



Health Care Quality: Enhancing Provider Accountability Through Payment Incentives and Public Reporting

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Summary

Quality gaps in the care delivered by the U.S health care system result in preventable mortality and morbidity and contribute costs to the system, with multiple indicators showing that quality of care could be improved. Although no single definition of high-quality health care has been agreed upon, the Institute of Medicine (IOM) provided a framework for considering the quality of care, based on six domains: (1) effective, (2) efficient, (3) equitable, (4) patient-centered, (5) safe, and (6) timely. Ongoing congressional interest in enhancing the quality of health care is likely given the federal role in the delivery and financing of health care through, for example, the Medicare and Medicaid programs.

Many efforts that aim to improve the quality of care focus on increasing health care providers' accountability for the care they provide. These efforts include, among others, the modification of payment through incentives and the public reporting of performance information. Many payment incentives and public reporting policies rely on quality measurement, and numerous issues arise when considering the use of quality measures in these policies. These include, among others (1) the availability of a comprehensive set of quality measures, (2) the strength of the evidence base supporting the measures, and (3) the relative mix of different measure types. The ability to directly compare the performance of providers is an essential component of many payment incentive and public reporting policies, and quality measurement allows for the generation of this comparative provider-specific performance information.

Emphasis has been placed on changing the way health care is paid for, away from a system where payment is simply a transaction based on the unit of care provided, to one where higher-quality, lower-cost care is preferentially rewarded. This policy approach is often referred to as value-based purchasing or value-driven health care, and such efforts may include payment incentives in the form of adjustments, performance-based payments, or fees. At the federal level, the Medicare program provides policymakers the opportunity to implement value-based purchasing approaches and other payment modifications; payment incentive policies implemented in the Medicare program may provide valuable data that private insurers and others may use when considering implementing these approaches.

Policymakers have undertaken efforts to enhance provider accountability through the public reporting of performance information; these efforts have generally occurred in concert with policies that modify payment to improve quality. Theoretically, making provider performance information public serves to correct an existing information asymmetry; that is, an imbalance in information between the provider and user of a service, in this case, health care services. Consumer decision making in health care is influenced by a number of factors, including, among others (1) awareness of the information, (2) relevance of the information, and (3) usability of the information. Other factors unrelated to the performance information itself may also affect consumer use of this information (e.g., location of hospital). The impact of public reporting on both consumer decision making, as well as quality improvement efforts by providers, is unclear, although evidence suggests that consumers do not use performance information very often in their decision making.

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Introduction

Quality gaps in the care delivered by the U.S health care system result in preventable mortality and morbidity and contribute costs to the system.¹ Multiple indicators show that quality of care could be improved; these indicators include high rates of healthcare-associated infections (HAIs) and a lack of adherence to evidence-based guidelines, among others. For example, approximately 100,000 people die each year from HAIs, at an estimated cost ranging from \$28.4 to \$45.0 billion dollars.² In addition, a 2007 study found that only 46.5% of children receive care recommended by evidence-based guidelines, and a similar study conducted in 2003 concluded that adults receive only 55% of indicated care.³ The *2010 National Healthcare Quality Report*, released annually by the Agency for Healthcare Research and Quality (AHRQ) of the U.S. Department of Health and Human Services (HHS), found that health care quality is suboptimal, especially for low-income individuals and certain minority groups.⁴ Quality of care also varies geographically; for example, a recent study found that high-quality, low-cost hospitals were less likely to be small or located in the South.⁵

Although no single definition of high-quality health care has been agreed upon, the Institute of Medicine (IOM) provided a framework for considering the quality of care, based on six domains: (1) effective, (2) efficient, (3) equitable, (4) patient-centered, (5) safe, and (6) timely.⁶ Numerous efforts have been undertaken in recent years to improve the quality of health care; despite this, the consensus remains that progress in quality improvement across the health care system has been variable and, in some cases, slower than anticipated.⁷

Many efforts that aim to improve the quality of care focus on increasing health care providers' accountability for the care they provide.⁸ This includes, in some cases, a focus on improving the

¹ A "quality gap" has been defined as "(t)he difference between health care processes or outcomes observed in practice and those potentially achievable on the basis of current professional knowledge. The difference must be attributable in whole or in part to a deficiency that could be addressed by the health care system." Ranji SR, Shetty K, Posley KA, Lewis R, Sundaram V, Galvin CM, Winston LG. Prevention of Healthcare-Associated Infections. Vol 6 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under Contract No. 290-02-0017). AHRQ Publication No. 04(07)-0051-6. Rockville, MD: Agency for Healthcare Research and Quality. January 2007.

² Centers for Disease Control and Prevention. National Vital Statistics (2009). Scott, D.R. "The Direct Medical Costs of HAIs in US Hospitals and the Benefits of Preventions." http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.

³ Mangione-Smith, R., Decristofaro, A. H., Setodji, C. M., Keesey, J., Klein, D. J., Adams, J. L., et al. (2007). "The Quality of Ambulatory Care Delivered to Children in the United States." *NEJM*, 26(5), 644-649. E. A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *NEJM*, 348(26), 2003.

⁴ Agency for Healthcare Research and Quality. "National Healthcare Quality Report," 2010. <http://www.ahrq.gov/qual/nhqr10/Key.htm>.

⁵ Jha, AK et al. (2011) "Low-Quality, High-Cost Hospitals, Mainly In South, Care For Sharply Higher Shares Of Elderly Black, Hispanic, And Medicaid Patients." *Health Affairs*: 30(10): 1904-1911. Small hospitals are defined in this study as those hospitals having between 6 and 99 beds.

⁶ Institute of Medicine. "Crossing the Quality Chasm: A New Health System for the 21st Century." The National Academies Press; 2001.

⁷ "Health Policy Brief: Improving Quality and Safety." *Health Affairs*, April 15, 2011.

⁸ From the health care provider perspective, externally directed accountability efforts may be considered separately from internally focused quality improvement efforts. However, it has been suggested that alignment between the two is necessary for the best patient outcomes. Perla RJ et al. (2010) "Accountability Measures to Promote Quality Improvement." *NEJM* 363: 1975-1976.

value of health care; that is, the ratio of desired or positive outcomes to long-term costs.⁹ In all cases, efforts include accountability to an external actor, for example the public, regulators, or payers.¹⁰ Policymakers have used three basic policy approaches in an effort to enhance provider accountability, among other things. These include (1) payment incentives, (2) public reporting of performance data, and (3) quality assurance through regulation and accreditation.¹¹ These approaches are used for several purposes, including to determine appropriate reimbursement, to drive market share, and to demonstrate quality and cost-efficient performance.¹²

Payment incentives and public reporting encourage providers to change their behavior to improve quality and/or value. Regulatory oversight and accreditation of providers, on the other hand, first serve an oversight function and generally rely on mandating certain behavior, as opposed to incentivizing it (in addition to having an increasing focus on improving quality).¹³ This report focuses on payment incentives and public reporting, specifically.

Many payment incentive and public reporting policies rely on quality measurement. For example, payment incentives based on provider performance rely on a comprehensive set of quality measures that can directly or indirectly measure clearly identified outcomes, among other things. Quality measures that highlight meaningful differences in provider performance, and that address outcomes of interest to patients, facilitate the effectiveness of publicly reporting quality performance data.¹⁴ Policymakers have taken steps to address these measurement needs, for example through support for health services research or the development of quality measures in areas in which they do not currently exist. In some cases, these measurement needs were not adequately addressed prior to the implementation of policies; this contributed to initial provider questions about the effectiveness of such policies.¹⁵

Improving the quality of health care involves all components of the health care system; therefore, policies supporting (1) an adequate and appropriately trained health care workforce;¹⁶ (2)

⁹ Bohmer, RMJ et al. (2011) “The Four Habits of High-Value Health Care Organizations.” *NEJM* 365: 2045- 2047.

¹⁰ The Joint Commission. (2011) “Improving America’s Hospitals: The Joint Commission’ Annual Report on Quality and Safety.” http://www.jointcommission.org/assets/1/6/tjc_annual_report_2011_9_13_11_.pdf. Hereinafter “The Joint Commission, 2011.”

¹¹ Chassin, MR et al. (2010) “Accountability Measures- Using Measurement to Promote Quality Improvement.” *NEJM*, 363: 683-688.

¹² The Joint Commission, 2011.

¹³ Beginning in the 1980s, there has been a shift in accreditation philosophy from review of structural standards to a focus on performance measurement and processes of care. See National Health Policy Forum, “Hospital Oversight in Medicare: Accreditation and Deeming Authority,” NHPF Issue Brief No. 802, May 6, 2007. To receive payment from Medicare, health care providers must meet certain statutory requirements and comply with regulations established by the Secretary of the Department of Health and Human Services (DHHS). See National Health Policy Forum, “Hospital Oversight in Medicare: Accreditation and Deeming Authority,” NHPF Issue Brief No. 802, May 6, 2005.

¹⁴ Research has indicated that the limited applicability and utility of publicly reported quality measure data is a challenge to the effectiveness of public reporting efforts, generally. See, for example, Christianson, JB et al. (2010) “A Report Card on Provider Report Cards: Current Status of the Health Care Transparency Movement.” *J Gen Intern Med* 25(11): 1235-41.

¹⁵ For example, when the Joint Commission (TJC) began its program to measure hospital quality in 1998, there was “no consensus [...] regarding the kinds of measures on which data should be gathered by hospitals.” The article goes on to note that, “hospitals strongly resisted collecting data on quality measures and reporting them publicly.” Chassin, MR et al. (2010) “Accountability Measures- Using Measurement to Promote Quality Improvement.” *NEJM*, 363: 683-688.

¹⁶ For more information on the role of the federal government in the training and development of the health care workforce, see CRS Report R42029, *Physician Supply and the Patient Protection and Affordable Care Act*, by (name redacted) and (name redacted).

interoperable health information technology;¹⁷ and (3) a robust evidence base, informed by health services research,¹⁸ are all relevant. In addition, improving the quality of care may be closely tied to other broad policy goals, such as (1) reducing health care disparities, (2) improving the affordability of health care, and (3) improving the health status of communities.¹⁹ However, a full discussion of these interactions is beyond the scope of this report.

Ongoing congressional interest in enhancing the quality of health care is likely given the federal role in the delivery and financing of health care through, for example, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Veterans Health Administration (VHA), and the Indian Health Service (IHS). This interest is reflected to date by significant legislative activity in this area, and most recently, by the passage of the Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152).²⁰ The ACA contains numerous provisions, directed at both the financing and delivery of care, that use the three policy approaches outlined above to target improvement in the quality of care.²¹

This report begins with a discussion of the role of quality measurement in policies to enhance provider accountability and presents selected policies addressing quality measurement in this context. It then provides an overview of payment incentives and public reporting of performance data to improve quality, along with selected policy examples for each approach.

The Role of Quality Measurement

Policies based on payment incentives and public reporting generally require the assessment of some combination of (or both) absolute and relative provider performance. These determinations rely on quality measures to determine current performance, as well as to monitor progress in performance. They also rely on information about the effectiveness of various interventions, care delivery models, treatment modalities, and therapeutics, and their links to health outcomes. Identifying desired outcomes, and evaluating the link between interventions and identified outcomes, relies on health services research. For example, comparative effectiveness research

¹⁷ The broad adoption of interoperable health information technology is described as “an essential foundation for our broader efforts to restructure health care delivery.... [I]t will facilitate new means of improving the quality, efficiency, and patient-centeredness of care.” Buntin MB et al. (2010) “Health Information Technology: Laying The Infrastructure For National Health Reform.” *Health Affairs* 29(6):1214-1219.

¹⁸ For more information on federal support for health and health care research, see CRS Report R41737, *Public Health Service (PHS) Agencies: Overview and Funding, FY2010-FY2012*, coordinated by (name redacted) and (name redacted).

¹⁹ For example, officials from the Centers for Medicare and Medicaid Services (CMS) note that the agency's hospital-acquired condition (HAC) policy, one of several comprising its quality agenda, “is not only a Medicare payment policy initiative. It is important to acknowledge that the establishment of the policy has had important impacts on public health improvements, beyond Medicare payment adjustments to hospitals.” Straube, B and JD Blum. (2009) “The Policy on Paying for Treating Hospital-Acquired Conditions: CMS Officials Respond.” *Health Affairs* 28 (5): 1494-1497.

²⁰ These two laws will together hereinafter be referred to as “the ACA.”

²¹ For more information about these provisions, see CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*, coordinated by (name redacted) and (name redacted); and CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by (name redacted).

(CER) may contribute to identifying desired outcomes by providing evidence about the effectiveness, harms, and benefits of treatment options for specific conditions.²²

Where quality measures are not available, or clearly identified outcomes are lacking, policies to enhance accountability through payment incentives or public reporting may be of limited value. In addition, simply making measures available or identifying outcomes are, on their own, unlikely to serve as sufficient impetus for change, or for comprehensive and well-coordinated change; instead, it is the application of policy approaches, using this information, that most often brings about desired changes.²³

Several considerations arise when considering the use of quality measures in policies aiming to enhance provider accountability through payment incentives or public reporting. These include, among others (1) the availability of a comprehensive set of quality measures, (2) the strength of the evidence base supporting the measures, (3) the National Quality Forum (NQF)-endorsement status of the measures, and (4) the relative mix of different measure types.

The effectiveness of policies that are based on quality measurement is at least partially determined by the comprehensiveness of available quality measures and, specifically, measures that span diseases and conditions, care settings, and provider types. NQF, a private, nonprofit membership organization concerned with improving health care quality performance measurement and reporting, notes that, “[t]here is a strong need for the development of quality and cost measures that will ensure broad transparency on the value of care and support performance-based payment and quality improvement around the most prevalent conditions and health risks that account for the greatest share of health care spending.”²⁴ Identifying measure gaps is a part of achieving that aim. In March of 2010, at the direction of the HHS, NQF convened the Measure Prioritization Advisory Committee to identify measure gap domains and sub-domains, among other things.²⁵ This effort was part of a larger effort to develop a measure development and endorsement agenda.²⁶ In a recent GAO report, HHS officials noted that critical measure gaps exist with respect to their health care quality programs and initiatives;²⁷ in addition, the ACA established new, and expanded the scope of existing, HHS quality programs and initiatives, increasing the need to fill existing measure gaps.

²² CER generates evidence of effectiveness, benefits and harms by comparing drugs, medical devices, tests, surgeries, or methods to deliver health care. See Clancy, C and FS Collins. “Patient-Centered Outcomes Research Institute: The Intersection of Science and Health Care.” *Science of Translational Medicine*, 2(34-38): 18-20; June 2010.

²³ For example, a recent commentary on CER notes that “(l)acking a substantial effort focused on implementation, the published results of comparative effectiveness research are unlikely to change medical practice on their own . . . (a)nother barrier to implementation is the potential impact of practice change to clinical practice revenue in which appropriate incentives should be considered to motivate changes in deep-rooted clinical practices.” See Ommaya, AK and J Kupersmith. “Challenges Facing the US Patient-Centered Outcomes Research Institute.” *JAMA*, 306(7): 756-757; August 17, 2011.

²⁴ See National Quality Forum (NQF), “Measure Development and Endorsement Agenda.” <http://www.qualityforum.org/MeasureDevelopmentandEndorsementAgenda.aspx>.

²⁵ An example of a measure domain is care coordination and management; an example of a sub-domain under this domain is communication. See Measure Prioritization Advisory Committee Report, “Measure Development and Endorsement Agenda.” <http://www.qualityforum.org/MeasureDevelopmentandEndorsementAgenda.aspx>.

²⁶ The final report of this Advisory Committee was released in January 2011. See Measure Prioritization Advisory Committee Report, “Measure Development and Endorsement Agenda.” <http://www.qualityforum.org/MeasureDevelopmentandEndorsementAgenda.aspx>.

²⁷ United States Government Accountability Office. “Health Care Quality Measurement: HHS Should Address Contractor Performance and Plan for Needed Measures.” January 2012, <http://www.gao.gov/assets/590/587658.pdf>.

In policies that have an accountability component, measures that are based on a robust body of evidence may be preferred.²⁸ For example, experts suggest that clinical process quality measures should be based on “a strong foundation of research showing that the process addressed by the measure, when performed correctly, leads to improved clinical outcomes.”²⁹ The evidence should consist of more than a single study and be a majority randomized trials, thus reflecting a higher standard than that used for the development of practice guidelines (practice guidelines may serve as the basis for the development of quality measures).³⁰ Research has suggested that high levels of performance on clinical process quality measures does not always correlate with a commensurate improvement in clinical outcomes.³¹

Quality measures may be endorsed by NQF; that is, candidate measures are evaluated against a specified set of criteria, and if these are met, the measure receives NQF’s endorsement.³² For use in policies aiming to enhance accountability, NQF-endorsed measures are generally preferred.³³ However, the endorsement process is lengthy and deliberative, and this can affect the availability of endorsed measures for end users (e.g., HHS).³⁴ If statute does not specifically require the use of NQF-endorsed measures, policymakers may face decisions about balancing the need to move programs forward with waiting for endorsed measures to become available.

There are a number of different types of quality measures available, and policies may include a mix of these types, depending on the purpose or goal of the specific policy. Types of quality measures include, among others (1) structure, (2) process, (3) outcome, and (4) patient experience of care (see **Textbox 1**). There is an increasing focus on shifting away from clinical process quality measures to outcomes measures; for example, the Centers for Medicare & Medicaid Services (CMS) notes that it is seeking to “move as quickly as possible to using primarily outcome and patient experience measures” in its public reporting and value-based payment systems.³⁵ However, clinical process quality measures are still the most commonly used type of measure in most measurement activities (for both accountability and quality improvement purposes).³⁶

²⁸ RAND Health. (2011) “Technical Report: An Evaluation of the Use of Performance Measures in Health Care.” http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR1148.pdf.

²⁹ Chassin, MR et al. (2010) “Accountability Measures- Using Measurement to Promote Quality Improvement.” *NEJM*, 363: 683-688.

³⁰ Ibid.

³¹ See, for example, Amal NT et al. (2011) “Despite Improved Quality Of Care In The Veterans Affairs Health System, Racial Disparity Persists For Important Clinical Outcomes.” *Health Affairs* 30(4): 707-715. This study found “a striking disconnect between high levels of performance on widely used process measures and continuing disparity and modest levels of improvement in important health outcomes.” The authors contend that clinical process quality measures need to be developed that are linked with improved clinical outcomes in specific racial subpopulations.

³² For more information about the NQF Measure Evaluation Criteria, see http://www.qualityforum.org/docs/measure_evaluation_criteria.aspx.

³³ HHS has stated that they prefer to use NQF-endorsed measures to meet their measurement needs because these quality measures are nationally recognized standards and in some cases HHS is required to use them. United States Government Accountability Office. “Health Care Quality Measurement: HHS Should Address Contractor Performance and Plan for Needed Measures.” January 2012, <http://www.gao.gov/assets/590/587658.pdf>; p. 35.

³⁴ United States Government Accountability Office. “Health Care Quality Measurement: HHS Should Address Contractor Performance and Plan for Needed Measures.” January 2012, <http://www.gao.gov/assets/590/587658.pdf>. See specifically, Appendix IV: Summary of Projects to Review the National Quality Forum’s Endorsement Process.

³⁵ 76 *Federal Register* 26491, May 6, 2011.

³⁶ A review of the use of performance measures, with particular emphasis on NQF-endorsed measures, for both accountability and quality improvement purposes, found that clinical process measures are the most commonly used (continued...)

Textbox 1. Types of Quality Measures

Process measures show whether steps proven to benefit patients are followed correctly. They measure whether an action was completed—such as writing a prescription, administering a drug, or having a conversation.

Outcome measures take stock not of the processes, but of the actual results of care. They are generally the most relevant measures for patients and the measures that providers most want to change. An example of an outcome measure is mortality within 30 days of hospitalization for a specific condition.

Patient experience measures record patients' perspectives on their care (these may be captured using process or outcome measures). An example of a measure of patient experience of care is adequacy of pain control while hospitalized.

Structural measures reflect the conditions in which providers care for patients. These measures can provide valuable information about staffing and the volume of procedures performed by a provider.

Source: National Quality Forum (NQF), "Measuring Performance, The Right Tools for the Job," at http://www.qualityforum.org/Measuring_Performance/ABCs/The_Right_Tools_for_the_Job.aspx.

The ability to directly compare the performance of providers is an essential component of many payment incentive and public reporting policies that aim to enhance provider accountability; at a basic level, the creation of incentives to improve quality relies on being able to make distinctions between providers. Quality measurement allows for the generation of provider-specific performance information, which, in turn, allows for these distinctions to be made based on relative comparisons between providers (as well as monitoring of improvement in individual provider performance). Given the central importance of quality measurement in payment incentive and public reporting policies, policymakers have taken steps to support the development of measures, and specifically in gap areas (see **Textbox 2**). For example, comparative performance information allows, among other things,

- payers and purchasers to selectively reward higher-quality performance (payment incentive);
- payers and purchasers to evaluate relative outcomes associated with new delivery models to guide payment incentives (payment incentive);
- providers to improve their own performance (public reporting); and
- patients to choose providers or care that best meets their needs (public reporting).

Despite the role of quality measurement in payment incentive and public reporting policies that aim to enhance provider accountability, and an increasing focus on these policies overall, questions remain about the link between quality measurement and actual quality of care. As discussed before, the link between clinical process quality measures and outcomes is not always clear. Experts suggest that more systematic surveillance efforts are needed to better understand trends, links between process and outcome, and facility-by-facility differences in performance.³⁷

(...continued)

type of measure, being used in 89% of reported measurement activities. RAND Health. (2011) "Technical Report: An Evaluation of the Use of Performance Measures in Health Care." http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR1148.pdf.

³⁷ "Health Policy Brief: Improving Quality and Safety." *Health Affairs*, April 15, 2011.

In addition, the meaning of quality to consumers may differ from the definition used by policymakers or regulators. For example, consumers value access, the availability of their providers, cost, and provider choice, among other things; these factors are variably captured in policy efforts that use quality measurement.³⁸ Consumers may also value health outcomes differently, complicating efforts to define and measure quality.

Textbox 2. Quality Measurement: Selected Policy Examples

Quality Measure Development

The Agency for Healthcare Research and Quality (AHRQ), the Centers for Medicare and Medicaid Services (CMS), and the Secretary of the Department of Health and Human Services (HHS) are directed by ACA Section 3013 to identify (1) gaps in existing quality measures and (2) existing measures that need improvement, updating, or expansion. A report on any gaps identified, and the process used to identify the gaps, will be made available to the public. The HHS Secretary will be funding or entering into agreements with eligible entities to develop, improve, update, or expand quality measures in areas identified as gap areas.

Source: ACA Section 3013.

Supporting Health Services Research to Develop Quality Measures

The Healthcare Quality and Research Act of 1999 (P.L. 106-129) established the Agency for Healthcare Research and Quality (AHRQ), whose mission it is to “to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions.”

AHRQ’s mission includes the promotion of “health care quality improvement by conducting and supporting research that develops and presents scientific evidence regarding all aspects of health care, including methods for measuring quality and strategies for improving quality.” Under general authorities, the agency conducts “research, evaluations, and training, support[s] demonstration projects, research networks, and multidisciplinary centers, provide[s] technical assistance, and disseminate[s] information on health care and on systems for the delivery of such care, including activities with respect to quality measurement and improvement.”

Source: PHSA Section 901(b)(1)(F) and PHSA Section 902(a)(1).

Payment Incentives for Quality

Emphasis has been placed on changing the way health care is paid for, away from a system where payment is simply a transaction based on the unit of care provided, to one where higher-quality, lower-cost care is preferentially rewarded.³⁹ This policy approach, representing a shift from volume-based or fee-for-service (FFS) payment to value-based payment, is often referred to as value-based purchasing or value-driven health care. Value-based purchasing may be defined as modifying reimbursement to encourage health care providers, through joint clinical and financial accountability, to deliver higher quality care at lower total cost.⁴⁰ Such efforts may modify

³⁸ Hibbard, JH et al. (2010) “What Is Quality Anyway? Performance Reports That Clearly Communicate to Consumers the Meaning of Quality of Care.” *Medical Care Research and Review* 67(3): 275-293.

³⁹ See for example Mayes, R. (2011) “Moving (realistically) from volume-based to value-based health care payment in the USA: starting with Medicare payment policy.” *Journal of Health Services Research Policy* 16(4): 249-251.

⁴⁰ Centers for Medicare & Medicaid Services. (2008) “Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program.” https://www.cms.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf.

payment through payment incentives. These incentives may include adjustments to payment (generally in the form of reductions) as well as performance-based payments; in addition, direct payment, generally in the form of a monthly fee, may be made for a desired activity (e.g., care coordination) that is not itself the actual provision of care.⁴¹

Payment incentives may be based on the reporting of, or performance on, a set of quality measures. For this reason, payment incentives may rely integrally on quality measurement. In addition, payment modification may create incentives that are directive; that is, incentives to modify the delivery of specific clinical care processes (e.g., by linking payment to specific clinical process quality measures). They also may create incentives that are non-directive; that is, incentives to modify overall delivery of care that link payment to performance on an outcome (e.g., rates of hospital readmissions or healthcare-associated infections [HAIs]), but that rely on individual providers to implement care delivery changes of their choice to improve performance on these outcomes.

This section begins by discussing the role of the Medicare program in this area and then summarizes the modification of payment through incentives. This discussion focuses on those payment incentives that have improving quality or value as their primary goal, rather than those aimed solely at altering resource use. In addition, it addresses mechanisms for the modification of payment, as opposed to different *models* of payment (e.g., capitation, shared savings); many of the payment incentives discussed here could theoretically be applied in the context of different payment models.

The Role of Medicare

At the federal level, the Medicare program provides policymakers the opportunity to implement value-based purchasing approaches and other payment modifications.⁴² Other coverage and financing arrangements generally are not under the sole or direct control of the federal government, and therefore do not afford federal policymakers a similar opportunity. For example, government health care delivery systems (e.g., the Veterans Health Administration [VHA] or the Indian Health Service [IHS]) in which the government is a direct provider of care (i.e., both paying for and delivering care) do not offer an opportunity to implement traditional value-based purchasing approaches that incentivize individual provider behavior change through accountability because services are not paid for individually and providers are salaried.⁴³ In addition, although the federal government does regulate the private health insurance market to an extent, this is a role that rests primarily with the states.⁴⁴ Some payment incentive policies have

⁴¹ For examples of this approach, see a listing of Medicare disease management and care coordination demonstrations in: Congressional Budget Office. (2012) "Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment." Issue Brief. <http://www.cbo.gov/ftpdocs/126xx/doc12663/01-18-12-MedicareDemoBrief.pdf>.

⁴² Mayes, R. "Moving (realistically) from volume-based to value-based health care payment in the USA: starting with Medicare payment policy." *Journal of Health Services Research Policy* 16(4): 249-251: October 2011.

⁴³ The Veterans Health Administration carries out numerous programmatic quality improvement efforts, although they are not based on modification of payment. See, for example, Congressional Budget Office (CBO), "Quality Initiatives Undertaken by the Veterans Health Administration," August 2009.

⁴⁴ Linehan, K. "Individual and Small-Group Market Health Insurance Rate Review and Disclosure." Issue Brief No. 844, National Health Policy Forum, September 28, 2011. The federal government now requires plans and health insurance issuers, within two years of the enactment of the ACA, to annually submit to the Secretary and to enrollees, a report addressing whether plan benefits and reimbursement structures achieve certain quality-related goals; for (continued...)

been established at the federal level for the Medicaid program (a shared federal-state program), although the states generally have responsibility for implementing their programs and are given wide discretion in doing so.⁴⁵

Although the opportunity to directly implement policies modifying payment, including value-based purchasing policies, is generally limited to the Medicare program at the federal level, these efforts may have a broader impact given Medicare's frequent role as a leader for private insurers.⁴⁶ Researchers note that "(o)ver the last 40 years, Medicare has exerted more influence on the organization, finance and delivery of USA health care than any other individual payer."⁴⁷ In recent years, CMS has implemented a range of initiatives, including value-based purchasing efforts, largely at the direction of Congress, in an effort to "transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries."⁴⁸

The effect of payment incentives on cost and quality is unclear, however. For example, a review by the Cochrane Collaboration concluded that there is little evidence of the success of financial incentives in improving the quality of primary health care, citing the need for additional study in this area.⁴⁹ Given this uncertainty with respect to the impact on health care cost and quality, payment incentives implemented in the Medicare program may provide valuable data that private insurers and others may use when considering implementing these approaches. Recently, the Congressional Budget Office (CBO) noted, in a review of Medicare demonstration projects meant to reduce cost and improve quality for the program, that "substantial changes to payment and delivery systems will probably be necessary for programs involving ... value-based payment to significantly reduce spending and either maintain or improve the quality of care provided to patients."⁵⁰

Overview of Payment Incentives

As mentioned above, payment incentives may be achieved through adjustments to payment or through performance-based payments. Additionally, a fee may be offered as direct payment, generally for a desired non-clinical service. Payment adjustments may be made using a predetermined adjustment factor or through non-payment for costs associated with specific care. Payment may be decreased by an adjustment factor (e.g., a specified percentage reduction)

(...continued)

example, improving health outcomes through the use of quality reporting, case management, care coordination and chronic disease management. ACA Section 1001(5) adding PHSA Section 2717 "Ensuring the Quality of Care."

⁴⁵ Medicaid recently undertook a payment adjustment policy for health care-acquired conditions (HCACs). This is modeled on Medicare's payment adjustment policy for hospital acquired conditions. The Medicaid policy authorizes each state to identify and add "other provider-preventable conditions" at the state's discretion. *76 Fed.Reg.* 32815, June 6, 2011.

⁴⁶ See, for example, the Medicare Payment Advisory Commission's (MedPAC) March 2007 Report to Congress, "Medicare Payment Policy," page ix. http://www.medpac.gov/documents/mar07_entirereport.pdf.

⁴⁷ Mayes, R. "Moving (realistically) from volume-based to value-based health care payment in the USA: starting with Medicare payment policy." *Journal of Health Services Research Policy* 16(4): 249-251: October 2011.

⁴⁸ *76 Federal Register* 26490, May 6, 2011.

⁴⁹ Scott, A et al. (2011) "The effect of financial incentives on the quality of health care provided by primary care physicians." *Cochrane Database of Systematic Reviews*, Issue 9, Art. No.: CD008451.

⁵⁰ Congressional Budget Office. (2012) "Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment." Issue Brief. <http://www.cbo.gov/ftpdocs/126xx/doc12663/01-18-12-MedicareDemoBrief.pdf>.

applied to specific charges or to annual updates in payment. For example, a payment adjustment may be applied for failing to complete a discrete activity (e.g., reporting data for a set of quality measures).⁵¹ Such an adjustment factor can be applied for failure to meet a specific performance threshold (e.g., being in the top 25% of hospitals in terms of number of hospital acquired conditions).⁵² Payment may also be adjusted such that it is withheld for the cost of care associated with a specific undesirable outcome in an individual patient.⁵³

Payment incentives may also be based on discrete performance, or improvement in performance over time. This type of performance-based payment may be given to individual providers, based on the individual provider's performance, and on this performance in the context of other participating providers' performance. In the Medicare program, a performance-based payment is often made in a budget-neutral manner; that is, all affected entities receive a specified decrease in payment. This generates money that may then be redistributed to the affected entities differentially as payment incentives based on performance.⁵⁴

A third type of payment incentive is the offering of a fee to providers in exchange for providing services that generally fall outside of the scope of direct care provision; the basis for this approach is the contention that in the absence of direct payment, these services would not be provided to patients. Examples include payment for carrying out administrative and other duties associated with care coordination or chronic disease management (e.g., patient education, tracking receipt of recommended clinical preventive services). In the context of fee-for-service Medicare, the payment may be a per-beneficiary, per-month fee. In addition, the fee may be at-risk; that is, all or some portion of the fee may be withheld if cost targets are not met. This strategy has been tested through multiple Medicare demonstrations with mixed results.⁵⁵

Payment incentives may also be blended; that is, policies may include some combination of the approaches outlined above. For example, while primary care physicians could receive a care coordination fee in exchange for carrying out the administrative duties associated with being a designated medical home for patients, payment for the actual provision of health care services could additionally be modified based in some part on performance on quality measures. This

⁵¹ An example of this type of payment adjustment is seen in the Hospital Inpatient Quality Reporting Program at CMS. If participating hospitals fail to report data on the Hospital IQR Program measure set, their annual payment update is adjusted down by a factor of 2%. For more information on the Hospital IQR Program, see https://www.cms.gov/HospitalQualityInits/08_HospitalRHQDAPU.asp#TopOfPage.

⁵² For example, the ACA (Section 3008) requires that hospitals not in the top quartile in terms of number of hospital acquired conditions will receive a payment adjustment decrease of 1% on applicable discharges. A hospital acquired condition is a condition that is acquired, or events that occur, during a stay in a healthcare facility. For more information on HACs generally, see https://www.cms.gov/hospitalacqcond/06_hospital-acquired_conditions.asp.

⁵³ Concerns have been raised about adjusting payment for quality based on an individual case. It has been suggested that a preferred approach to adjusting payment for quality would be to look at a year's worth of claims data to identify high rates of undesirable outcomes, and therefore possible facility-specific quality issues. See the American College of Cardiology, in comments to CMS on the proposed changes to the hospital inpatient prospective payment systems for acute care hospitals for FY2012, June 20, 2011, <http://www.cardiosource.org/advocacy/issues/~media/Files/Advocacy/Physician%20Payment/comments%20on%202012%20hospital%20inpatient%20rule.ashx>.

⁵⁴ For example, the CMS Hospital Value-Based Purchasing Program includes a requirement that incentive payments made under the program be budget neutral. That is, "the total amount available for value-based incentive payments for all hospitals for a fiscal year must be equal to the total amount of reduced payments for all hospitals for such fiscal year." 76 *Federal Register* 26532, May 6, 2011.

⁵⁵ See Congressional Budget Office. (2012) "Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment." Issue Brief. <http://www.cbo.gov/ftpdocs/126xx/doc12663/01-18-12-MedicareDemoBrief.pdf>.

would be an example of using a fee to pay directly for a desired service that is not currently being offered (administrative duties associated with being a medical home) and a performance-based payment incentive to reward performance on quality of care measures. The Patient Centered Primary Care Collaborative (PCPCC) proposed such a blended model, which has three components: (1) a fee-for-service payment based on office visits, (2) a performance-based component based on achievement of greater quality and efficiency, and (3) a care coordination payment to reimburse for the coordination work that takes place outside of the office visit and also to support health information technology as necessary to serve as a medical home.⁵⁶ See **Textbox 3** for specific examples of payment incentive policies.

⁵⁶ Patient-Centered Primary Care Collaborative. “Proposed Hybrid Blended Reimbursement Model.” <http://www.pcpcc.net/reimbursement-reform>.

Textbox 3. Payment Incentives: Selected Policy Examples

Adjustment

Section 5001(c) of the Deficit Reduction Act (DRA, P.L. 109-171) provides the statutory basis for CMS's regulation precluding reimbursement for certain conditions and events, termed hospital-acquired conditions (HACs). This provision states that the Secretary should identify at least two diagnosis codes, which when used as a secondary diagnosis code result in the assignment of a diagnosis-related group (DRG) that results in a higher payment. The statute stipulates that the conditions chosen must be either or both high-cost and high-volume; must be preventable by application of evidence-based practices; and must "result(s) in the assignment of a case to a diagnosis-related group that has a higher payment when the code is present as a secondary diagnosis."

Hospitals are required to report whether these conditions are present upon admission (POA). If they are not, and they are acquired or occur during the hospital stay, costs associated with their treatment will not be paid for by CMS. Specifically, Medicare will not pay for the more expensive bundle of care that would be associated with treatment for a condition plus an HAC; rather, CMS will only pay for the bundle of care associated with treatment for the condition itself.

Source: CMS. Hospital-acquired Conditions, https://www.cms.gov/hospitalacqcond/06_hospital-acquired_conditions.asp.

Performance-Based Payment

Beginning in FY2013, and as required by ACA Section 3001, CMS is required to implement a value-based purchasing program for hospitals, the Hospital Value-Based Purchasing (VBP) Program. This pay-for-performance program will adjust payment based on both performance and improvement on a set of quality measures; it also includes a public reporting component. Hospital performance on specific measures will eventually be publicly available through CMS's Hospital Compare website.

Source: CMS. Hospital Quality Initiatives, Overview, <https://www.cms.gov/HospitalQualityInits/>.

Additional Direct Payment: Fee

Medicare's Comprehensive Primary Care Initiative (through the Center for Medicare and Medicaid Innovation) supports the delivery of higher-quality, better-coordinated, and more patient-centered care by primary care practices. Specifically, primary care practices will be given additional resources in direct payment for certain services related to managing care for patients. This includes carrying out a five-part delivery model: (1) managing patients with high health care needs; (2) ensuring access to care; (3) delivery of preventive care; (4) engaging both patients and caregivers; and (5) coordinating care across the medical neighborhood. The additional resources will come to primary care practices in the form of a monthly care management fee on behalf of Medicare fee-for-service (FFS) beneficiaries; in the second two years of the four year program, participants will have the option of sharing any generated savings in addition to receiving a modestly reduced monthly care management fee.

Source: Department of Health and Human Services (HHS), "Fact Sheet: Comprehensive Primary Care Initiative," September 28, 2011, at http://innovation.cms.gov/documents/CPCi_FactSheet_final_10_3_11.pdf.

Public Reporting of Performance Information

Policymakers have undertaken efforts to enhance provider accountability through the public reporting of performance information; these efforts have generally occurred in concert with policies that modify payment to incentivize higher quality. Public reporting, in this context, may be defined as "the objective measurement and public disclosure of physician and hospital performance."⁵⁷ The objectives of public reporting are numerous, but include, among others (1) increasing the accountability of health care organizations, professionals, and managers; and (2)

⁵⁷ Ross, JE et al. (2010) "Datawatch: State-Sponsored Public Reporting Of Hospital Quality: Results Are Hard To Find And Lack Uniformity." *Health Affairs* 29(12): 2317-2322.

maintaining standards or stimulating improvements in the quality of care provided.⁵⁸ In addition, public reports are intended to encourage consumer participation through the facilitation of informed decision making.⁵⁹

The impact of public reporting on both consumer decision making, as well as quality improvement efforts by providers, is unclear.⁶⁰ Regardless, a number of efforts are underway in the Medicare program to make performance information publicly available, largely at the direction of Congress; these include websites providing comparative information about hospitals, nursing homes, and physicians, for example. This section discusses the theory underlying public reporting, factors influencing consumers' use of performance information to guide decision making, and the effect of public information on provider quality improvement efforts.

The Theory Underlying Public Reporting

Theoretically, making information on provider performance public serves to correct an existing information asymmetry; that is, an imbalance in information between the provider and user of a service, in this case, health care services.⁶¹ However, this information imbalance could, in fact, be exacerbated by the release of inaccurate information; additionally, this would have the potential to harm the reputation of providers.⁶² Assumptions underlying the public release of performance information include the contention that consumers want to make use of the data, and that they in fact will.⁶³

The public provision of performance information is expected to facilitate informed decision making among consumers with respect to their health care. This modified decision making, in turn, is expected to increase market share for those better performing providers.⁶⁴ This would create a feedback loop that would reward higher performing providers financially. With respect to health care providers, public reporting of performance information is “expected to fuel professional desire to improve care and improve quality, either out of concern for public image or in an effort to maintain professional norms and standards of self-governance.”⁶⁵

⁵⁸ Marshall, MN et al. (2003) “Public Reporting On Quality In The United States And The United Kingdom.” *Health Affairs* 22(3): 134-148.

⁵⁹ Faber M et al. (2009) “Public Reporting in Health Care: How Do Consumers Use Quality-of-Care Information? A Systematic Review.” *Medical Care* 47(1): 1-8.

⁶⁰ Ketelaar NABM, et al. (2011) “Public release of performance data in changing the behavior of healthcare consumers, professionals or organizations.” *Cochrane Database of Systematic Reviews*, Issue 11.

⁶¹ In microeconomic theory, information asymmetry is an example of a classic market failure, within the theory of perfect competition. This theory holds that in certain cases, the market fails to create conditions that will support a perfectly functioning market, and in this case, government intervention is warranted to correct that failure. Here, the basic contention is that the market will not correct the imbalance of information between the patient/consumer and the provider of health care, creating inherent inefficiencies; therefore, this information must be publicly supplied. See for example, Weimer WL and AR Vining. “Policy Analysis: Concepts and Practice.” Prentice Hall, 1999; pp. 107-115.

⁶² Tu JV et al. (2011) “Effectiveness of Public Report Cards for Improving the Quality of Cardiac Care: The EFFECT Study: A Randomized Trial.” *JAMA* 302(21): 2330-2337.

⁶³ Faber M et al. (2009) “Public Reporting in Health Care: How Do Consumers Use Quality-of-Care Information? A Systematic Review.” *Medical Care* 47(1): 1-8.

⁶⁴ Ross, JE et al. (2010) “Datawatch: State-Sponsored Public Reporting Of Hospital Quality: Results Are Hard To Find And Lack Uniformity.” *Health Affairs* 29(12): 2317-2322.

⁶⁵ Ibid.

Issues with Consumer Use of Performance Information

In practice, the theory underlying public reporting of performance information is complicated by a number of other factors related to consumer decision making in health care. This decision making may be influenced by (1) characteristics of the performance information itself (e.g., how user-friendly it is); (2) characteristics of the consumer herself (e.g., health literacy); and (3) factors that are important to the consumer but unrelated to performance information or objective quality of care (e.g., referrals from family members or friends).

Characteristics of the performance information itself that influence its use by consumers include, among others (1) awareness of the information, (2) relevance of the information, and (3) usability of the information (e.g., its presentation). Data suggest that the public's familiarity with public sources of performance information is generally low; for example, one survey found that only 6% of the public had heard of CMS's Hospital Compare website (see **Textbox 4**).⁶⁶ Studies have indicated that in some cases, consumers find performance information to be of limited relevance; specifically, for example, information must apply to conditions that are relevant to the consumer and must distinguish between high-quality and low-quality care in a clear manner.⁶⁷ Finally, although a consumer's ability to use performance information is affected by the way in which the performance information is presented, it also is dependent on personal characteristics of the consumer herself, such as her ability to understand technical clinical process quality measures.⁶⁸

Consumer decision making in health care is also known to be influenced by a number of factors unrelated to performance information. These factors include, for example, referrals from trusted family or health care providers, hospital location, and cost (e.g., varying insurance cost-sharing).⁶⁹ These competitive factors may outweigh use of performance information in decision making altogether, in some cases.

The Effectiveness of Public Reporting

Public reporting aims to both motivate quality improvement activities by health care providers and to facilitate consumer participation in their health care through informed decision making. Studies suggest that consumers are generally not making use of performance information in their health care decisions. For example, one survey found that only 7% of the public had seen and used quality information about hospitals, and only 6% had seen and used quality information about physicians.⁷⁰ This is likely due, at least in part, to the presentation of the information, the actual information being presented, and other factors that are also valued by the consumer (e.g., hospital location).

⁶⁶ Kaiser Family Foundation (KFF), "2008 Update on Consumers' Views of Patient Safety and Quality Information: Summary and Chartpack." October 2008, <http://www.kff.org/kaiserpolls/upload/7819.pdf>. See p. 3.

⁶⁷ Metersky, ML. (2011) "Point: Will Public Reporting of Health-care Quality Measures Inform and Educate Patients? Yes." *Chest* 140(5): 1115-1116.

⁶⁸ Lagu T and PK Lindenauer. (2010) "Putting the Public Back in Public Reporting of Health Care Quality." *JAMA* 304(15): 1711-1712.

⁶⁹ Ibid.

⁷⁰ Kaiser Family Foundation (KFF), "2008 Update on Consumers' Views of Patient Safety and Quality Information: Summary and Chartpack." October 2008, <http://www.kff.org/kaiserpolls/upload/7819.pdf>. See p. 3.

The impact of the public reporting of performance data on motivating quality improvement efforts by providers is unclear. One study found, for example, that the release of performance information is not correlated with an increase in performance on clinical process quality measures.⁷¹ This study also found, however, that hospitals receiving publicly available performance reports on both an early and delayed basis undertook quality improvement initiatives in response to this information. That is, many hospitals initiated quality improvement efforts upon learning about the public reporting activity from hospitals in the group receiving early feedback, but before receiving their own hospital-specific feedback.

Textbox 4. Public Reporting: Selected Policy Examples

The CMS Hospital Compare Website

In 2005, the Centers for Medicare and Medicaid Services (CMS) established, as part of its Hospital Quality Alliance: Improving Care through Information initiative, the Hospital Compare website to publicly display facility-specific performance data. This site displays information collected through the CMS Hospital Inpatient Quality Reporting (IQR) Program (formerly the Reporting Hospital Quality Data for Annual Payment Update, or RHQDAPU). Information displayed includes quality measure data (measuring both clinical processes and clinical outcomes), cost data, and patient reports of care. This website also displays performance data from other sources, for example, The Joint Commission (TJC), and recently began displaying facility-specific rates of certain health care-associated infections (HAIs).

Source: Hospital Compare website, at <http://www.hospitalcompare.hhs.gov>.

National Strategic Framework for Public Reporting

The ACA requires the HHS Secretary to establish and implement an overall strategic framework to carry out the public reporting of performance information. Performance information summarizing data on quality measures will be made available to the public through standardized websites. Such performance information must include information regarding clinical conditions to the extent such information is available, and would where appropriate, be provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions.

Source: ACA Section 3015.

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⁷¹ Tu JV et al. (2009) "Effectiveness of Public Report Cards for Improving the Quality of Cardiac Care: The EFFECT Study: A Randomized Trial." *JAMA* 302(21): 2330-2337.

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