

# Paying For Performance: Medicare Should Lead

**W**HE THE UNDERSIGNED ARE UNITED IN OUR BELIEF that a unique opportunity now exists to address the crisis of quality facing the nation's health system. The human and financial costs of medical error and substandard care have been exhaustively documented. A robust inventory of measures and standards for quality improvement has been developed and continues to grow. The strategic concept of paying for performance—a bedrock principle in most industries—has begun to emerge in health care in a variety of experiments in both the private and public sectors. But further progress is by no means assured.

Despite a few initial successes, the inertia of the health system could easily overwhelm nascent efforts to raise average performance levels out of mediocrity. At issue is not the dedication of health professionals but the lack of systems—including information systems—that reduce error and reinforce best practices, as such systems do in other industries such as aviation and nuclear power. We have concluded that such systematic changes will not come forth quickly enough unless strong financial incentives are offered to get the attention of managers and governing boards. As the biggest purchaser in the system, the Medicare program should take the lead in this regard. Decisive change will occur only when Medicare, with the full support of the administration and Congress, creates financial incentives that promote pursuit of improved quality.

Quality is not an issue for partisanship. Nor, in urging that Medicare take a leading role, are we suggesting that such an initiative be dominated by government. Indeed, both private payers and public agencies have made important strides in recent years in tackling the quality challenge. The National Committee for Quality Assurance has promulgated widely used performance indicators for health plans. The National Quality Forum has brought public and private payers together with consumers, researchers, and clinicians to broaden consensus on performance measures and best practices for a growing portfolio of health care settings, conditions, and treatments. The Agency for Healthcare Research and Quality (AHRQ) has established itself as an honest broker of evidence-based treatment standards. The self-insured employers in the Leapfrog Group have moved boldly to tie provider payment to selected performance indicators; and many insurers, health plans, and provider systems are testing new disease management models and other approaches that tie payment to performance.

The Centers for Medicare and Medicaid Services (CMS) has taken significant steps toward a quality strategy based on quality measurement and incentives. The agency's publication of performance data on nursing homes and home health agencies has heightened public awareness of the value of information on quality

and has alerted the provider community that it has a critically important role to play in adopting best practices and improving patient safety. While information on hospital and physician performance is much more difficult to collect and organize, the CMS plans to extend the consumer information campaign to hospitals and in the meantime has launched a breakthrough demonstration project with Premier Inc., a national alliance of nonprofit hospitals, to pay quality-improvement incentive bonuses for Medicare patients at participating institutions. Three other large hospital groups—American Hospital Association, Federation of American Hospitals, and Association of American Medical Colleges—are collaborating with the National Quality Forum, the CMS, AHRQ, and the Joint Commission on Accreditation of Healthcare Organizations in a voluntary quality-reporting initiative announced late in 2002.

Measured against the magnitude of the problem, however, these efforts have barely begun to achieve critical mass and momentum. The Institute of Medicine noted a “cycle of inaction” in its landmark 1999 report on medical error. Just as sobering are the results of a large national study published recently in the *New England Journal of Medicine*, which found that patients were receiving an average of only 55 percent of recommended care across a variety of conditions and treatments. The complexity and sensitivity of measures, standards, and quality-reporting regimes often discourage providers from embracing voluntary quality initiatives and fuel resentment of the costly data-gathering burden that quality improvement may entail. The uneven deployment of nonstandardized information technology in the health sector has frustrated the development of promising opportunities to gather comparative performance information efficiently and to promulgate sophisticated decision-support and error-prevention systems.

The available measures are less than perfect, but the CMS–Premier demonstration and the National Quality Forum’s hospital initiative show that we have adequate tools to accelerate the pace of change. Standardized, interoperable electronic data formats mandated by the Health Insurance Portability and Accountability Act (HIPAA) are now making their way forward. The CMS’s demonstration authority gives the agency the power to continue to expand experimentation and testing of models. Congress has an opportunity to advance quality of care nationally by endorsing the goal of differential quality payments and supporting Medicare’s initiatives toward that goal.

Our recommendation—to the executive branch; to Congress; to employers and health plans; and to hospitals, physicians, nurses, and other health professionals—is that payment for performance should become a top national priority and that Medicare payments should lead in this effort, with an immediate priority for hospital care. Sustained leadership within Medicare will be a crucial ingredient. The current CMS administrator has shown aggressiveness and commitment. His successors must follow suit to assure that quality improvement becomes a priority throughout the agency, year in and year out. A major initiative by Medicare to

pay for performance can be expected to stimulate similar efforts by private payers, just as Medicare's adoption of prospective payment for hospitals did two decades ago. We call on the administration and congressional leaders of both parties to act in a bipartisan spirit on health care quality and to join the campaign to rally our underperforming health care system by empowering Medicare to take the further necessary and decisive steps to make pay-for-performance a national strategy for better quality. We should settle for nothing less.

DONALD M. BERWICK  
INSTITUTE FOR HEALTHCARE IMPROVEMENT, BOSTON, MA

NANCY-ANN DEPARLE  
J.P. MORGAN PARTNERS LLC, WASHINGTON, DC

DAVID M. EDDY  
ASPEN, CO

PAUL M. ELLWOOD  
JACKSON HOLE GROUP, JACKSON HOLE, WY

ALAIN C. ENTHOVEN  
STANFORD UNIVERSITY, STANFORD, CA

GEORGE C. HALVORSON  
KAISER PERMANENTE, OAKLAND, CA

KENNETH W. KIZER  
NATIONAL QUALITY FORUM, WASHINGTON, DC

ELIZABETH A. MCGLYNN  
RAND, SANTA MONICA, CA

UWE E. REINHARDT  
PRINCETON UNIVERSITY, PRINCETON, NJ

ROBERT D. REISCHAUER  
URBAN INSTITUTE, WASHINGTON, DC

WILLIAM L. ROPER  
UNIVERSITY OF NORTH CAROLINA, CHAPEL HILL, NC

JOHN W. ROWE  
AETNA, HARTFORD, CT

LEONARD D. SCHAEFFER  
WELLPOINT HEALTH NETWORKS, THOUSAND OAKS, CA

JOHN E. WENNBERG  
DARTMOUTH MEDICAL SCHOOL, DARTMOUTH, NH

GAIL R. WILENSKY  
PROJECT HOPE, BETHESDA, MD