I. DISCUSSION OF TIMELINE

II. PAYING FOR PERFORMANCE – REWARDS & INCENTIVES

Rewards – Quality payments are directed to top scoring hospitals. Rewards can be either to a set percentage (top 5 percent or top 10 percent), or to hospitals that exceed a set threshold.

Strengths

- Quality payments are directed to the hospitals with the demonstrably best care.
- Quality payments are directed to hospitals with demonstrated capacity to organize themselves to deliver high quality care.

Weaknesses

- Payment to top performers may give no inducement to hospitals that are medium to low scorers – if rewards are unattainable why make investments/efforts to achieve marginal gains?
- Will likely concentrate quality payments in a limited number of hospitals over time.
- May reward status quo performance and not efforts/investments in improved quality.

Incentives – Quality payments are directed to hospitals that make significant improvements against their own baseline standards.

Strengths

- All hospitals have a financial inducement to make efforts to improve quality.
- Quality funds are more likely to be tied to efforts investment that lead to improvements in overall quality.

Weaknesses

- Hospitals that made efforts/investments in quality prior to the start of the quality funding are not rewarded for those efforts.

III. OTHER ISSUES

Timing – When should quality payments be made. Ideally, quality payments should be made as quickly as possible to help cover costs of investments in improvements.

Mix of rewards and incentive payments. Reward and incentive payments can each be included in quality payments. A share of funds could be targeted at just the highest scorers while other payments could go to those with the greatest improvements over baseline.

Changes overtime. The quality payment structure may need to be dynamic over time reflecting the changes in quality measures. Incentives and reward funds should be targeted to maximize the inducement to hospitals to make efforts to improve care.

IV. SOURCE OF FUNDS. Quality payments can come from several sources.

Existing funds. In this model funds that are already used to fund hospital are tied to quality scores. This is a zero sum game with some hospitals gaining financial benefit relative to their peers. In the HSCRC such an approach might involve tying a portion of each hospitals update factor to its quality score.

Direct funding. New funds are added to the system and these funds are tied to quality. This approach, at least initially, avoids the winners and losers problem that using existing funds creates, all hospital have the opportunity to gain financial benefit from improving quality.

Generated Savings. Under his approach quality payments are made from the savings that improvements in quality generate. The challenges of this approach is quantifying the savings that quality leads to.

V. MECHANICS OF INCENTIVE PAYMENTS

Structure Target universally, i.e. just to a hospital's update factor
Target specifically, i.e. increase payment allowance for a limited set of procedures.

The mechanics of the payments will be linked to composites developed

Mechanics will also be dependent on the levels of awards (Thresholds)

VI. MAGNITUDE OF AWARD

There is general agreement that quality payments must be significant, but what does that mean? A payer may make significant quality payments for its patients but be only a small part of a providers case mix diluting any payment incentive. The rate setting system avoids that problem. For the purposes of this exercise, significant should be defined as sufficient to justify investments to achieve quality improvements. If improvements in quality will require the hiring of additional staff to perform new functions any quality payments should equal or exceed the cost of that staff.