Pay for Performance: Pay More or Pay Less?

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Several recent publications in the radiology literature have reported on the growing phenomenon of pay for performance. This potent new business model seeks to reward health care providers with financial incentives for improvements in the performance and delivery of medical services. This paper briefly reviews some of the obstacles to the implementation of this strategy in the practice of radiology. Radiologists are encouraged to participate actively with payers in discussions about improving quality care but should carefully consider the potential contractual implications associated with these initiatives.

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The pay-for-performance movement has been compared with a tsunami [1] and a freight train that will not be sidetracked or derailed [2]. Backed by demands from powerful, prestigious organizations, health care providers will, like it or not, be held to higher standards of accountability in the future [1, 3–8]. Patient expectations are on the rise [1,9]. Consistent with the maxim "Radiology is best performed by radiologists," radiologists are also the ones best suited to provide input to payers on appropriate standards for patient safety and quality imaging. The ACR has already developed several programs designed to foster quality medical imaging, providing a firm foundation on which to build.

THE PAY-FOR-PERFORMANCE MOVEMENT

The pay-for-performance movement is the logical outgrowth of three reports issued from the Institute of Medicine: *To Err is Human: Building a Safer Health System* [10], *Crossing the Quality Chasm: A New Health System for the 21st Century* [11], and *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality* [12]. The first, centered on public safety, alleged that 44,000 to 98,000 Americans die each year as a direct result of medical errors. In the two subsequent publications, the Institute of Medicine proposed several solutions to address concerns regarding the quality of health care in the United States, including the specific suggestion to reward health care providers with economic incentives for demonstrable improvements in the provision of medical services.

In response to these recommendations, a host of private, public, and government organizations, including the Leapfrog Group, Bridges to Excellence, the Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services, the Institute of Healthcare Improvement, the National Committee for Quality Assurance, the National Patient Safety Foundation, the Partnership for Patient Safety, the Robert Wood Johnson Foundation, and of course the Institute of Medicine, have sought to shape the direction of health care policy and/or to institute pay-for-performance programs [1, 3–8]. The Leapfrog Group in particular has drawn significant attention because of its size (more than 160 public and private organizations), membership (including AT&T, Boeing, Exxon, Ford, General Electric, General Motors, Microsoft, PepsiCo, and Xerox, among others), and number of covered lives (more than 34 million) [7]. Recently, the Joint Commission on Accreditation of Healthcare Organizations announced that more than 100 pay-for-performance programs are in existence [8]. The financial inducements of these programs typically range from 1% to 10% and take the form of either an added bonus or an "at risk" withholding from the contractually agreed-on remuneration level [5,6].

As this concept gained momentum, the Centers for Medicare and Medicaid Services developed the Hospital Quality Incentive Demonstration Project in 2003. This 3-year pilot program involving 278 voluntarily participating hospitals is designed to determine if economic incentives are effective at improving the quality of inpatient care in five clinical conditions: acute myocardial

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infarction, coronary artery bypass grafting, heart failure, community-acquired pneumonia, and hip and knee replacement [13]. Participating hospitals will compete for bonus money on the basis of data submitted for each of the five clinical conditions. Those scoring in the top 10% of all hospitals will receive 2% bonuses above their base rates for that condition, while those scoring in the next 10% will receive 1% bonuses [5,6]. On a somewhat worrisome note, in the third year of the project, hospitals falling in the bottom 10% will be penalized 2% of their base rates (even if they have demonstrably improved quality), while hospitals electing not to participate will also be penalized 0.4% of their associated revenues [6]. A second aim of the project is to develop new quality metrics and an incentive framework for high-quality healthcare [13].

A HISTORICAL PROSPECTIVE

At this point in the discussion, it is worthwhile to briefly review some of the promises and pitfalls of the last powerful paradigm to sweep through American medicine: managed care. The public was pledged a new, innovative direction in health care, focusing on preventive medicine and health maintenance. Patients would select primary care physicians who would serve as their personal gatekeepers and shepherd them through the complex and bewildering array of modern medical diagnostic testing before referring them to specialists for therapy if necessary. Paperwork would be streamlined, and precertification procedures and utilization review would be used to monitor the process and ensure that only the appropriate quality care was delivered. Americans responded in droves, and enrollment in health maintenance organizations grew rapidly from 13 million in 1980 to 56 million by 1995, while an additional 91 million were covered under the less restrictive preferred provider organizations in the same year [14].

In retrospect, of course, the reality did not match the rhetoric, and managed care was declared a partial economic success but a political disaster. Although costs were temporarily contained, it became obvious patient choice and access to specialty care had been compromised, while providers chafed under voluminous paperwork and onerous precertification procedures and utilization review, which served as both barriers to care and rationales to deny payment for services rendered [9]. The transformation of health care into a commodity simultaneously led to a dramatic increase in the percentage of for-profit health maintenance organizations from 12.0% in 1981 to 63.3% in 1997 [15]. As competition increased among managed care plans and profit margins were squeezed, payers resorted to delayed payment of claims, as well as outright denial [16,17] and even defended this behavior as a necessary stratagem to maintain lower premiums for the benefit of their subscribers [18]. Ultimately, the government intervened with the passage of managed care reform legislation, including prompt-payment bills in virtually every state in the country [16,17].

This historical perspective is relevant to the current discussion for the following four reasons:

- First, the growth of managed care was fueled by a desire to contain health care costs and thereby maximize corporate profitability by many of the same Fortune 500 companies that are now members of the Leapfrog Group [7,14].
- Second, many of the pay-for-performance incentive plans are extensions of policies developed and/or used under managed care [4,6].
- Third, the entrepreneurs and venture capitalists of managed care companies (many of which are also members of the Leapfrog Group) are frequently the ones responsible for administering and paying for pay-for-performance plans [7].
- Finally, it suggests the possibility that the current interest of payers in value may have evolved from the hard-learned mistake of managed care, namely, that health care modification without quality improvement as the core target will be unsuccessful in the long term.

PAY-FOR-PERFORMANCE OPPORTUNITIES IN DIAGNOSTIC IMAGING

Traditionally, discussions regarding health care delivery in America have centered on access, cost, and quality [19]. Each of the three participants (patients, payers, and providers) in turn has had a stake in these interrelated core issues but has also tended to focus principally on a single specific area. At the risk of oversimplification, patients have been chiefly concerned with access to medical care when the need arose; payers have focused primarily on cost containment; and providers, in their roles as patient advocates, have emphasized quality.

The ACR, consistent with its slogan, "Quality Is Our Image," has taken a leadership role in the development of programs designed to enhance patient safety and promote quality medical imaging. These include practice guidelines, technical standards, accreditation programs, appropriateness criteria for medical imaging, and the RADPEER program, with additional imaging-related quality metrics under development. As a result, ACR members are now uniquely situated to promote their agenda of quality imaging with patient advocate groups, payers, and the government at the local and national levels. The ACR has also pursued a long-term strategic initiative to link payment with accreditation in an attempt to ensure quality, a by-product of which may be to limit self-referral and inappropriate use. The success of