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Paying for Quality and Doing It Right

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Paying for Quality and Doing It Right

Robert A. Berenson*

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I. Introduction

Scholars have amply documented the poor quality of American health care.¹ There are two aspects to this lack of quality: Substandard care is tolerated and acceptable care fails to live up to its potential.² The poor state of

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1. See generally Elizabeth A. McGlynn et al., *The Quality of Health Care Delivered to Adults in the United States*, 348 *NEW ENG. J. MED.* 2635 (2003) (basing research on interviews with patients and conducting chart reviews in twelve metropolitan areas, and finding that patients received only 54.9% of recommended care); Mark A. Schuster et al., *How Good Is the Quality of Health Care in the United States?*, 76 *MILBANK Q.* 517 (1998) (providing a comprehensive literature review documenting the poor level of quality in American health care).

2. See generally COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *CROSSING*

quality overall is mirrored in the care provided to Medicare beneficiaries. The same physicians, hospitals and other providers who serve the public generally also serve Medicare beneficiaries.³ Many scholars have engaged in a long-standing debate over whether quality should be improved by removing the bad apples from health care or by improving typical practice and thereby raising the mean or median of care.⁴ Improving care, however, should involve both eliminating substandard care and improving typical practice.⁵ Strategic reasons may exist to either "protect the floor" or "raise the ceiling" on quality in any particular initiative or activity, but stewards of the Medicare program should be committed to both efforts.

Developing a Medicare policy that protects and promotes quality would be easy if quality were a dichotomous variable, with each particular provider either supplying acceptable or subpar health care. But most quality exists on a continuum, and falls along a bell-shaped curve. Thus, the toughest challenge is to determine which part of the curve represents substandard or unacceptable quality.⁶ Most quality is "acceptable" by public program standards even if there is plenty of room for improvement.

Complicating things further, any particular provider's quality is highly variable by condition. For example, the hospital that is best at treating diabetics with severe eye complications may be only mediocre at managing diabetics

THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001) (detailing problems with the American health care system and offering recommendations).

3. See Steven Asch et al., *Measuring Underuse of Necessary Care Among Elderly Medicare Beneficiaries Using Inpatient and Outpatient Claims*, 284 JAMA 2325, 2329–30 (2000) (demonstrating significant deficiencies in care provided to Medicare beneficiaries on forty measures of "necessary" care or avoidable outcomes); Stephen F. Jencks et al., *Quality of Medical Care Delivered to Medicare Beneficiaries*, 284 JAMA 1670, 1670 (2000) (showing that the median state score on twenty-two accepted process-based quality measures was sixty-nine out of 100, with large interstate variation in performance); Stephen F. Jencks et al., *Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001*, 289 JAMA 305, 310–11 (2003) (documenting modest improvement from the mediocre quality performance in the previous study).

4. See Donald Berwick, *Continuous Quality Improvement as an Ideal in Health Care*, 320 NEW ENG. J. MED. 53, 54–55 (1989) (discussing the necessary steps for continuous quality improvement); David C. Hsia, *Medicare Quality Improvement—Bad Apples or Bad Systems*, 289 JAMA 354, 354 (2003) (reviewing the arguments and endorsing quality improvements that raise the bar for all practitioners).

5. In the Medicare context, this argument has played out in the gradual evolution of various Peer Review Organizations (now called "Quality Improvement Organizations") from organizations that focused on inspection of "bad apples care" to ones that promote quality improvement.

6. See, e.g., Timothy S. Jost, *Oversight of the Competence of Health Care Professionals*, in REGULATION OF THE HEALTHCARE PROFESSIONS 17–19 (Timothy Jost ed., 1997) (discussing regulatory mechanisms used for addressing the substandard care problem).

with serious vascular problems.⁷ In addition, a never ending string of well-publicized, horrendous system errors leading to death at the "best" places—Dana Farber, Mount Sinai, Sloan Kettering, and, most recently, Duke University—reminds us that system safety and the concentrated expertise necessary for providing cutting-edge quality certainly may not be congruent.⁸ However, the focus on purely technical aspects of care, such as whether physicians follow recommended guidelines for diagnosis and treatment, has faced complex operational challenges. Factoring in the patient and consumer perspective complicates matters even more.⁹ Although for purposes of policy analysis there is a common tendency to separate the issues of "access" from those of "quality," in the world where beneficiaries live, the concepts are merged.¹⁰ Thus, closing a hospital for technical quality deficiencies should involve important considerations such as the potential loss of jobs, as well as more patient-centered aspects of quality and availability.

This complexity makes one want to throw up one's hands and just continue to rely on or hope that physicians will take responsibility for quality as mandated by their professional ethics. By adopting this attitude, the Centers for Medicare and Medicaid Services (CMS) and its contractors might aspire to pay claims efficiently and provide good service to beneficiaries. CMS might also try to figure out how to manage costs, which again has emerged as a major issue dominating public policy attention.¹¹

7. See Mark Chassin, *Assessing Strategies for Quality Improvement*, HEALTH AFF., Jan./Feb. 1997, at 151, 157 (noting that hospitals currently cannot be expected to score well in all practice areas).

8. See, e.g., Tim Friend, *Spotlight on Medical Error: Mistakes Happen When Safeguards Fail to Operate*, USA TODAY, Apr. 2, 2003, at D9 (discussing deaths at Dana Farber and Duke University Hospitals); *Transplant Tragedy Reveals Larger Problem, 98,000 Deaths in U.S. Blamed on Medical Errors*, WINNIPEG FREE PRESS, Feb. 23, 2003, at B2 (noting pervasive problems at Duke University, Dana-Farber and Sloan-Kettering Hospitals).

9. See Elizabeth A. McGlynn, *Six Challenges in Measuring the Quality of Health Care*, HEALTH AFF., May/June 1997, at 8, 9–11 (describing the need to balance the perspectives of purchasers, patients, and physicians in measuring quality).

10. One of the more personally valuable things I did in my tenure at the Health Care Financing Administration (now called the Centers for Medicare and Medicaid Services) was to visit rural hospitals in Oklahoma, Texas and Mississippi. In many old rural communities, the hospital was the core economic engine—the leading employer around which other small enterprises revolved. In one hospital, I heard a Medicare beneficiary explain how she had never been to the big city sixty miles away—Jackson, Mississippi—and certainly would not be going there for medical care. It is true that patient satisfaction with care often is considered one of the important measures of quality. Patient satisfaction measures, however, focus on the nature of the care received and not on basic issues of availability and ease of access to services.

11. See Katherine Levit et al., *Trends in U.S. Health Care Spending, 2001*, HEALTH AFF., Jan./Feb. 2003, at 154, 164 (concluding that increases in health care spending would require new cost-cutting actions); see also CARA S. LESSER & PAUL B. GINSBURG, CTR. FOR STUDYING

As a social insurance program, Medicare relies upon providers in the private sector to supply health care services. Other developed countries with social insurance systems tend to defer to provider self-governance or corporatism, which often includes the authority to allocate funds among guild members.¹² Certainly, the tradition of deferring to professional authority over clinical matters is ingrained in social health insurance programs such as Medicare.

This Article will fundamentally challenge the notion that Medicare should maintain a passive attitude toward the state of quality provided to Medicare beneficiaries. First, this Article will explore the reasons why Medicare should be an active promoter of quality, emphasizing that its current payment system and related policies already send strong signals that influence provider behavior and performance.¹³ This Article next explains the difference between purchasing and buying health care and identifies some of the current impediments to Medicare becoming a strong purchaser.¹⁴ The Article then presents a purchaser model that identifies numerous interventions, in addition to paying for quality, that should be part of a comprehensive purchasing approach.¹⁵ This Article points out that many generally accepted interventions, at least conceptually, raise the same issues as those presented by an explicit policy of paying differentially for quality.¹⁶ The Article concludes by focusing specifically on conceptual and technical issues that must be dealt with when paying for quality. The Article explains how these issues might be dealt with by using two examples: end stage renal disease (ERSD) services and Medicare+Choice plan payments.¹⁷

HEALTH SYS. CHANGE, HEALTH CARE COST AND ACCESS PROBLEMS INTENSIFY, ISSUE BRIEF NO. 63 (2003) (finding that higher health costs have created skepticism about potential for "market-led solutions to the cost, quality, and access problems facing the health care systems today"), at www.hschange.org/CONTENTS/559 (last visited Sept. 15, 2003) (on file with the Washington and Lee Law Review).

12. See Till Barnighausen & Rainer Sauerborn, *One Hundred and Eighteen Years of the German Health Insurance System: Are There Any Lessons for Middle- and Low-Income Countries?*, 54 SOC. SCI. & MED. 1559, 1577-79 (2002) (noting that the central state government, as well as the market, have played a secondary role in the day-to-day decision-making in the German health care finance system).

13. See *infra* notes 30-31 and accompanying text (discussing Medicare's impact on provider behavior and private purchasers' inability to affect quality due to market realities).

14. See *infra* note 42 and accompanying text (noting that CMS is not allowed to affect provider care and generally is precluded from paying for quality).

15. See *infra* notes 45-53 and accompanying text (summarizing the tools that CMS might use as part of a strategic-purchasing initiative).

16. See *infra* notes 45-53 (outlining a framework for a new purchasing strategy).

17. See *infra* Part VII and accompanying text (proposing the Medicare+Choice program

II. Why Medicare Needs to Be a Promoter of Quality

Good reasons exist as to why Medicare should not accept a passive position regarding quality that merely defers to professionalism. First, left on their own, physicians and other providers likely will not be serious about quality improvement (raising the ceiling) or even improving basic safety (protecting the floor).¹⁸ Despite the Institute of Medicine's well-documented and enlightened description of the quality epidemic, the provider response has been limited.¹⁹ The failure to respond is not surprising because the majority of doctors do not believe that serious system problems involving safety or quality exist.²⁰ Regarding quality and safety, most physicians subscribe to the folk wisdom, "If it ain't broke, don't fix it."²¹

as an area on which to focus quality purchasing efforts).

18. See Hsia, *supra* note 4, at 394 (discussing alternative approaches to quality control of health care, such as raising the median of quality care and cutting off the tail of substandard care).

19. See INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26–68 (Linda Kohn et al. eds., 2001) (detailing relationship between errors in health care and avoidable deaths and injuries by claiming that 98,000 people die needlessly each year due to mistakes); Sandra G. Boodman, *No End to Errors*, WASH. POST, Dec. 3, 2002, at F1 (finding that three years after the release of the Institute of Medicine's report, little has been done to reduce the possibility of medical injury). Another important example of physicians' lack of responsiveness to specific quality enhancing opportunities is found in the results of the Study to Understand Prognoses and Preferences for Risks and Outcomes of Treatment (SUPPORT). See generally Alfred F. Connors et al., *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risk of Treatment (SUPPORT)*, 274 JAMA 1591 (1995). The study provided information on prognosis to dying patients and clinicians and also provided a highly-trained nurse to facilitate communication and to improve pain control. *Id.* However, despite the intervention to enhance decision-making at the individual patient-clinician level, the experience of seriously ill and dying patients remained poor. *Id.* at 1596.

20. See Robert J. Blendon et al., *Views of Practicing Physicians and the Public on Medical Errors*, 347 NEW ENG. J. MED. 1933, 1935 (2002) (finding that neither physicians nor the public appreciate that poor systems cause most medical errors and a majority of physicians do not think that patient safety is a major problem); Michael L. Millenson, *The Silence*, HEALTH AFF., Mar./Apr. 2003, at 103, 103–04 (arguing that medicine's continued quiet refusal to take quality improvement actions has undermined the moral foundations of medical professionalism). Even during this round's crisis of affordable professional liability insurance, organized medicine seeks to impose caps on noneconomic damages but does not take any responsibility for the prevalent safety problems that lead to lawsuits. See Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1598 (2002) (arguing that the tort system in medical malpractice does a poor job of deterring medical errors).

21. Indeed, among the various failings of medical professionalism, one of the most egregious is the core principle of individual autonomy, which has its roots in medical training. While autonomy does have useful attributes, such as the willingness to take heroic responsibility for a patient, this focus on individual autonomy and responsibility is a main factor leading to

Second, even when physicians and other providers are motivated to improve quality, the need to sustain their financial well-being often impedes quality improvement activities. In short, investing resources and effort in quality improvement often does not pay for itself and therefore meets resistance.²² The perverse reimbursement incentives used by both public and private purchasers of care are a major barrier to provider-initiated efforts in quality.²³ Thus, if CMS takes no new action, Medicare's policies will continue to contribute to provider complacency and frustrate well-intentioned quality improvement efforts.

Third, after spending decades accepting the current system, some employers and purchasing groups have tried to improve quality by becoming more active purchasers. Indeed, these active purchasers have demonstrated the potential for quality improvement through paying-for-quality programs. For example, the Business Roundtable founded an effort known as the Leapfrog Group, which uses its contracting authority to promote specific quality/safety activities related to mostly urban hospitals.²⁴

Additionally, private purchasers in a few geographic areas actually pay differentially for quality. For example, Empire Blue Cross Blue Shield, a New York-based health insurer, worked with four large employers to design a system that rewards hospitals that meet the Leapfrog criteria. Private purchasers have established other payment-for-quality initiatives in Cincinnati, Louisville,²⁵ and

inexcusable system breakdowns like those at the best medical institutions in the country.

22. See Sheila Leatherman et al., *The Business Case for Quality: Case Studies and An Analysis*, HEALTH AFF., Mar./Apr. 2003, at 17, 19–22 (examining four case studies of quality improvement activities to understand the financial and clinical implications and finding the lack of a business case).

23. See COMM. ON QUALITY OF HEALTH CARE IN AM., *supra* note 2, at 191–95 (describing payment mechanisms that inhibit quality improvement).

24. The Leapfrog Group initially identified three hospital safety measures to focus on: (1) computer physician order entry; (2) evidence-based hospital referrals; and (3) intensive care unit physician staffing. See THE LEAPFROG GROUP FOR PATIENT SAFETY, LEAPFROG PURCHASERS TOOLKIT, at <http://www.leapfroggroup.org/toolkit.htm> (last visited Jan. 27, 2004) (on file with the Washington and Lee Law Review); see also LESSER & GINSBURG, *supra* note 11 (describing hospital response to the Leapfrog Initiative and noting that many hospitals have chosen to adopt and build on the Leapfrog recommendations for quality health care); David Brown, *The End of an Error? Big Business, Launching a New Era of Reform, Is Pressuring Hospitals to Cut Mistakes*, WASH. POST, Mar. 26, 2002, at F1 (describing efforts of the Leapfrog Group to pressure providers).

25. See Robert Galvin, *Purchasing Health Care: An Opportunity for a Public-Private Partnership*, HEALTH AFF., Mar./Apr. 2003, at 191, 194–195 (describing quality initiatives in Cincinnati and Louisville); see also AARON KATZ ET AL., CTR. FOR STUDYING HEALTH SYS. CHANGE, COMMUNITY REPORT NO. 9, HMOs ALIVE AND WELL IN ORANGE COUNTY (2003) (describing tiered network products that provide different cost sharing obligations for beneficiaries based on their choice of provider), at www.hschange.org/CONTENTS/590/

California.²⁶ So far, these efforts have had little effect. Even the committed self-funded employers often lack the requisite market clout to affect provider behavior. By the time Medicare, Medicaid, the small and medium group insurance markets, the uninsured, workman's compensation programs, and patient self-pay obligations are eliminated, the remaining large employer market share of expenditures may only be 10 to 20% in a typical market. Further, private plans ordinarily put no more than 10% of their total payments in such a quality bonus pool.²⁷ In real terms, perhaps 1 to 2% of overall provider revenues might be affected through any particular private payment-for-quality contract. Perhaps this percentage is enough to get providers' attention and motivate them to take the steps necessary to achieve available bonuses, but it is unlikely to be sufficient to change business as usual fundamentally. Thus, although some of these private sector pay-for-performance initiatives are well-intentioned and often well-designed, private purchasers have little ability to move markets and overcome physician and hospitals' resistance to change.²⁸

Other structural problems influence the well-meaning efforts of private employers and certain health plans to improve quality, including free rider problems, lack of first mover advantage, and lack of economies of scale.²⁹ In

words=tiered+network (last visited Sept., 20 2003) (on file with the Washington and Lee Law Review). Although tiering is supposed to be based on a combination of cost and quality measures, health plans have for now focused almost exclusively on cost. *Id.*

26. See David A. Hyman, *Does Medicare Care About Quality?*, 46 PERSP. IN BIO. & MED., 55, 62 (2003) (outlining the paying-for-quality initiatives in California). For examples of the kinds of measures being developed, see generally *Pacific Business Group on Health*, at www.pbgh.org (last visited Jan. 27, 2004); *The Integrated Healthcare Association*, at <http://www.ihc.org/Ihaproj.htm> (last visited Jan. 27, 2004).

27. See Kelly J. Devers, *From the Field: Quality Improvement by Providers: Market Developments Hinder Progress*, HEALTH AFF., Sept./Oct. 2002, at 201, 204 (finding that depending on the market and the health plan, physicians receive a bonus of 4 to 10% for meeting the quality goals defined by HEDIS and patient satisfaction indicators).

28. Private purchasers themselves acknowledge that their market clout is limited. For example, MedPAC recently stated, "many private purchasers and plans are experimenting with mechanisms . . . to reward those who provide high-quality care. Yet, they all agree that Medicare's participation in these efforts is critical." MEDICARE PAYMENT ADVISORY COMMITTEE, MEDPAC REPORT TO CONGRESS: VARIATION AND INNOVATION IN MEDICARE 108 (June 2003) [hereinafter MEDPAC]. Also, in response to announcement of the CMS demonstration of paying for hospital quality, Gerry Shea, chief policy officer of the AFL-CIO, said corporations "have been dying to do this kind of thing but needed the government to take the lead." Ceci Connolly, *Pilot Test Will Pay Hospitals for Quality*, WASH. POST, June 11, 2003, at A3.

29. See Robert A. Berenson, *Bringing Collaboration into the Market Paradigm*, HEALTH AFF., Nov./Dec. 1998, at 128, 129-30 (arguing that the way in which medical markets have evolved presents formidable barriers to health plans trying to get market advantage by emphasizing quality activities, and suggesting that health plans should collaborate on quality in ways consistent with the antitrust laws).

short, although some scholars think that the private sector should take the lead in promoting quality in general, and in paying for quality in particular,³⁰ such a position leads us nowhere but to the status quo—providers still will not improve quality on their own and private purchasers, even when motivated, have a limited ability to affect provider behavior.

In fact, Medicare's payment and associated policies drive most provider behavior, for better or worse. For example, when Medicare pays generously to physicians and hospitals to perform invasive cardiac procedures but pays little for secondary prevention and disease management, cardiologists and cardiac surgeons structure their professional activities around performing the invasive procedures.³¹ Thus, by not explicitly focusing on how its coverage and payment policies affect quality, Medicare implicitly is rewarding certain behaviors that have a major effect on the quality of care that beneficiaries are receiving.

III. The Difference Between Purchasing and Buying Health Care

Traditionally, public purchasers in international social health insurance and national health systems have expressed concern about the total amount they spend, the general boundaries of the benefit packages that they fund, and what care is considered mainstream and what is considered alternative care. These purchasers, however, generally are less concerned about trying to influence the nature of the care they finance.³² Recently, however, purchasers have placed an increased emphasis on the performance of health systems. This attention has developed a consensus that the broad goals of health systems should include improvement in population health, responsiveness to legitimate public expectations, and fairness in financing.³³ In order to achieve improvements in

30. See generally Bruce Vladeck, *If Paying for Quality Is Such a Bad Idea, Why Is Everyone for It?*, 60 WASH. & LEE L. REV. 1345 (2003) (arguing that it is undesirable for a public purchaser to balance cost against quality).

31. See THE CTR. FOR STUDYING HEALTH SYS. CHANGE, *COMPETITION REVS UP THE INDIANAPOLIS HEALTH CARE MARKET*, at <http://www.hschange.org/content/523/> (2003) (discussing the effect of competition on Indianapolis health care market) (on file with the Washington and Lee Law Review).

32. See generally Martin McKee & Helmut Brand, *Purchasing to Promote Population Health*, in *PURCHASING TO IMPROVE HEALTH SYSTEMS PERFORMANCE* (J. Figueras et al. eds., forthcoming 2004).

33. See WORLD HEALTH ORG., *THE WORLD HEALTH ORG. REPORT 2000 HEALTH SYSTEMS: IMPROVING PERFORMANCE I* (2000) (evaluating health care systems that use these goals to improve health care quality), available at <http://www.who.int/whp2001/2001/archives/2000/en/pdf/overview.pdf> (on file with the Washington and Lee Law Review).

population health, purchasers need to be more actively concerned about how the health care delivery system operates. In systems based on social insurance principles, this need provides a rationale for providers to move from the passive payment of claims to the active purchase of services.

Beyond the goal of improved population health, the nature of health care provides an additional justification for public payors to assume an active purchaser role. As demonstrated in Nobel Laureate Kenneth Arrow's seminal article, the relationship between patients and health care professionals is characterized by an asymmetry of information, certainly with regard to the technical aspects of care.³⁴ The stress on the traditional principal-agent relationship that results because of this asymmetry of information emphasizes the need for purchasers to act on behalf of their patients in certain areas of care.³⁵

It is important to understand that active purchasing involves many strategies beyond those considered in this Article. Indeed, in a comprehensive purchaser strategy, paying differentially for quality likely would be one of the least-used purchasing techniques. In brief, a strategic purchasing framework involves a cyclical set of activities.³⁶ The first step in the framework is to assess health needs and, in particular, those needs that are less likely to be voiced by consumers and patients themselves. The second step is to determine how best to meet the identified needs by drawing on evidence of effectiveness, not just in relation to interventions on specific clinical problems, but also to the organizational structures and incentive systems that are most likely to result in delivery of effective care. The third step is to purchase care that complies with

34. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 951–52 (1963) (explaining the disparity of knowledge between doctor and patient and its effect on the doctor/patient relationship).

35. The recent documentation of quality failures in health care has changed the political context surrounding patient assistance and information initiatives. Some now argue that information technology, such as the Internet, offers an opportunity to "empower" patients to overcome any information asymmetry and to act fully on their own behalf, both as patients in their interactions with health care professionals and as consumers in selecting their insurance product among an array of options. See Deborah Hass-Wilson, *Arrow and the Information Market Failure in Health Care: The Changing Content and Sources of Health Care Information*, 26 J. HEALTH POL., POL'Y & L. 1031, 1039–40 (2001) (noting that patients can now access a wealth of information on the Internet regarding medical diagnoses, hospital quality, doctor reputation and style of practice); see also Jon B. Christianson et al., *Defined-Contribution Health Insurance Products: Development and Prospects*, HEALTH AFF., Jan./Feb. 2002, at 49, 51 (discussing consumer-directed health plans and outlining the relevant research). Nevertheless, even if consumers could improve their ability to actively participate on their own behalf, it would still be logical for purchasers to assist individuals in dealing with the remaining information asymmetry.

36. See generally McKee & Brand, *supra* note 32.

this specification. The fourth and final step in the cycle is to monitor the impact of this process, seeking to assure that effective care is firmly in place. Because health needs are changing and the delivery system is evolving, the assessment of health needs has to be a continuous process.³⁷

Before discussing the tools that Medicare could use as an active, strategic purchaser to encourage quality improvement for Medicare beneficiaries, it is important to realize that the Centers for Medicare and Medicaid Services (CMS), the agency with primary responsibility for administering Medicare, must confront major barriers before becoming a purchaser. From its inception as a political compromise, the Medicare program has been prohibited from interfering in the practice of medicine and from limiting beneficiaries' access to all participating providers in the program.³⁸

Perhaps the most important policy concern about Medicare as an active purchaser relates to the government's exercise of market power. In the case of purchasing for improved quality, this exercise runs the risk of distorting the market based on which provider or providers may be relatively favored.³⁹ Medicare is subject to Section 553 of the Administrative Procedures Act,⁴⁰ which Congress established to limit agency discretion and provide the opportunity for public review and comment—certainly a constraint in relation to the relative freedom that private sector purchasers enjoy.⁴¹

37. Although strategic purchasing models typically focus on quality aspects of care to improve the health of the population, the same framework and many of the same tools also can be used to improve the major component of value and cost—where value represents desired quality at an acceptable cost. See Robert A. Berenson & Dean R. Harris, *Using Managed Care Tools in Traditional Medicare—Should We? Could We?*, 65 LAW & CONTEMP. PROBS. 139, 149–54 (2002) (arguing that Medicare should implement certain traditional managed care techniques to reduce unnecessary spending in a way that would be more acceptable to beneficiaries and providers and that would withstand legal challenge). See generally Robert A. Berenson, *Getting Serious About Excessive Medicare Spending: A Purchasing Model*, HEALTH AFF., (Dec. 10, 2003), available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.586v1/DC1>.

38. See 42 U.S.C. § 1395 (2000) (stating that no federal official or employee can control or influence the practice of medicine or the manner in which medical services are provided). Some statutory exceptions exist to this general limitation on agency prerogatives. For example, Medicare has considerable authority in the designation of organ transplant centers. See Berenson & Harris, *supra* note 37, at 144 n.30 (citing 42 U.S.C. § 1395 and noting that Medicare has occasionally used its statutory authority to act like a purchaser, not a payor).

39. See also Medicare: *The Need for Reform: Hearing Before the House Comm. on the Budget*, 107th Cong. 48–50 (2001) [hereinafter *Hearings*] (testimony of William J. Scanlon, Director, Health Care Issues, United States General Accounting Office) (describing the hope that despite its size, Medicare will not disrupt the health care market when purchasing services).

40. 5 U.S.C. § 553 (2000) (outlining the rulemaking procedures government agencies must follow).

41. See Peter D. Fox, *Applying Managed Care Techniques in Traditional Medicare*,

Due to procedural restrictions that limit discretion and the national nature of the program and its defined, uniform benefits, CMS generally has not been an active health care purchaser.⁴² When it purchases, CMS relies on the more traditional tools it has used since the inception of the program: regulated entry into the program and statutory coverage and payment policies. In recent years, CMS has begun to broaden its approach, for example, by providing information and education to providers and beneficiaries through the Quality Improvement Program⁴³ and the National Beneficiary Education Program.⁴⁴ These tentative efforts at purchasing have not yet included a commitment to paying for performance, of which paying differentially for quality is a component.⁴⁵

Over the years, some individuals within CMS have attempted to develop a comprehensive purchasing model, which they have recently expanded.⁴⁶ For

HEALTH AFF., Sept./Oct. 1997, at 44, 45–46 (discussing constraints faced by the federal government when implementing managed care); Timothy S. Jost, *Governing Medicare*, 51 ADMIN. L. REV. 39, 62–63 (1999) (noting that when courts apply the Administrative Procedures Act to Medicare, they generally give deference to CMS rules); *see also Hearings, supra* note 39, at 51 (testimony of Dir. William J. Scanlon) (contrasting Medicare's ability to change program requirements with that of private plans).

42. MILBANK MEM. FUND, *Medicare's Attempts at Value-Based Purchasing: Challenges and Opportunities*, in VALUE PURCHASERS IN HEALTH CARE: SEVEN CASE STUDIES 101, 103–04 (2001) (reviewing CMS's attempts to be a value purchaser and the main barriers it has confronted).

43. *See* 42 U.S.C. §§ 1320c–1320–12 (2000) (renaming the Peer Review Program as the Quality Improvement Program).

44. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *MEDICARE & YOU: THE NATIONAL MEDICARE EDUCATION PROGRAM* (2000) [hereinafter *MEDICARE & YOU*] (providing information about the National Medicare Education Program, including the distribution of data about care providers), at <http://www.cms.hhs.gov/media/press/release.asp?Counter=374> (last modified Oct. 30, 2002) (on file with the Washington and Lee Law Review).

45. CMS generally is precluded by statute from paying for quality. CMS used its authority to establish a risk adjustment method for Medicare+Choice plans. These plans were designed to modify monthly payments to health plan contractors for the underlying health status of beneficiaries and to provide bonus payments to Medicare+Choice plans that meet specified quality measures for management of enrollees with congestive heart failure. This modification relies on the rationale that programs designed to meet national standards are a real cost that the risk adjustment system should recognize. *See* Press Release, Centers for Medicare and Medicaid Services, *Medicare+Choice Organizations To Be Paid More for Outpatient Management of Congestive Heart Failure* (May 9, 2000) (describing health care financing administration plans to implement a risk adjustment payment system to reward hospitals that invest in quality improvements), available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=200> (on file with the Washington and Lee Law Review).

46. The purchasing tools identified here are an expansion of the purchasing model being used at the Centers for Medicare and Medicaid Services. It was developed by Stephen Jencks and his colleagues in the CMS Office of Clinical Standards and Quality. *See generally* Stephen F. Jencks, M.D., *Reinvention in the Air*, Presentation at the Statewide Momentum for Health Care Quality Improvement Summit (Oct. 29, 2002), at www.hsag.com/Conf/Jencks

the purposes of this discussion, it is important to summarize the different tools or levers that CMS potentially could use as part of a strategic-purchasing initiative. These categories of tools, with examples, include:

- Regulatory requirements that govern provider participation, e.g., hospital conditions of participation;⁴⁷
- Benefit design, e.g., reduced cost-sharing for specified prevention services;⁴⁸
- Coverage policy, e.g., covering organ transplants only in designated centers;⁴⁹
- Payment policy, e.g., paying physicians using a fee schedule based on resource costs of production;⁵⁰
- Technical assistance to providers, e.g., the Quality Improvement Organizations (previously called Peer Review Organizations);⁵¹
- Consumer information and education, e.g. the National Beneficiary Education Program;⁵²
- Paying for performance, e.g., bonuses for Medicare+Choice plans for performance on national standards for congestive heart failure processes;⁵³

%20Plenary%20Revised%20(ch).pdf (last visited Oct. 13, 2003) (on file with the Washington and Lee Law Review).

47. See 42 C.F.R. § 482 (2002) (regulating conditions that hospitals must meet to participate in Medicare programs).

48. See 42 U.S.C. §§1395w-23 (2000) (outlining various elements of the payments received by Medicare+Choice programs).

49. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE COVERAGE ISSUES MANUAL § 35-87 (describing Medicare coverage of a variety of health conditions), available at http://63.241.27.78/manuals/PUB06PDF/PART_35.pdf (last visited Sept. 20, 2003).

50. See BARRY FURROW ET AL., HEALTH LAW § 11-20(b) (2d ed. 2000) (describing Medicare's resource-based relative value scale for physician payment).

51. See CTRS. FOR MEDICARE & MEDICAID SERVS., PEER REVIEW ORG. MANUAL: HEALTH CARE QUALITY IMPROVEMENT PROGRAM § 16,000 (discussing how statistical information can be used to identify patterns of care and to improve the overall quality of patient care under the Quality Improvement Project), at <http://www.cms.hhs.gov/manuals/19pro/pr16.asp#11> (last modified Aug. 26, 2002) (on file with the Washington and Lee Law Review).

52. See MEDICARE & YOU, *supra* note 44 (describing the way in which the National Medicare Education Program collects and distributes data documenting care providers' performance and results).

53. Coverage and payment policy refers to the rules that apply to all providers, whereas

- Collaboration among purchasers to achieve common objectives, e.g. participation in the National Quality Forum;
- Intervention directly in health care delivery, usually through contracting arrangements with organizations doing similar work for managed care organizations, e.g., disease management demonstrations.

An active strategic-purchasing regime, however, would employ a mix of the various tools. Yet, at any time, a particular purchasing tool may receive the greatest emphasis and generate the greatest controversy, often because of the views of the particular CMS administrator in place. For example, William Roper, who was administrator at the end of the second Reagan Administration, achieved national attention with his emphasis on publishing hospital mortality data to help inform Medicare beneficiaries' choice of hospitals.⁵⁴ After Roper's departure, clinical outcomes received much less attention. In Bruce Vladeck's tenure at CMS, he withdrew the hospital mortality data because of his view that the data was insufficiently case-mix adjusted and therefore not valid.⁵⁵ More

differential payment clearly distinguishes among providers. For example, many Medicare beneficiaries do not take advantage of the relatively recent benefit for screening colo-rectal cancer. See 42 U.S.C. §§ 1395x(s)(2)(R), 1395x(pp) (2000) (stating the parameters of Medicare coverage of colo-rectal screening); 42 U.S.C. § 1395x (2000) (outlining qualifications and guidelines for colo-rectal cancer screening). This new coverage has made the service more accessible. Payment policy, now precluded by the rules underlying the resource-based relative value schedule (RBRVS), might pay all Medicare physicians—family physicians, internists and gastroenterologists—substantially more than the standard RBRVS amount for performing stool tests for occult blood, sigmoidoscopies and colonoscopies. In this case, paying differentially for quality outcomes, e.g. performing colo-rectal screening on a specified percentage of patients, would be problematic because in the traditional program there would not be a population denominator on which to base the payment calculation. Although paying for performance or paying for quality appears to be the most controversial potential purchasing tool that CMS might adopt and is the primary subject of this paper, creative usage of the coverage and payment policy probably offers the greatest potential for obtaining higher quality for Medicare beneficiaries—but would be even more controversial than paying differentially for quality.

54. See William L. Roper et al., *Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice*, 319 NEW ENG. J. MED. 1197, 1197–98 (1988) (discussing the Health Care Financing Administration's four-step "effectiveness" program, which includes "annual release of information about mortality rates among Medicare patients according to hospital" and plans to expend this information with geographic variables).

55. See Jesse Green et al., *Analyzing Hospital Mortality: The Consequences of Diversity in Patient Mix*, 265 JAMA 1849, 1852–53 (1991) (analyzing the hospital mortality rates for Medicare patients as published by the Health Care Financing Administration and concluding that the case mix needs expansion and that variables for patient age and nursing home patients should be added to adjust the rates); Rolla Edward Park et al., *Explaining Variations in Hospital Death Rates*, 264 JAMA 480, 484 (1990) (investigating the methods used by the Health Care Financing Administration and reasoning that mortality rates are not completely indicative of lower quality because the differences in mortality may be linked to other factors). Although Vladeck withdrew the publication of hospital mortality data, some lower profile efforts to

than a decade after Roper's initial foray into clinical outcomes reporting, Thomas Scully, the current administrator, has again focused attention on quality reporting. Scully initially has focused on nursing home quality reporting, but plans to systematically provide quality data for many Medicare providers.⁵⁶

IV. Distinctions Without a Difference

As noted earlier, Congress has permitted and even required CMS to engage in some purchasing activities, though not always using purchasing terminology, in the areas of regulatory entry barriers, coverage and payment policy, technical assistance to providers, and consumer education.⁵⁷ Indeed, the recent trend is to advocate that Medicare should pay differentially for quality, and some experts have explored the technical issues of this idea to some degree.⁵⁸ In contrast, conceptual concerns of the kind raised by Bruce Vladeck's article in this volume have received less examination.⁵⁹

One of Vladeck's more troubling arguments is that quality is not randomly distributed among providers but rather is correlated with the relative affluence of the communities that physicians and hospitals serve.⁶⁰ Thus, he argues, a straightforward incentive for achieving a threshold score on national quality

provide beneficiaries with comparative information continued, e.g., Medicare Compare, which was a comparison of Medicare+Choice plans. See Press Release, Centers for Medicare & Medicaid Services, Medicare & You: The National Education Program (June 22, 1998) (describing the variety of information located at the Medicare website, including a database with comparative information about hospitals and other care providers), available at <http://www.cms.hhs.gov/media/press/release.asp?Counter=72> (on file with the Washington and Lee Law Review). Unlike Roper's initiative, these comparisons emphasize structural elements—e.g., the benefits offered, the geographic areas covered, and not the more controversial elements related to performance on quality measures.

56. See Editorial, *The Ultimate Weapon for Nursing Homes*, ST. LOUIS POST-DISPATCH, Nov. 13, 2002, at B6, available at 2002 WL 2596579 (describing CMS nursing home initiative and suggesting that objective information may lead to quality improvement and better informed choices). See generally KATHERINE BERG ET AL., CTRS. FOR MEDICARE & MEDICAID SERVS., IDENTIFICATION AND EVALUATION OF EXISTING QUALITY INDICATORS THAT ARE APPROPRIATE FOR USE IN LONG-TERM CARE SETTINGS (2002) (identifying and describing quality measures used in conjunction with the Nursing Home Quality Initiative), available at http://cms.hhs.gov/quality/nhqi/task2_final.pdf (on file with the Washington and Lee Law Review).

57. See *supra* notes 43–45 and accompanying text (describing CMS's ability to use its limited purchasing power to encourage certain quality improvement goals).

58. See MEDPAC, *supra* note 28, at 107–25 (analyzing the various financial incentive programs that Medicare could establish to improve quality of care).

59. See generally Vladeck, *supra* note 30.

60. *Id.* at 1361.

measures⁶¹ would send extra Medicare dollars to Vermont and Minnesota but not to Louisiana or Texas, even if the quality in the former states does not change.⁶² As a result, the rich would get richer, and because Medicare works in a budget-constrained world, the poor would become poorer.⁶³

As discussed below, CMS can mitigate the "rich get richer" argument that Vladeck presents. However, for the purpose of argument, let us accept that paying for quality provides disproportionate rewards for those providers whose financial positions place them in the best position to receive those rewards. If the desire not to advantage further those already doing a good job is a compelling constraint on paying for quality, then some broadly accepted purchasing approaches should be criticized because they would likely have similar effects on the relative financial impact on providers.

For example, despite the vacillating commitment of CMS to providing comparative quality information, most people accept that one of CMS's legitimate and important roles is to provide valid, objective data to help inform beneficiaries' choices. This choice exists in both the selection of an insurance vehicle, that is, traditional Medicare or a Medicare+Choice plan and, in the selection of particular providers at the point of service. The objections to using this purchasing tool tend to be "technical"—whether the quality data is appropriately case-mix adjusted so as to be valid, whether the data is reliable, and whether the data is understandable and useful. These are important and difficult technical issues, but for the most part, there is broad agreement on the desirability of providing such information to beneficiaries if the technical hurdles can be overcome.

For purposes of this discussion, assume CMS is able to provide beneficiaries with data that successfully overcomes these technical hurdles. One example of this type of data is the comparative information regarding the clinical outcomes of coronary artery bypass surgery (CABG), in terms of both morbidity and mortality.⁶⁴ One goal of providing clinical outcome data is that

61. CMS has adopted this type of payment model in their initial payment for quality demonstration. See PREMIER, INC., THE HOSPITAL QUALITY INCENTIVE DEMONSTRATION PROJECT (discussing the guidelines and payment procedures for the up-coming Hospital Quality Incentive Project), at <http://www.premierinc.com/all/informatics/qualitydemo/overview/index.html> (last visited Jan. 28, 2004) (on file with the Washington and Lee Law Review).

62. See Vladeck, *supra* note 30, at 1361.

63. Notably, the Premier payment for quality demonstration contains a provision for reduction of payment to hospitals that score poorly. See PREMIER, INC., *supra* note 61 ("In the third year, demonstration project hospitals that fail to improve their performance in a specific clinical area beyond a minimum threshold established in the first year of the project will be subject to a payment reduction of 1 or 2%.").

64. The following four papers on the effect of public release of cardiac mortality data after

some physicians who refer patients to hospitals for CABG surgery may act on this information and alter their normal referral patterns, while some beneficiaries may alter their care-seeking patterns. Accordingly, if hospital A has better outcomes data, it will treat more CABG patients. Hospitals B, C, and D, with less than average outcomes data, will treat marginally fewer patients.

Under the Medicare payment system, hospital A would get more average diagnosis related group (DRG) payments, while spending marginal costs. Hospital A would become a financial "winner" and hospitals B, C, and D would be financial "losers," with the dollar amounts at stake probably numbering far in excess of the kinds of marginal financial incentives typically proposed in paying-for-quality initiatives.⁶⁵

On this point, it is possible to move from the theoretical to the real by looking at what many consider to be one of the CMS's most successful demonstrations.⁶⁶ This demonstration approach used to be called the "Centers

coronary artery bypass grafting (CABG) surgery together conclude that while some studies have found a reduction in mortality, others have found limited or no effect. See David W. Baker et al., *Mortality Trends During a Program that Publicly Reported Hospital Performance*, 40 MED. CARE 879, 884–87 (2002) (investigating whether publicly reported hospital outcomes reduced mortality rates and improved quality of care and concluding that "hospital profiling" did not have an overall positive effect on the measured conditions); William A. Ghali et al., *Statewide Quality Improvement Initiatives and Mortality after Cardiac Surgery*, 277 JAMA 379, 381 (1997) (discussing a study of CABG mortality rates in Massachusetts when no statewide reporting system of outcome data existed and noting an overall decrease in CABG mortality rates that could be attributed to factors such as technological advances); Edward L. Hannan et al., *Improving the Outcomes of Coronary Bypass Surgery in New York State*, 271 JAMA 761, 765–66 (1984) (discussing the four-year period following the CABG surgery registry of data and proposing that the public registry improved the quality of care and reduced in-hospital mortality rates associated with CABG); Gerald T. O'Connor et al., *A Regional Intervention to Improve the Hospital Mortality Associated with Coronary Artery Bypass Graft Surgery: The Northern New England Cardiovascular Study Group*, 275 JAMA 841, 844 (1996) (analyzing results of an intervention program designed to decrease in-hospital mortality rates associated with CABG surgery and concluding that post-intervention decreased mortality rates were only temporarily associated with the intervention program).

65. The recently announced hospital payment for quality demonstration with Premier has an upside bonus of up to 2% and a downside loss of 1 or 2%. See PREMIER, INC., *supra* note 61 and accompanying text (discussing the parameters and results of Hospital Quality Incentive Demonstration Project).

66. See *Medicare Reform: Modernizing Medicare and Merging Parts A and B: Hearing Before the Subcomm. on Health of the House Comm. on Energy and Commerce*, 107th Cong. 25 (2001) [hereinafter *Medicare Reform Hearing*] (statement of William J. Scanlon, Director, Health Care Issues, United States General Accounting Office) (examining possible Medicare modernization by analyzing past incentive and quality programs, potential incentives, and the advantages of "merging parts A and B" within the payment system); MEDPAC, *supra* note 28, at 140–41 (observing the experience of hospitals, doctors, and other care providers in the CABG quality demonstration program and analyzing the results, which increased overall quality of care and decreased costs, but did not increase market share for the participating hospitals).

of Excellence" demonstration, but CMS changed the name to "Medicare Partnerships for Quality Services,"⁶⁷ because hospitals excluded from the list did not want the public to view them as less than excellent.⁶⁸

The original CABG demonstration, which took place between 1991 and 1996, bundled all hospital and physician services that apply to two related bypass surgery DRGs. CMS selected seven hospitals based on price, quality, service, and other criteria. In addition to receiving specific information about the documented outcome differences, centers were allowed to waive some or all patient cost-sharing obligations,⁶⁹ and could pay for transportation costs—even for family members—given the immunity from the anti-kickback prohibitions.⁷⁰ Importantly, beneficiaries retained the choice of seeking care at any participating hospital according to standard statutory cost-sharing and other terms.⁷¹

As a result, the CABG demonstration cut program costs by 10% for the 10,000 CABG surgeries performed, reduced expected mortality, and received high beneficiary satisfaction.⁷² Although most of the savings resulted from negotiated discounts, about 9% of the savings resulted from a shift in market share to lower-cost-demonstration hospitals.⁷³ Hospital and physician trade associations have raised major objections to a government program which designates some providers as higher quality care providers than others and pays for services on a differential scale. Consequently, the objectors have effectively prevented a follow-up Centers of Excellence demonstration in Illinois, Ohio, and Michigan, and have consistently opposed giving CMS statutory authority to apply Centers of Excellence principles to Medicare more broadly.⁷⁴

67. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PARTNERSHIPS FOR QUALITY SERVICES DEMONSTRATION, at <http://www.cms.hhs.gov/healthplans/research/mpqsdem.asp> (last modified Sept. 24, 2002) (discussing the recent change in the program name due to concerns raised by non-participating hospitals and care providers) (on file with the Washington and Lee Law Review).

68. *Id.*

69. "Because most beneficiaries have some form of supplemental coverage," waiving cost-sharing would have attenuated value as an incentive. See MEDPAC, *supra* note 28, at 117 (describing possible CMS incentives to improve quality of care and to budget CMS spending).

70. See Medicare-Medicaid Anti-Fraud and Abuse Amendments, 42 U.S.C. § 1320a-7(b) (2000) (outlining "criminal penalties" for illegal acts associated with federal programs, such as Medicare).

71. See MEDPAC, *supra* note 28, at 140 (discussing the positive results of the CABG quality demonstration).

72. *Id.*

73. *Id.*

74. See *Medicare Reform Hearing*, *supra* note 66, at 26 (discussing objections to the quality demonstration and concerns about further implementation); Kristen Hallem, *Doctors*

Clearly, providers are concerned about the loss of business which would result from a decreased volume of services, and not the differential payments.⁷⁵ This experience highlights the political difficulties CMS faces in trying to become a strategic purchaser of health care. The focus of this discussion is that opposition to paying for quality should logically extend to other purchasing activities that on first glance may appear more straightforward and less controversial, such as informing beneficiaries to assist them in making better choices.⁷⁶ Paying for quality may seem more radical than providing robust consumer information. The two approaches are, in fact, complementary purchasing tools that have different appropriate applications. The theoretical and actual examples also re-emphasize that a comprehensive purchasing strategy would be a more effective way to use purchasing tools than a concentration on the merits of paying for quality might suggest.

V. Paying for Quality Can Reward Different Kinds of Performance

Paying for quality typically is translated as paying for achieving specified quality outcomes. As noted earlier, this particular approach must confront technical barriers. These barriers include the need to do case-mix adjustment, which raise issues of validity, reliability, and usefulness.⁷⁷ Some quality experts have argued that quality processes, as well as outcomes, should be the appropriate locus of quality attention for a number of reasons, including the fact that measures need to provide a clear link to the concrete actions that organizations can make to improve their quality.⁷⁸ For purposes of Medicare's

Fear Excellence Designation, 30 MOD. HEALTHCARE 30, 30 (2000) (observing that physicians have reservations about the "Centers for Excellence" designation, which they believe to be aimed at price discounts for CMS rather than a sincere attempt to improve quality).

75. Because of efficiency gains from combining Part A and Part B services, designated centers could theoretically get paid less than baseline and still do better financially. See MEDPAC, *supra* note 28, at 140 (discussing hospital efficiency gains achieved during the CMS quality demonstration and how such gains affected overall hospital costs).

76. A recent survey of Wisconsin hospitals found that making hospital performance information public aroused "negative attitudes, anger, and distrust among the hospitals," and created more concern about loss of public image rather than loss of market share. See Judith Hibbard et al., *Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?*, HEALTH AFF., Mar./Apr. 2003, at 84, 92 (evaluating the Quality Counts public performance report in Wisconsin and how it affects the participating hospitals).

77. See *supra* Part IV (discussing the various technical barriers that any payment-for-quality initiative must overcome).

78. See McGlynn, *supra* note 9, at 11 (arguing that measures should be selected in a way that enables healthcare providers to directly affect practitioners' performance). HEDIS data tends to represent both process and proximate outcome measures. As a result, HEDIS data has

consideration of payment for quality, rewards might be considered not only for measures of process and outcomes, but also for structural components of quality.⁷⁹

As noted earlier, Vladeck and other experts are concerned that paying for quality will reward already well-funded, elite providers at the expense of the rest in a zero-sum game. The approach suggested in this discussion, however, should at least partly address this serious concern about tiering and equity in any paying-for-quality activities. First, because paying for quality can include both structural and process elements of quality, and not just outcomes, some of the specific measures might be designed so that institutions serving low-income or other disadvantaged populations are better positioned to do well and receive quality bonuses.

For example, under Title VI of the Civil Rights Act,⁸⁰ all hospitals, health plans, and other health care institutions must provide translation and interpreter services for anyone with "limited English proficiency" (LEP), in order to avoid national origin discrimination.⁸¹ The burden of complying with these LEP-related obligations naturally falls disproportionately on providers and plans based in geographic locations with large populations of non-English speakers. Despite this correlation, current Medicare provider payment rules do not take into account the significant financial burden that this difference creates for providers and plans that must provide translation, interpreter, and related services.

One strategic-purchasing approach to this inequity might include differential payments as part of the basic administrative pricing systems which

been used in health plan payment quality initiatives. See MIDWEST BUSINESS GROUP ON HEALTH ET AL., REDUCING THE COSTS OF POOR QUALITY HEALTH CARE THROUGH RESPONSIBLE PURCHASING LEADERSHIP 27 (2003) (noting the use of HEDIS data as sets of "standardized indicators designed to evaluate health plan performance in a variety of areas") [hereinafter MIDWEST BUSINESS GROUP], available at <http://www.mbg.org> (on file with the Washington and Lee Law Review).

79. Avedis Donabedian's conceptualization of aspects of quality includes three basic levels of quality: "the 'structural' elements of care, such as professional credentials or accreditation status of a hospital or health plan; the 'processes' of care, or essentially what practitioners do to and for their patients from prevention and screening through diagnosis, treatment, and palliation or counseling; and the 'outcomes' of care, both short- and long-term." Kathleen N. Lohr, *How Do We Measure Quality?*, HEALTH AFF., May/June 1997, at 22, 24-25 (citing Avedis Donabedian, *Evaluating the Quality of Medical Care*, MILBANK MEM. FUND Q., July 1996, at 166).

80. 42 U.S.C. § 2000d (2000).

81. See Title VI of the Civil Rights Act of 1964: Policy Guidance on the Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52,762 (Aug. 30, 2000) (providing information about the responsibilities that health and social services providers have to persons with LEP).

recognize unique categories of provider organizations that meet certain criteria for providing burdensome LEP-related services. These differential payments would be similar to the rules that allow for differential payment to specific categories of rural hospitals, such as "sole community hospitals" and "critical access hospitals."⁸² Under this formulation, extra payments would be made regardless of performance in implementing LEP services.

An alternative approach would be to construct quality structure and process measures that recognize and reward organizations that provide exemplary LEP services to non-English speaking populations. Arguably, this approach would generate more interest and would stimulate the exchange of the most effective practices. This approach could also be constructed to provide relatively small additional payments in aggregate to exemplary institutions, thereby avoiding the inevitable political fights that would occur if additional payments were proposed for all institutions falling into a new payment category. Under this approach to strategic purchasing, all organizations would be eligible to receive quality-related bonuses. However, a hospital in Westchester County, New York, which serves a predominantly affluent population, would likely be less interested in making the commitment to meet specified language-related measures than a hospital in East Harlem, which serves a lower income, multi-ethnic population.

The second response to the concern that paying for quality would accentuate tiering relates to the assumption of a zero-sum game, which means that paying some hospitals more for quality would result in other hospitals getting less. Some scholars that make the "business case for quality" suggest that improving the quality of health care would actually save substantial sums, and suggest that purchasers can improve quality and save money at the same time.⁸³ Although reducing the quality problems of overuse and misuse may generate savings, one must acknowledge that substantial underuse of necessary services exists in areas of care where patients are not receiving interventions that would improve the quality of their care.⁸⁴ Correcting underuse would often result in a net cost to the system, although in some cases, providing an

82. See 42 U.S.C. § 1395ww(d)(5)(D) (2000) (defining "sole community hospital" status); 42 U.S.C. § 1395x(mm) (2000) (defining "critical access hospital" status).

83. See MIDWEST BUSINESS GROUP, *supra* note 78, at i (evaluating the "business case" for responsible purchasing of health care and calculating that "30 percent of all direct health care outlays today are the result of poor-quality care").

84. The theory that quality problems take three forms—"overuse," "misuse," and "underuse"—was initially proposed by quality of care expert Mark Chassin and has been broadly accepted. See Mark Chassin, *Quality of Care: Time to Act*, 266 JAMA 3472, 3472–73 (1991) (describing the three varieties of quality problems and suggesting the possibility of a new type of data to study underuse).

underused preventive service might allow a patient to avoid a more expensive complication. At least some of the business case for quality analysis tends to discount or ignore the costs of correcting underuse.⁸⁵ Also, for the most part, the recent studies examining geographic variations in quality received by Medicare beneficiaries document underuse, rather than misuse and overuse.⁸⁶ This finding implies that the immediate action items to improve these documented quality problems could address underuse deficiencies, and as a result, paying for quality may cost money and support concerns that paying additionally for some underused procedures may require reductions for other procedures in order to maintain budget neutrality.

While much of the focus of quality measurement has been on documenting underuse, easily identifiable areas of overuse and misuse exist in the care provided to the Medicare population, areas where quality improvement would save substantial dollars. Indeed, if overall budgetary constraints were of compelling concern, the initial paying-for-quality initiatives might concentrate on those clinical conditions and geographic areas where improvement in quality could be expected to save money. One of the advantages to being a strategic purchaser, rather than a passive buyer, is that one can be selective with one's targets and goals. As noted earlier, CMS used the authority of establishing a risk adjustment mechanism in the Medicare+Choice program to reward plans that achieved a national threshold of performance care for patients with congestive heart failure. These plans included the performance of tests to measure the left ventricular function to help assess the nature of the heart failure. These tests were followed, where appropriate, based on the results of left ventricular testing, with prescription of an angiotensin 1-converting enzyme

85. In their estimate that 30% of excess spending is due to quality problems, the authors of the Midwest Business Group Report argue that available evidence does not permit an accurate determination of underuse and therefore does not include a financial impact of underuse in their calculations. See MIDWEST BUSINESS GROUP, *supra* note 78, at 10 (discussing the possible, yet uncertain, impact of underuse on health cost projects and rejecting it from inclusion in the report's calculation). However, researchers at Dartmouth recently have found that the significant geographic variation in Medicare spending suggests that 30% of spending is excessive and that higher spending areas did not do better than low spending areas on the content, quality, accessibility of care, outcomes, and satisfaction with care. Elliot S. Fisher et al., *The Implications of Regional Variations in Medicare Spending, Part 1: The Content, Quality, and Accessibility of Care*, 138 ANNALS INTERNAL MED. 273, 273–76 (2003); Elliot S. Fisher et al., *The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care*, 138 ANNALS INTERNAL MED. 288, 297–98 (2003).

86. See Jencks et al., *Change in the Quality of Care Delivered to Medicare Beneficiaries*, *supra* note 3, at 310 (analyzing national study that illustrates overall improvement in quality of care but notes that the study presents a "somewhat unbalanced picture of Medicare Services"); Asch et al., *supra* note 3, at 2330 (concluding that results of the underuse monitoring system indicate widespread underuse, especially in vulnerable populations).

inhibitors (ACEI) as therapy.⁸⁷ In this case, greater adherence to these measures should not only reduce medical complications and improve quality of life, but also should reduce the number of costly hospital admissions.⁸⁸

Consistent with the broad strategic-purchasing model described earlier, CMS currently is engaged in a variety of disease management demonstrations, including a recently announced full capitation demonstration of disease management which included congestive heart failure.⁸⁹ The agency should also consider separate contracts with independent vendors that can assist traditional Medicare providers and suppliers—including physicians and hospitals—to deliver quality services. However, rewarding those traditional providers directly for achieving specified targets of quality that are associated with reduced hospitalization rates for CHF is an alternative approach that might be easier to administer or might be preferable in geographic areas that do not have the volume to support payment to a separately contracted disease management organization. Regardless of which approach is used, CMS could choose to emphasize clinical problems where enhanced quality should result in decreased program spending, thereby mitigating concerns that the program would contribute to tiering by rewarding some hospitals at the expense of others.

VI. Opportunities for Paying for Quality

Other examples exist in Medicare where paying for quality might result in improved quality provided to Medicare beneficiaries and where the extra payments made would not have to assume a zero sum, with winners and losers. That is, the initiative might result in net savings for Medicare. The End Stage Renal Disease (ESRD) Program is one of the most well-developed areas of quality measurement. It is now known with reasonable assurance that

87. CTRS. FOR MEDICARE & MEDICAID SERVS., EXTRA PAYMENT HEART FAILURE QUALITY INDICATORS: SPECIFICATIONS FOR REQUIRED QUALITY INDICATORS (2002), *available at* <http://www.cms.hhs.gov/healthplans/chf/hfqpxpay.asp> (on file with the Washington and Lee Law Review).

88. See generally Michael W. Rich et al., *A Multidisciplinary Intervention to Prevent the Readmission of Elderly Patients with Congestive Heart Failure*, 333 NEW ENG. J. MED. 1190 (1995) (showing that a multidisciplinary intervention can improve quality of life and reduce hospital use and medical costs for elderly patients with congestive heart failure).

89. For an overview of the CMS disease management demonstrations, see Press Release, Centers for Medicare and Medicaid Services, HHS to Launch Medicare Demonstrations to Improve Health Care Through Capitated Disease Management Demonstrations (Feb. 27, 2003) (describing the Medicare disease management demonstrations which target chronic diseases and promote technology and quality of care), *available at* <http://www.cms.hhs.gov/healthplans/research/cdmpress.pdf> (on file with the Washington and Lee Law Review).

achieving a defined threshold of adequacy of hemodialysis sessions predicts lower rates of mortality for ESRD patients and is associated with lower rates of hospitalization.⁹⁰ This particular measure—Kt/V or its functional equivalent URR⁹¹—does not need to be case-mix adjusted.⁹² While measures of mortality rates for beneficiaries with ESRD would have to be case-mix adjusted, this intermediary outcome measure related to the adequacy of individual hemodialysis sessions does not.

Admittedly, reducing mortality rates would result in net increased costs for the Medicare program. Achieving the recommended threshold of dialysis adequacy, however, also significantly reduces hospitalization rates for these patients overall and for specific dialysis-related conditions, such as cardiac and infectious complications.⁹³ One could attempt to estimate the net expenditure difference associated with both decreasing mortality rates and decreasing hospitalization rates for beneficiaries with ESRD. Regardless, an intervention to improve performance of dialysis offers promise as a high priority strategic purchasing activity. Indeed, using the purchasing tool of technical assistance to providers, CMS already has had a significant impact on dialysis unit performance.⁹⁴

The ESRD example illustrates an important point about quality. The strategy that CMS has been using in this case has not focused on weeding out

90. See Garabed Eknayan et al., *Effect of Dialysis Dose and Membrane Flux in Maintenance Dialysis*, 347 NEW ENG. J. MED. 2010, 2018 (2002) (interpreting data concerning high-flux membrane and increased dosages of dialysis and concluding that neither leads to higher survival rates or reduced hospitalizations as compared to "standard doses and use of low-flux membranes"); William M. McClellan et al., *Mortality of End-Stage Renal Disease Is Associated with Facility-to-Facility Differences in Adequacy of Hemodialysis*, 9 J. AM. SOC'Y NEPH. 1940, 1940 (1990) (explaining data gathered from 213 hemodialysis treatment facilities that proves a "consistent association between high doses of dialysis and reduced mortality").

91. In the measure Kt/V, "K represents the rate of urea clearance by the dialyzer in millimeters per minute, t the duration in minutes of treatment session, and V the volume of distribution of urea in the patient in milliliters." Eknayan et al., *supra* note 90, at 2010. This formula is a measure of urea clearance. *Id.* The Urea Reduction Ratio is calculated as the predialysis blood urea nitrogen (BUN) minus postdialysis BUN, multiplied by 100. *Id.*

92. See McClellan et al., *supra* note 90, at 1945–47 (concluding that lower average levels of dialysis adequacy are associated with higher rates of death and that this association persists after controlling for differences in patient and non-patient characteristics).

93. See Eknayan et al., *supra* note 90, at 2016 ("Although, in our study, total mortality was not significantly reduced in the high-flux group, possible reductions in the rate of death and hospitalizations from cardiac causes were suggested.").

94. See CTRS. FOR MEDICARE & MEDICAID SERVS., 2001 ANNUAL REPORT, ESRD CLINICAL MEASURES PROJECT 20 (2001) (describing overall improvement in dialysis treatment with "86% of the sampled patients . . . receiving dialysis with a delivered Kt/v \geq 1.2, an increase of two percentage points over late 1999," among other improvements), available at <http://www.cms.hhs.gov/esrd/1c.pdf> (on file with the Washington and Lee Law Review).

substandard performance. Instead, the program has focused on the quality continuum, where some units do marginally better than others on some measures of performance.⁹⁵ The misguided notion that quality is a dichotomous variable—that is, a provider either provides acceptable quality or not—is not supported by the data from hemodialysis centers. As such, a proposal that Medicare should adopt a policy of including "quality" providers and excluding "non-quality" providers would not work.⁹⁶ CMS has been trying to improve the quality of acceptable performance and thereby to move the quality curve. As a result, CMS seems to have been successful in improving the adequacy of hemodialysis.

Nevertheless, a recent study concludes that because all methods of raising dialysis dose were associated with higher costs, the existing payment system may be hindering ongoing efforts by the federal government and professional societies to implement guidelines calling for an increase in dose in order to reduce the mortality rate.⁹⁷ The study also argues that a dose-adjusted payment system would be more complex than the existing system, because it involves standardizing the methods of measurement and instituting audit capabilities sufficient to deter fraudulent reporting. The study further suggests that the complexities of adjusting administered prices to achieve the objective of increasing dialysis dose for certain patients might make the effort infeasible.⁹⁸

An alternative purchasing strategy to adjusting administered prices would involve paying for quality. This alternative would require marginally higher

95. There actually are 16 separate measures representing adequacy of hemodialysis, maintaining vascular access, and anemia management in the Clinical Performance Measures Project. See CTRS. FOR MEDICARE & MEDICAID SERVS., END STAGE RENAL DISEASE (ESRD) CLINICAL PERFORMANCE MEASURES I (listing the separate clinical performance measures), at <http://www.cms.hhs.gov/esrd/id.pdf> (last visited Sept. 7, 2003) (on file with the Washington and Lee Law Review).

96. Vladeck argues that "if a substantial proportion of providers can reach quality thresholds that make them eligible for incentive payments, the moral defensibility of permitting those who can't to continue serving program beneficiaries at all is a serious problem." Vladeck, *supra* note 30, at 1361. One must recognize that a major difference exists between a threshold for receiving a quality incentive payment and a threshold for acceptable quality to serve beneficiaries. In the case of ESRD facilities, a threshold of adequacy of dialysis is associated with better outcomes; no clear dividing line exists on the range of quality measures that can be used to assess the quality of ESRD facilities. Notably, the experience has been that performance is not fixed, meaning that over time more dialysis units have improved their performance to exceed the threshold on this particular measure, which is a more preferable strategy than cutting lower performers out of the program altogether.

97. Richard A. Hirth et al., *Practice Patterns, Case Mix, Medicare Payment Policy, and Dialysis Facility Costs*, 33 HEALTH SERVS. RES. 1567, 1587 (1999).

98. See *id.* at 1587 (analyzing the methods of increasing dialysis dose and other advances that may require adjustment to the Medicare payment policy).

payment to dialysis units that achieve a threshold performance, measured by the percent of patients whose Kt/V is greater than the clinical threshold of 1.2. The Kt/V measure already is the gold standard and is being reliably measured and reported by scholars and practitioners.⁹⁹

The broader point that the ESRD example demonstrates is that in an opportunistic way, CMS already uses strategic purchasing approaches to obtain better quality for Medicare beneficiaries and to enable beneficiaries to access high quality providers. Paying differentially for quality is merely one set of available purchasing tools. Although differential payment raises particular technical issues that would have to be confronted, paying for quality in this case does not seem to raise fundamental philosophical or ideological problems, as critics suggest.¹⁰⁰

VII. Paying for Quality in Medicare+Choice

Recently, the author joined with two other policy analysts to propose a specific paying-for-quality initiative in the Medicare+Choice program.¹⁰¹ In this case, the proposal is straightforward. Instead of giving all Medicare+Choice plans an increase above that provided in the controversial, statutory administrative pricing formula,¹⁰² any increases should take the form of bonuses. These bonuses would be between 1% and 3% above current payment rates, and would be given to Medicare+Choice plans that have outstanding performance records, as demonstrated by score achievement on well-recognized quality measures.¹⁰³

99. See *supra* note 91 and accompanying text (describing use of Kt/v measure and its proper calculation). If marginal payment is tied to dialysis adequacy measure reporting, of course a new potential for fraudulent reporting exists, but it seems that auditing here would be simpler than that suggested for dose-adjusted payment.

100. See generally Vladeck, *supra* note 30.

101. See LYNN ETHEREDGE ET AL., GEORGE WASHINGTON HEALTH INSURANCE REFORM PROJECT, QUALITY INCENTIVES FOR MEDICARE+CHOICE PLAN 2 (2002) (outlining issues and options for designing a new system of quality bonuses for Medicare+Choice plans), available at <http://www.achp.org/media/q:mcplans.pdf> (on file with the Washington and Lee Law Review).

102. See generally MEDPAC, *supra* note 28 (explaining Medicare's payment rates for Medicare+Choice plans).

103. See ETHEREDGE ET AL., *supra* note 101, at 4–6 (suggesting what quality measures should be used and offering an example of the quality bonus scheme that should be implemented).

A logical rationale exists for launching a payment-for-quality initiative based on Medicare+Choice plans.¹⁰⁴ Medicare+Choice plans have accountable management structures and are responsible for populations of enrollees. These features provide the denominator that often is lacking in the traditional program and is needed to calculate many quality outcome measures.¹⁰⁵ In addition, the National Committee for Quality Assurance has pioneered well-accepted quality measures that are routinely used to compare HMO performance. These measures are based on the Health Plan Employer Data and Information Set (HEDIS), which includes a patient satisfaction component called the Consumer Assessment of Health Plan Satisfaction (CAHPS).¹⁰⁶

Regarding the concern that paying for quality would result in inequitable tiering, it could hardly be a more inequitable payment system than the one currently utilized in Medicare+Choice programs. Currently, beneficiaries in places such as Dade County, Florida, and Los Angeles County are able to get generous prescription drug benefits because Medicare+Choice plans are overpaid. Beneficiaries in Minneapolis and Portland, Oregon, however, get no prescription drug benefits because their plans are underpaid.¹⁰⁷ When determining how much additional funding Medicare+Choice plans should

104. See *id.* at 2 (arguing that Medicare+Choice plans' accountability management structures and the existence of valid and well-accepted quality measures create an opportunity for improved care not yet experienced by enrollees under Medicare's traditional fee-for-service (FFS) program).

105. For example, rates of screening—such as screening mammography—need to have a denominator of women, in a specified age group, who are eligible to receive the test. Because HMOs have a defined population of enrolled women, this rate can be calculated. In contrast, in the traditional Medicare program there is no enrollment. Whereas it would be possible to measure the number of screening mammograms a particular imaging center performed, there is no enrollment-based denominator on which to derive a screening mammography rate. Analysis of these kinds of measures in the traditional Medicare program tends to be made on a geographic basis, not tied to individual provider performance.

106. See NAT'L COMM. FOR QUALITY ASSURANCE, HEDIS 2004 SUMMARY TABLE OF MEASURES AND PRODUCT LINES (using set of standardized performance measures to inform consumers and purchasers and enable them to compare the performance of managed care programs), at <http://www.ncqa.org/Programs/HEDIS/Hedis%202004%20Summary%20Table.pdf> (last visited Sept. 23, 2003) (on file with the Washington and Lee Law Review).

107. See Robert A. Berenson, *Medicare+Choice: Doubling or Disappearing*, HEALTH AFF. (Nov. 2001), at 65, 72–73 (describing the geographic differences in Medicare+Choice programs), at www.healthaffairs.org/Library/v21i1/s2.pdf (on file with the Washington and Lee Law Review); see also *Minnesota v. United States*, 102 F. Supp. 2d 1115, 1124–24 (D. Minn. 2000) (concluding that geographic differences in payments to counties under Medicare+Choice program may be unfortunate but do not violate equal protection rights because Congress's policy is rationally related to legitimate objectives of containing costs and expanding health care delivery options), *aff'd*, 273 F.3d 805 (8th Cir. 2001).

receive, it makes greater policy sense for CMS to distribute the additional funds to high-quality medical service providers than to distribute uneven payments arbitrarily under plans based on the local payment levels found in the traditional Medicare program.

One of the difficult design issues in this proposal relates to what kind of outstanding quality performance should be rewarded. In other words, should bonuses be based on national leadership, market area leadership, and/or a health plan's individual improvement?¹⁰⁸ This design issue certainly would be relevant to any approach to paying for quality care in the traditional program as well as in Medicare+Choice, given the well-documented variations in quality by state and region of the country.¹⁰⁹ The use of national standards would reward prototype health plans that "offer national models, benchmarks and best practices for the rest of the Medicare program."¹¹⁰ Certainly, targeting quality bonuses to high, national performance levels would seem most consistent with the notion of paying for quality.

It is likely, however, that these national-level standards would be beyond the immediate reach of many health plans that inherit as a baseline the practice patterns of the providers they contract with or employ. Thus, one might include a strategy for targeting quality incentives for regional leadership, even if the incentives do not meet national performance standards.¹¹¹ "Area-based bonuses would provide incentives for health plans to offer Medicare enrollees better quality of care than would be otherwise available, and they could establish a competitive learning and performance dynamic among health plans competing in regional or local markets."¹¹²

Another approach for providing quality incentives would be to reward Medicare+Choice plans for improvements in their own quality scores from previous years.¹¹³ A bonus system that considers levels of improvement might

108. See ETHEREDGE ET AL., *supra* note 101, at 3–4 (detailing how quality bonuses based on national excellence, market area leadership, and health plan improvement may be a viable program).

109. See Jencks et al., *Quality of Medical Care Delivered to Medicare Beneficiaries*, *supra* note 3, at 1675 (finding real geographic differences in the way care is delivered to the Medicare fee-for-service (FFS) population).

110. ETHEREDGE ET AL., *supra* note 101, at 3.

111. See *id.* at 3 (offering different quality bonus systems based on national excellence, regional leadership, and/or health plan improvement).

112. *Id.* at 4.

113. Currently, the Medicare Quality Improvement System for Managed Care (QISMC) regulations require individual performance improvement projects as a contract requirement. See 42 C.F.R. § 422.152(a) (2002) (requiring each Medicare+Choice organization offering one or more Medicare+Choice plans to have an ongoing quality assessment and performance improvement program for the services it furnishes to Medicare+Choice patients).

strengthen the incentives even for poorly performing plans to do better. This bonus system would eliminate the concern that quality bonuses only allow the rich to get richer.

Building on the paying for quality approach for Medicare+Choice plans, the Alliance of Community Health Plans—a trade association representing many non-profit health maintenance organizations—in conjunction with Group Health Cooperative of Puget Sound, a Seattle-based health plan, recently developed a proposal that would allocate 75% of the incentive payment pool to the top 25% of plans nationally and grant the remaining 25% to plans based on state level performance, as long as the plan achieved the 60th percentile nationally.¹¹⁴

VIII. Conclusion

Bruce Vladeck correctly argues that the characteristic of payment systems that has the greatest effect on providers is the absolute level of payments, and that adding an additional signal relative to quality may not provide any additional incentives.¹¹⁵ Put another way, the base payment system may often convey basic performance signals that overwhelm marginal incentives, such as providing modest bonuses for achieving specified quality measures.

Thus, if the basic payment signal rewards physicians and hospitals for admitting patients to the hospital and performing procedures on them, it is that signal—in combination with other considerations such as professional judgment, patient preferences, and ability to pay and the nature of provider competition—that will determine provider behavior. In the face of that basic financial incentive, providing a small, marginal incentive to keep patients out of the hospital may not have much effect.

This reality has two basic implications for paying-for-quality initiatives. First, specific paying-for-quality incentives must make sense in the context of the other forces that are affecting provider behavior and will be meaningless if those other forces dominate. Put another way, paying for quality would have influence "all other things being equal." As part of a comprehensive purchasing strategy, paying for quality programs must be aligned with other program policies.

The corollary is that, as currently conceptualized and tentatively implemented, paying for quality does not raise the troublesome concerns that

114. MEDPAC, *supra* note 28, at 119.

115. See Vladeck, *supra* note 30, at 1360 (arguing that setting a threshold for financial incentives is an unsolvable problem).

are specific to this particular payment approach. The concerns raised by Vladeck and others would apply equally or even more to other approaches to improving quality—such as giving consumers more robust information on which to make choices, and selecting centers of excellence that are given a degree of program preference. Those who oppose paying differentially for quality should logically also oppose these other approaches to influencing the delivery system and how beneficiaries make choices.

Yet, to do so would be to adopt a nihilistic policy that inevitably would result in support for the status quo of mediocre care provided to Medicare beneficiaries. Private sector efforts to influence quality are limited by their lack of expertise and the requisite market share. If allowed to do so, Medicare has a unique opportunity to take the lead in creating quality incentives.

Legitimate concerns exist about some of the design issues in paying for quality. If done poorly, there may be untoward side effects such as exacerbated hospital tiering. However, Medicare, as a broadly supported social insurance program, is likely to be more sensitive to some of the difficult design issues that will determine who benefits and who loses under a regime of paying for quality.

ADDENDUM

In the November/December issue of the health policy journal *Health Affairs*, fifteen prominent health policy leaders signed an open letter urging the Medicare program to take the lead in promoting the concept of "paying for performance," arguing that as the biggest purchaser in the system, Medicare's leadership was essential to overcome the inertia in the system.¹ In the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress mandated that the Institute of Medicine evaluate leading health care performance measures in the public and private sectors and suggest options to implement policies that align performance with payment under the Medicare program.²

1. See generally Donald M. Berwick et al., Open Letter, *Paying for Performance: Medicare Should Lead*, HEALTH AFF., Nov./Dec. 2003.

2. H.R. CONF. REP. NO. 108-391, at 561 (2003).