MEASURING UP?

Governments Move To Improve Quality and Cut Costs

By Gunjan Sinha

The U.S. health care system is poised to change. In December 2006, Congress passed a bill that enables the Centers for Medicaid and Medicare Services (CMS) to offer doctors a 1.5% bonus payment if they adhere to certain quality guidelines.

As part of various pilot projects, CMS already rewards health care providers for reporting specific quality measures of their care—so-called pay-for-performance programs. The new bill, however, authorizes CMS to expand the program to include all practicing physicians. It also signaled that the health care community has largely accepted the concept. The hope is that pay for performance might not only improve patient care but also save CMS money over the long term.

But determining how to put such a system into practice remains contentious.

In 2004, Britain implemented the world’s first national pay-for-performance system. However, since the two nations’ health care systems substantially differ, Britain’s system can’t be adapted to the United States. Moreover, Medicare has not pledged more funds to launch the program—which might prevent pay for performance from taking off in the United States, experts say.

The Proposal

Years of skyrocketing health care costs have forced CMS to look closely at how to streamline health care services. One promising way is to pay physicians to reduce redundant care. For example, CMS research has shown that 21% of Medicare beneficiaries who are hospitalized with heart failure are readmitted within 30 days. Yet even though studies show that prescribing beta-blocker drugs at discharge can cut rehospitalization rates by 22%, only 21% of eligible patients receive prescriptions for them. Medicare’s payment system presently does not encourage physicians to prevent readmissions.

Consequently, one CMS-sponsored demonstration project offered financial incentives to more than 260 hospitals to report data on 34 quality measures, including whether a patient was prescribed beta blockers at discharge. The measures are related to five clinical conditions. The project ran for 3 years, ending last fall. To stimulate competition, CMS reported each hospital’s first-year performance on its Web site. CMS expects to release final data this year. Only hospitals scoring in the top 20% for the 34 quality measures will receive a 1%–2% bonus payment. CMS will cut pay to hospitals that don’t score within a given threshold.

Other ongoing pilot projects involve physician groups and other health care providers. However, CMS expects to broaden its voluntary reporting program to all physicians beginning this July. Doctors will be eligible for bonuses for reporting data related to quality measures (there are now 66 measures). Although the agency is still working out the details, they expect that the program will focus on specific conditions, said Ellen Griffith, CMS spokesperson. “If the measure applies to the patient’s condition, the treating physician, whether primary care or other specialty, may report it.”

Experts largely support the idea. “In other parts of the economy we don’t assume that everybody doing a service does it equally well and should be paid the same,” said Gail Wilensky, Ph.D., an economist and senior fellow at the nonprofit Project HOPE. “Why should health care be exempt?”

But some question whether existing quality measures will improve patient health and cut costs—both of which are CMS’s long-term goals. Most measures gauge quality by asking whether a doctor performed a specific test or prescribed a particular drug—so-called process measures. Most don’t assess whether the process improved patient health. In fact, a recent Journal of the American Medical Association study by Rachel Werner, M.D., Ph.D., at the Philadelphia Veterans Affairs Hospital, analyzed data from more than 3,000 hospitals and found that the 10 measures used to assess hospital performance in treating three conditions only modestly correlated with a lower risk of mortality during the days after hospital discharge. Another JAMA study found no correlation between quality measures for patients hospitalized with heart failure and clinical outcomes. The measures in this study were established by the American College of Cardiology and American Heart Association.

That doesn’t mean the measures are wrong, commented Susan Horn, Ph.D., founder of the Institute for Clinical Outcomes Research in Salt Lake City. “But we need a more comprehensive approach to establishing them.” Quality measures are based on clinical evidence. But clinical trial participants don’t reflect the general population, nor does the setting mirror real life, Horn said. Werner, for example, could not assess whether patients took their medication as prescribed or adhered to other lifestyle changes. Instead, Horn advocates clinical research that more closely mirrors typical patients in realistic settings as a way to establish quality measures more tightly related to health outcomes.
But although such measures might benefit patients, they may hurt physicians. One measure proposed for physician practices, for example, asks doctors how many of their diabetic patients’ hemoglobin A1c levels remain under 7%—a value thought to minimize long-term complications.

“But I might have a patient whose blood values I just cannot stabilize, despite my best efforts,” said Nancy Nielsen, M.D., Ph.D., associate dean for medical education at New York School of Medicine in Buffalo and board member of the American Medical Association. Doctors working in disadvantaged neighborhoods, for example, may have a tough time getting patients to comply with advice.

“We want to be held responsible for the quality of our care,” Nielsen said. “But we want to be held responsible for things we can do something about.” Otherwise pay for performance might inadvertently encourage doctors to reject tough cases or penalize them for factors beyond their control.

**Learning From Britain**

That’s where policy makers can look to Britain. After a decade of research showing inconsistent care across the United Kingdom, England’s National Health Service (NHS) launched the Quality and Outcomes Framework (QOF) in 2004. The framework works through a point system: Physicians earn points according to how well they adhere to 76 quality measures. Like those proposed in the United States, most are process measures. Doctors can earn up to 1,000 points this year, and each point is worth an average of £124.60 ($242).

“It has really improved patient care,” commented Mayur Lakhani, M.D., chairman of the Royal College of General Practitioners. For example, NHS data suggest that 15% more young people had their Hemoglobin A1c levels measured in 2005 than the year before.

The program has seen little protest from U.K. physicians, partly because the British Medical Association worked closely with NHS to ensure that the program addressed physicians’ concerns. For one, the QOF doesn’t penalize doctors for factors beyond their control or for a patient’s negligence. Through a system of “exception reporting,” doctors can exclude patients from their NHS evaluation. A doctor shouldn’t be forced to control a diabetic’s sugar or cholesterol levels when that patient has cancer, explained Martin Roland, Ph. D., director of the National Primary Care Research and Development Centre at the University of Manchester. Roland played a key role in designing QOF. Doctors have considerable leeway and can exclude patients at their discretion—even for repeatedly missing appointments. Although that allowance leaves room for dishonesty, NHS periodically audits doctors. If the numbers look fishy, NHS will investigate.

More importantly, NHS developed software to monitor the system, which the agency distributes to participating physicians at no extra cost (more than 8,000 general practitioners participate, covering more than 99% of all registered patients). Each physician enters patient data and services performed into the program. The data are transmitted electronically to NHS.

**Issues for the U.S.**

QOF has been more straightforward to implement in the United Kingdom, experts said, because it applies only to the general practitioners who make up about 50% of all U.K. physicians, and it covers primarily chronic conditions. By contrast, U.S. health care is much more fragmented, leaving experts wondering which doctors CMS will hold accountable for quality. Primary-care doctors make up only about 20% of physicians in the United States, and patients with several conditions might see specialists more often than seeing their primary-care doctors.

Many see this lack of coordination among physicians as a major roadblock to better care. “What this country knows that it needs is unified electronic medical record keeping,” Nielsen said. “Doctors should be able to prescribe drugs electronically, pull up a lab report from a hospital, or an x-ray from another facility.”

Although dozens of companies do sell software to record patient data and submit bills electronically, most programs aren’t compatible with other systems. The NHS, which developed its own software, sidestepped this problem.

Perhaps the biggest difference between the two nations is money. NHS introduced QOF with substantial funding. The bonus program made up a quarter of some general practitioners’ incomes last year, part of which physicians reinvested in their practices by hiring more staff.

U.S. physicians have complained that a 1.5% bonus isn’t enough. The amount will not cover extra administrative costs or software. What’s more, CMS anticipates that the money saved through streamlined services can be funneled into bonuses. But adhering to quality measures will mean more screening tests and higher costs in the short term, not lower. Consequently, some doctors might have to accept pay cuts for others to earn bonuses. “That could be very demoralizing for some physicians,” Roland warned.

Pay for performance is indeed a work in progress. Even the United Kingdom has experienced unintended consequences. Some groups have complained that diseases not covered under QOF, such as osteoporosis, are being neglected, whereas others are being overemphasized. NHS does, however, plan to modify the program in coming years, reflecting the need for the system to evolve in response to practical experience, Lakhani said.

“Pay for performance can work,” he added. “Sure, there are going to be problems along the way. But this has been really good for patients. That’s what really matters.”

© Oxford University Press 2007. DOI: 10.1093/jnci/djk121