions and paying for it with their own money (even if said money is allocated to them by a third party), *patients, referral sources, and payers will each, quite naturally, pursue their own agenda, an agenda that likely defines quality in substantially different ways.*

Current quality measures are predominantly patient centered. The assumption is that referral sources, in particular, will pursue the same quality outcomes for their patients. But this is not necessarily the case. Referral sources certainly weed out agencies that provide "sub-standard" levels of care. But all too often, the "value" referral sources ascribe to "premium care" pales in comparison to the value they ascribe to being "easy to work with", i.e. the "no-hassle" factor – quality measures that are far more marketing and operationally centered than clinical.

Payers, of course, are more likely to measure quality in financial terms – reductions in expense and/or increases in profits. Accordingly, they are not moved to pay for quality for quality's sake, but only to the extent that it improves financial returns. In such a complex health care system, it is extremely difficult to capture and calculate the return on investment from spending more of the best providers in one health care segment to achieve savings in the same or another health care segment, especially when some of the savings occur long after the added cost is incurred. Thus, it is no surprise that the government is currently floating only the most modest reimbursement premiums for premium quality – about 1 percent initially, phasing up to 2 percent by 2012.

With neither referral sources nor payers necessarily choosing to work with the "best" providers, and the "best" providers only picking up an extra 2 percent (an amount, by the way, that may be offset by the increased expense it might take to achieve the highest quality measures), the incentive to be the best, is at best, weak.

The Law of Unintended Consequences

It is well documented that when incentive programs are offered, they are often earned without the grantor

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necessarily achieving the intended results. Consider one real-life example we are familiar with, where in an effort to earn incentive payments by reducing day's sales outstanding (a measure of accounts receivable collection performance), A/R clerks simply "wrote-off" outstanding balances rather than collect the cash. With current proposals for home health P4P rooted in a limited number of OASIS measures that are self-reported by the agency, at best there will now be a financial incentive to focus largely on clinical interventions that impact these specific measures, rather than the patient as a whole.

At worst, beyond simply a better Homecare Compare score, there will now be even greater incentive to possibly "game" the system. Both could yield increased payments without necessarily improving quality of care. Moreover, even in the absence of such behaviors, with the added financial component, the best providers may find their performance subject to unwarranted inquiry.

The Model is Flawed

In order for incentive programs to be most effective, they must be designed so that the providers of the service recognize a strong and meaningful connection between their performance and their pay. Accordingly, among other things, incentives must (1) reward the "right" activity, (2) be easy to calculate, (3) be paid quickly (i.e. reasonably soon after the premium service is provided), and (4) be meaningful.

We've already discussed the challenges pay for performance will have with respect to rewarding the "right" activities. We certainly anticipate that the calculations will be complex (especially because (a) they will depend upon developing accurate "risk-adjusted" measures, and (b) because they will be based not on raw scores, but as a comparison to other agencies in a given area, creating further "dislocation" between a caregiver's action and the eventual payment.

Given anticipated complexity, it will be challenging for such incentives to be paid quickly, again weakening the connection between action and reward. And finally, payments are to be made to the company and not caregivers at the patient level. Unless they receive a meaningful portion of the incentive through some other bonus mechanism, which will also likely add to the complexity and time delay, the upside will be largely misplaced and therefore meaningless. Even if funds make it to the caregiver level, with a premium rising to only 2 percent, there simply may not be enough incentive dollars to go around to be truly rewarding.

In the end, we believe that in order for a pay for performance program to truly work, health care needs to be provided in a true "free market" much like any other consumer goods...one that is free from artificial price controls established by the government, where as referenced above, the patient is the referral source, the consumer, and the payer. Such a system, where providers are free to charge whatever they want for the level of quality they wish to provide, based on the market segment they wish to target…a system where consumers decide how much quality they want and how much they're willing to pay…a system where not everybody gets, nor does everybody want the highest quality money can buy…a system where basic, mid-level, and high-end health care service alternatives can coexist side by side…a system that, in the end (though we may be evolving towards it), we are not completely ready, or perhaps willing to embrace.

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