

Medicare and P4P

David B. Nash, MD, MBA



It has not resulted in much fanfare yet, but I am sure that it will. I am speaking of the latest report from the Institute of Medicine (IOM) in its series called “Pathways to Quality Health Care.” The most recent report is called *Rewarding Provider Performance: Aligning Incentives in Medicare*.¹

First, I’d like to summarize some of the main messages in the new IOM report and give our readers a sense of its potential impact on P&T committees nationwide. In 1970, the National Academy of Sciences established the IOM in order to:

secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. The Institute acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an advisor to the federal government and upon its own initiative to identify issues of medical care, research, and education.²

You can read more about the IOM at its Web site, www.national-academies.org.

Of course, it was the IOM that nearly six years ago brought us the famous and important report, *Crossing the Quality Chasm*.³ This 2001 report outlined the critical quality deficiencies in the health care system and was generally regarded as the follow-up report to the infamous *To Err is Human*, first published in 1999.⁴ Most P&T committee members by now, I hope, are familiar with both of these reports.

This current report, *Rewarding Provider Performance*,¹ I believe, is a watershed event in the history of the Medicare program. It recommends a national design and implementation of a pay-for-performance (P4P) program for the entire Medicare system. The IOM believes that paying health care providers for higher-quality care, as measured by selected standards and procedures, will allow us to accomplish the following:

- encourage the most rapid, feasible performance improvement by all health care providers.
- support innovation and constructive change throughout the health care system.
- promote better outcomes of care, especially through coordination of care for all providers and at all times.

The IOM calls for an initial phased approach to implement this P4P program. Specifically, the organization recommends that Congress derive initial funding (over the next three to five years) for a P4P program in Medicare largely from existing funds and that it create provider-specific pools from a reduction in base Medicare payments for each class of providers. These would include hospitals, skilled nursing facilities, Medicare advantage plans, dialysis facilities, home health agencies, and physicians. In essence, the IOM is suggesting that we implement a Medicare-wide P4P program by reducing the monies we currently pay to everyone throughout the system!

The IOM goes on to recommend that Congress give the Department of Health and Human Services the authority to aggregate the pools for different care settings into one consolidated pool. From this single pool, all providers would be rewarded when the development of new performance measures allows for shared accountability and more coordinated care for all health care provider settings. If this were to occur, it would represent a dramatic change in the overarching structure and function of the reimbursement activities for the Centers for Medicare & Medicaid Services (CMS).

The experts who formed the panel of authors of this report are intelligent; they know that this is a huge political battle, one that demands complete transformation of the payment procedures for the CMS. However, other aspects of the report are equally challenging.

The IOM report wants incentives to health care providers who submit per-

formance data to ensure that the information pertaining to their performance is transparent and is made public so that it is meaningful and understandable to consumers. The report also recommends that all Medicare providers submit performance measures for public reporting and that they participate in a P4P program as soon as possible.

Although the IOM recognizes that the initial measurement requirements might be narrow, it understands that the pace of expanding the measurement sets needs to be sensitive to the operational challenges faced by health care providers who work in many different kinds of practice settings. That is why the IOM is requesting an implementation period of three to five years starting immediately.

Once again, this is an extraordinary challenge for every P&T committee in almost every hospital that treats Medicare patients.

Are you ready to monitor the quality and safety of medical care in your institution more effectively and efficiently?

Do you have the appropriate personnel currently on the team ready to meet such potential challenges posed by the IOM?

It has been more than five years since the publication of *Crossing the Quality Chasm*. Although progress is being made, it is painfully slow, as we try to create the patient-centered, transparent, effective, and timely health care system of the future.

P&T committees will play a critical role in this transformation. I sense that the leadership at the IOM—and within the CMS—is becoming impatient with the pace of reform. It is our responsibility not only to monitor the work of the IOM but also to be prepared to enact the inevitable reforms necessary.

Readers can review the entire IOM report at the National Academies Press’ Web site (www.nap.edu/catalogue/11723.html).

As usual, I am interested in your views. I can be reached at my e-mail address, david.nash@jefferson.edu.

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