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Pay for Performance: Emerging Solutions for Value-Based Purchasing

Institute on Health Care Costs and Solutions

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Introduction

Although health care costs continue to rise, quality and patient safety remain at unacceptable levels. As a result, large employers and payers are looking ahead and developing a number of solutions.

One of these solutions is *Pay for Performance*, which rewards health care practitioners and institutions for using evidence-based medicine to improve patient health status and health outcomes. The business case for *Pay for Performance* is based on the *expected* offsets in the form of reductions in complications or rates of admission; better compliance and health education for patients that help in lowering complication rates; and getting the "correct diagnosis for the right treatment at the right setting the first time."

Indirect cost measures are associated with corresponding productivity improvements. Recommendation 10 of the Institute of Medicine's (IOM) *Crossing the Quality Chasm* states:

> ***Private and public purchasers should examine their current payment methods to remove the barriers that currently impede quality improvement, and to build in stronger incentives for quality improvement.***

There are various ways to achieve this goal, including recognition, rewards, reductions in administrative burdens and support for improvements. Purchasers are using a number of methods, including quality improvement project awards, fees based on performance, bonuses, and incentives or cost differentials for consumers.

The need for improvement has been demonstrated in numerous studies. For example, Rand and Juran[1] have noted that fewer than one in three diagnoses made by clinicians is evidence-based and that there is only one chance in four that patients will do as they are

directed to do by their physician. Other research shows that poor quality wastes money. A stark example of this waste is the $500 million expended in a single year for inappropriate antibiotic prescriptions.

Medical errors and lack of use of evidence-based practices are both areas of concern to employers because they drive up direct and indirect health care costs for employees, retirees and dependents. The National Business Group on Health's Institute on Health Care Costs and Solutions recognizes in its guiding principles the need to improve the quality of health care and to eliminate waste, including avoidable medical errors, while using a return on investment standard to test different approaches.

The IOM report, *Priority Areas for National Action,*[2] focuses on 20 areas for health care quality improvement. Two areas, care coordination and self-management/health literacy, are considered cross-cutting (i.e., care across patient conditions, services and settings over time) since improvements would benefit a "broad array of patients." The other identified priorities include asthma treatment; management of diabetes and hypertension; medication management; and obesity. This priority list is useful when considering where to target initiatives for improving quality, including those initiatives developed in *Pay for Performance.*

The Ninth Annual National Business Group on Health/Watson Wyatt 2004 Survey found that employers are concentrating attention on three areas of tactics and activities:

- Increasing cost sharing through contributions, deductibles and co-payments with employees;
- Increasing employees' access to tools and health information for informed choices, including information on hospital and provider quality; and
- Using value purchasing.

The emerging value-based purchasing principles identified in the survey include the following:

- Implementation of tiered network health plans based on quality and cost;
- Factoring quality of health care information into health plan contracting;
- Factoring quality of health care information into health plan selection;
- Participation in The Leapfrog Group; and
- Offering one or more plan designs based at least partially on provider performance.

Leading employers are taking provider performance one step further and developing *Pay for Performance* initiatives. This briefing paper provides the following:

1. Review of the status of *Pay for Performance* with discussion of two major initiatives;
2. Results and measures;
3. Success factors; and
4. Steps for employers in considering whether to develop initiatives.

Status of Pay for Performance

The Ninth Annual National Business Group on Health/Watson Wyatt Survey 2004 findings indicate that employers are still facing significant cost increases. More employers are passing on at least a portion of these increases to employees, while also providing consumers with written, web-based and telephonic support for education and decision making, as well as for enabling self-management of chronic conditions. The survey also found increased use by employers of information about quality when selecting vendors and contractors.

Pay for Performance initiatives attempt to address both cost and quality "by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients, and deliver safe, timely, effective, efficient, equitable and patient-centered care."[3] With increased attention to quality measurement and monitoring, especially for chronic conditions such as asthma and diabetes, studies have demonstrated that these measures can positively influence health care quality improvements.[4]

Examples of *Pay for Performance* include those developed and implemented by purchasers, physicians, health plans, and other industry health care researchers and experts. The Leapfrog Group has developed The Leapfrog Incentive and Reward Compendium that documents and categorizes both financial and non-financial programs. The former reward providers with quality bonuses, whereas the latter help gain public recognition for providers. The majority of the programs included in the compendium are initiated by health plans, purchasers and purchasing coalitions, and they target hospitals, physicians, health plans and consumers. This compendium includes *Pay for Performance* examples.[5] And the number is growing, as this approach is used to address improvements in clinical quality and cost.

This issue brief looks at examples of *Pay for Performance* programs and how they apply to purchasers. Special attention is given to methods of promoting, testing and measuring the effectiveness of programs that are oriented to the provider community.

Rewarding Results develops, tests and evaluates the effectiveness of *Pay for Performance* programs to determine if they significantly contribute to improved health care outcomes.[6] It is an $8.8 million awards initiative of the Robert Wood Johnson Foundation and the California HealthCare Foundation. Two of its six projects directly involving purchasers—Integrated Health Association (IHA) and Bridges to Excellence (BTE)— are described below as a way to illustrate two different approaches to *Pay for Performance.*

Integrated Health Association (IHA)

The Integrated Health Association (IHA) is a California leadership coalition consisting of health industry stakeholder groups, consultants, pharmaceutical companies, health plans, physicians, academic institutions, purchasers and consumers. IHA has collaborated with six California health plans (Aetna, Blue Cross of California, Blue Shield of California, CIGNA Health Care of California, HealthNet and PacifiCare), physicians and the Pacific Business Group on Health (PBGH) in a comprehensive *Pay for Performance* program with the following measures and weights for the three domains as shown in the chart below.

Domain	Measure Description	Weights 2003	Weights 2004
Clinical	1. Childhood immunization status 2. Breast cancer screening 3. Cervical cancer screening 4. Use of appropriate medication for people with asthma 5. Cholesterol management—LDL screening and control 6. Diabetes—HbA1c screening and control 7. Chlamydia screening	50%	40%
Patient Satisfaction	1. Specialty care 2. Timely access to care 3. Doctor-patient communication 4. Overall ratings of care	40%	40%
IT Investment	1. Integrate clinical electronic data sets at group level 2. Support clinical decision making at point of care	10%	20%

As indicated in the chart, the weights for measurement year 2004 were changed from the 2003 measurement year to reflect an increased emphasis on an investment in technology. The initial development work was made into a report describing how the framework for the project was established[7] in terms of measure selection, testing results for accuracy and completeness of data.

The programs designed by the individual health plan participants[8] describe the payment threshold, bonus pool size or potential, frequency and type of payment, and contractual or other requirements.

Bridges to Excellence (BTE)

Bridges to Excellence (BTE) was developed by employers, physicians, health care services researchers and other industry experts with the goal to "create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate they have implemented comprehensive solutions in the management of patients, and deliver safe, timely, effective, efficient, equitable and patient-centered care."[9] BTE targets three areas: diabetes, cardiac care and physician office practices.

Diabetes Care Link (DCL)

The Diabetes Care Link (DCL) seeks to improve the quality of care for patients with diabetes, and provides an opportunity for physicians who demonstrate they are top performers in diabetes care. This is evidenced by receiving recognition from the National Committee for Quality Assurance's (NCQA) Diabetes Physician Recognition Program (DPRP). Physicians who qualify can earn up to $80 per year for each diabetes patient covered by a participating employer and plan. Co-sponsored with the American Diabetes Association, DPRP is voluntary, requiring physicians or physician groups to submit specific data to demonstrate that they are providing quality diabetes care. The program offers tools and products to help patients with diabetes become engaged in their own care. The cost to employers is no more than $175 per diabetic patient per year, with savings of $350 per patient per year.

Cardiac Care Link (CCL)

The Cardiac Care Link (CCL) focuses on improving care for patients with cardiovascular disease. The Heart/Stroke Recognition Program by NCQA and the American Health Association/American Stroke Association provides the basis for physicians to demonstrate top performance in cardiac care and earn up to $160 per year for each patient covered by a participating employer and plan. Products and tools are available to help patients with self-care management. The cost to employers is no more than $200 per cardiac patient per year, with savings up to $390 per patient per year.

Physician Office Link (POL)

The Physician Office Link (POL) is designed to promote and reward office practices for using systematic information to enhance the quality and safety of patient care, with physicians earning up to $50 per year for each patient covered by a participating employer. Monitoring patient medical history and following up with both patients and other providers are the areas targeted for improvement. A report card for each physician office is made available to the public.

Expected costs and savings for purchasers are shown in the table below.[10,11]

Table 1

	Physician Office Link	Diabetes Care Link	Cardiac Care Link
Performance Incentive	Population-based, up to $50 per patient per year	Condition-specific, $100 per diabetic patient per year	Condition-specific, up to $160 per cardiac patient per year
Frequency	Yearly	Yearly	Yearly
Targeted Provider	All physicians	PCPs and endocrinologists	PCPs and cardiologists
Patient Engagement	Provider report card	Diabetes Care Rewards, certified diabetic educators	Cardiac Care Rewards, certified dieticians
Expected Costs	Up to maximum of $65 per patient per year	Up to $150 per diabetic patient per year	TBD
Expected Gross Savings Estimate	$110 per patient per year	$350 per diabetic patient per year	$190 to $390 per cardiac patient per year

BTE programs have been established in Boston, MA; Albany-Schenectady, NY; Cincinnati, OH; and Louisville, KY. The first bonus payments were made in 2003,[12] with the largest payment at $7,500. First payments made in Boston in 2004 included one for nearly $40,000.[13]

Results and Measures

All of the *Pay for Performance* programs have common or related measures, with the emphasis on patient satisfaction and defined clinical measures most often associated with diabetes or cardiovascular disease. The majority of the programs use well established targets for screening, preventive care and patient satisfaction. What remains an open issue is the need for comparative data, a broad range of meaningful measures and uniformity of measurement to ease administration.

The programs appear to be moving toward rewarding systemic change and the use of technology to improve efficiency and systems of care. Examples are registries and physician reminder systems which have been demonstrated to be effective in improving the quality of care. Both the BTE and IHA programs include information technology (IT) incentives.

In many programs, the results are not yet available, nor are details on how the bonuses or incentives are distributed to individual physicians or patient care teams, especially in group practices or clinics. PacifiCare, working with the California Hospital Association to develop the PacifiCare Quality Incentive Program, has shown the following change in service rates from Q2 2002 to Q2 2003:[14]

+7.6% LDL Cholesterol Testing

+27.3% Hemoglobin A1C Testing

+8.3% Breast Cancer Screening

+15.9% Cervical Cancer Screening

+44.7% Childhood Screening

Early results for Bridges to Excellence (BTE) are shown in Table 1. A separate part of the BTE program deals with patient incentives to improve self care by using "Care Rewards." These are coupons based on accumulated points that are used for purchasing lifestyle products such as health condition-monitoring software, sugar-free foods and health information books.

For diabetes, the preliminary cost savings from the BTE program are based on comparisons between diabetic patient cost averages for NCQA-recognized physicians vs. cost averages for non-recognized physicians. They demonstrate that endocrinologists who are NCQA-recognized have patient costs of $1,747 compared to $1,989 for those not recognized; and that NCQA-recognized primary care physicians (PCPs) average patient costs of $1,394

compared to $1,627 for those not recognized.[15] This translates to 10 to 15 percent savings, with a range of overall savings from $240 to $550 per patient annually.

Results from other health plans have shown increases in the targeted area such as rate of influenza vaccination, use of care plans and other physician interventions that are likely to be used by the patient. When measured, the plans have shown corresponding reductions in rates of hospital admissions and emergency room visits as well as a positive impact on lost work/school time. ***An interesting note is that while some providers appear to be influenced by the incentive programs, others are influenced by public reporting. This suggests the need to use both incentives and publicly reported information, including physician recognition by consumers, to achieve higher physician awareness.***

Differences among markets and physician practices can complicate payment options. Overcoming these factors is important to advancing *Pay for Performance* as a lever for increasing health care quality. Since there are a number of influencing factors, not all results can be directly correlated to *Pay for Performance,* making both measurement and analysis more complex.

Success Factors

Pay for Performance initiatives and programs are still in their early stages. Lessons learned from the experiences include many challenges which depend upon the region and health care market. Success is more likely if the initiative does the following:

- Develops accurate report cards and measures, especially for preventive services and chronic condition management, which improve quality and outcomes for providers;
- Employs standardized metrics that are meaningful, consistent, comparable and useful;
- Demonstrates evidence for cost reductions and return on investment with relevance for clinical and business perspectives;
- Uses incentives that are meaningful enough to change behavior, whether in direct dollars or non-financial incentives such as removal of administrative burdens and/or public disclosure of data;
- Provides opportunities to get agreement on measures and prepare for future measurement including sustainability over time with adjustments as needed;
- Engages providers in the development of the measures to engender trust and buy-in for participation;

- Addresses appropriately adversarial relationships that may exist and impede *Pay for Performance* programs;
- Discusses realistically winners and losers (the objective is to improve care but not increase the size of the health care "pie," rewarding superior performance with additional pay);
- Develops common understandings and cooperative relationships;
- Provides an open process with a safe environment to discuss performance incentives, especially with the involvement of multiple stakeholders who compete in local markets;
- Sustains stability in performance incentives and "real money" that is meaningful to physicians, in the mode of continuous quality improvement over time;
- Accurately defines what is needed in resources for both payment and administration;
- Promotes use of information technology to improve efficiencies and decision support mechanisms;
- Represents a significant portion of the physician practices, coordinated in geographic areas for ease of administration and measurement;
- Provides flexibility in addressing the changing preferences and performance expectations of sophisticated consumers and purchasers; and
- Addresses ease of administration and implementation, especially for the provider.

Potential Actions for Employers

The outlook for *Pay for Performance* is continued growth. Employers may want to address opportunities for involvement in the following ways:

- Check with your health plan(s) or local business coalition on health for current activities and programs on *Pay for Performance*; use the compendium available through The Leapfrog Group as one resource (http://www.leapfroggroup.org/ircompendium.htm);
- Get involved in initiatives in your location such as Bridges to Excellence (www.bridgestoexcellence.org) to help make implementation more feasible;
- Review the top areas of cost and most prevalent health conditions in your population and ask your health plans what programs they have for promoting more effective prevention and treatment for these conditions (thus allowing you to focus on areas with the greatest potential for return on investment);

- Ask for basic provider performance information, either directly or through collaborative efforts with other purchasers (this may be hospital or physician/medical group performance, depending on the market and health plan);
- Support transparency and the development and use of common metrics; and
- Request information on tiered network programs that use BOTH cost and quality metrics.

Summary

With programs being initiated by purchasers, health plans and practitioners, *Pay for Performance* examples are plentiful in the marketplace and growing. Integrated Health Association in California and Bridges to Excellence in its four markets illustrate the complexity of these programs, the variety of measures that build on national sources and early results as the programs continue to evolve. Actions by employers range from an awareness of these initiatives to active involvement in developing them.

As with all programs that address change in the health care industry, each initiative should be reviewed with the following questions in mind:

- Do results show a significant improvement in patient care and outcomes?
- Does the program help take waste out of the health care system?
- Has the planning carefully looked at any potential unintended consequences?
- Does the program create financial incentives with enough dollars to produce structural systemic change?

If the answer to each of these questions is yes, the initiative is providing a valuable service in improving provider accountability, enhancing health care quality for employees, and advancing long-term employer viability and growth.

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Written by:

Suzanne Mercure
Principal, Barrington & Chappell, Falls Church, VA

About The Institute on Health Care Costs and Solutions

The Institute on Health Care Costs and Solutions, an initiative of the National Business Group on Health, formerly the Washington Business Group on Health, was established in November 2001. Its mission is to provide an intense focus on finding effective solutions to the high cost of health care benefits confronting large employers.

Additional copies of this *Issue Brief* are available to members at www.businessgrouphealth.org, or contact Andrew Lundeen at lundeen@businessgrouphealth.org for more information.

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Institute on Health Care Costs and Solutions
50 F Street N.W., Suite 600 • Washington D.C. 20001
Phone (202) 628-9320 • Fax (202) 628-9244 • www.businessgrouphealth.org

Helen Darling, President, National Business Group on Health, and President, Institute on Health Care Costs and Solutions

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