The accelerating movement from the traditional US health benefits coverage system of “defined benefits” (where employers provide a package of defined benefits to their employees) to a system of “defined contributions,” (where employers contribute a set amount and then require employees to decide how much of their health benefit dollars to spend by selecting from a range of benefit plans), is being driven by employers seeking to limit cost increases significantly above other inflation indices. This “sea-change” in the US Healthcare delivery system represents a fundamental shifting of the financial risk of health coverage from the employer to employees, which presents both challenges and opportunities for healthcare providers, based on the fundamental underlying factors of quality, convenience of services provided, and access for patients and their families, who will now be more directly involved in the “purchase and payment” decision continuum.

These changes come in the wake of an ongoing national controversy over several recent studies finding that medical errors are a leading cause of death in the U.S., and the resulting demands waged by both private and public payors regarding accountability of providers. The Institute of Medicine’s (“IOM”) 1999 study reported that as many as 44,000-98,000 deaths may be directly linked to medical errors.¹

Indeed, deaths related to preventable adverse events exceed deaths attributable to motor vehicle accidents, breast cancer or AIDS.² Over the last several years, the IOM report and others have increased public awareness of medical errors.³ A recent 2003 study by the US Agency for Healthcare Research on healthcare quality of care in the US found that errors related to nosocomial infections acquired in hospitals are common with approximately two million patients infected and ninety thousand deaths, resulting in an annual cost of approximately $4.5 billion.⁴

"…several fundamental questions arise concerning P4P, e.g., who decides what "performance" is and who will measure what "performance metrics" are achieved…"

This transparency and full disclosure to the public regarding provider fees, quality and other information related to safety and medical errors, will significantly impact the future of the healthcare delivery market. In this market milieu, niche providers, who have a reputation for quality, convenience, and quick turn responsiveness to patient needs, pose an even more formidable competitive challenge to more established provider systems in the healthcare marketplace. However, several fundamental questions arise concerning the potential risks associated with this apparent paradigm shift to patient “pay for performance” (P4P), e.g.; (a) who decides what “performance” is and who will measure what “performance metrics” are achieved; and, (b) more importantly, without an accurate, comprehensive, and uniform quality reporting system currently in place, there exists the opportunity for market oligopoly healthcare and insurance providers to manipulate the currently voluntarily reported physician quality data in furtherance of their own market control and profit agendas, thereby further detracting from physician autonomy and eroding physician control over their own quality and treatment protocols.

The Centers for Medicare and Medicaid’s (CMS) April 2005 “Physician Group Practice Demonstration”, which offered participating physician practices financial “reward” payments for improvements made in quality and cost-efficient healthcare delivered to Medicare fee-for-service beneficiaries.⁵ While initially viewed as a positive step in addressing the medical error epidemic plaguing the US, there is a growing concern as to the great potential for abuse of this voluntary reporting system. As stated in a recent New England Journal of Medicine November 2006 article;,

“Perhaps the greatest fear is that implementation of pay for performance could cause more harm than good. For instance, unless physicians are firmly convinced that risk adjustment is sufficient, they could decide that the easiest way to achieve high scores is to avoid sick of challenging patients (those who need them the most); systems serving the disadvantaged

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could see their revenues fall (undermining our tattered safety-net programs); and the emphasis on financial incentives could further undermine morale and the core professional value of altruism that is already threatened by the increasing commercialization of medicine.”¹

Perhaps the best prescription for understanding the impact of P4P is to “stay tuned for further updates.”

¹ “To Err is Human: Building a Safer Health System” Edited by Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson, Committee on Quality Health Care in America, Institute of Medicine, 1999, p. 1.


Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of HEALTH CAPITAL CONSULTANTS (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Intuition of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: “The U.S. Healthcare Certificate of Need Sourcebook” [2005 – Beard Books], “An Exciting Insight into the Healthcare Industry and Medical Practice Valuation” [2002 – AICPA], and “A Guide to Consulting Services for Emerging Healthcare Organizations” [1999 John Wiley and Sons].

Mr. Cimasi is the author of numerous additional chapters in anthologies, books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious “Shannon Pratt Award in Business Valuation” conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows.

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the Senior Vice President of HEALTH CAPITAL CONSULTANTS (HCC), where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia, and is a Fellow of the American College of Healthcare Executives. He has co-authored “Research and Financial Benchmarking in the Healthcare Industry” (STP Financial Management) and “Healthcare Industry Research and its Application in Financial Consulting” (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser’s Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.

Anne P. Sharamitaro, Esq., is the Vice President of HEALTH CAPITAL CONSULTANTS (HCC), where she focuses on the areas of Certificate of Need (CON); regulatory compliance, managed care, and antitrust consulting. Ms. Sharamitaro is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as an editor for the Journal of Health Law, published by the American Health Lawyers Association. She has presented healthcare industry related research papers before Physician Hospitals of America and the National Association of Certified Valuation Analysts and co-authored chapters in “Healthcare Organizations: Financial Management Strategies,” published in 2008.