HEALTH CAPITAL Topics

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Pay for Performance (P4P): Who Gets to Decide?

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]

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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.
[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] "New Push After Transplant Tragedy – Hospitals Search for Ways to Prevent Errors, Help Doctors Learn From Others" DoctorQuality, Oct. 1, 2003).
[1] "National Healthcare Quality Report", U.S. Department of Health and Human Services Agency for Healthcare Research and quality, Rockville, MD, December 2003, p. 147.
[1] "Medicare Physician Group Practices: Innovations in Quality and Efficiency," The Commonwealth Fund, http://www.cmwf.org/publications/publications_show.htm?doc_id=428880, (Accessed 12/28/06); "CMS Large0Group P4P Demonstration Resulting in Enhanced Care, Physician Changes," Healthcare Financial Management Association News, December 6, 2006 (Accessed 12/18/06)

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