Pay for Performance and Beyond: A Recipe for Improving Healthcare

A fundamental reform to provider payment is needed that will drive pay-for-performance methods forward and lead the way to a myriad of improvements in delivering today's healthcare.

By François de Brantes, Bridges To Excellence

In 2003, Dr. Lalude[1] received a letter offering him a financial bonus from employers in his community for the quality of care he was delivering to his diabetic patients. To qualify for the bonus, Dr. Lalude had to randomly select medical records for 35 of those patients. Once the selection was complete, he would then need to record key measures of their health status, as well as the care they had received, and report it to the National Committee for Quality Assurance (NCQA). For Dr. Lalude the qualifying process seemed simple and required few hours of work. In return, he would be getting several thousand dollars because he was confident in the quality of care he was delivering to his patients.

However, after going through the records, he realized he would not qualify for the reward. The average blood pressure, cholesterol level and blood sugar level of his patients were not as good as he had initially thought, and not good enough for him to receive the bonus. In fact, his average score of 45 percent was almost identical to the average score of physicians that had been studied by Beth McGlynn.[2]

Dr. Lalude realized he needed to improve internal processes and systems so that his office could systematically flag diabetics, keep a log of their health status and allow him to focus on the subset of patients who were not monitoring their diabetes appropriately. Once these changes were implemented, Dr. Lalude and his staff no longer waited for patients to show up at the office, but took a proactive approach and reached out to individual patients to gather feedback on their vital signs and encourage regular office visits. By 2004, Dr. Lalude's average patient scores had dramatically improved and he was able to qualify for recognition and the bonus. Dr. Lalude transformed his practice because he knew that it was the right thing to do for his patients and the quality of care he was delivering to them. He did not do it simply for the monetary rewards, though the incentives gave him that much more of a reason to re-evaluate the quality of his care. Up until that point, Dr. Lalude really did not have a reason to question his performance as a physician. Now he has a system in place that tells him how he is doing and helps him target his efforts.

Dr. Lalude's story has been repeated throughout the country by several thousands of physicians who have been participating in programs that encourage them to deliver better care. These programs have been called pay for performance to distinguish them from the more common way of paying for care today: pay for volume (fee for service). The better-known pay-for-performance efforts include the Integrated Healthcare Association's (IHA's) P4P[3] effort in California, and Bridges To Excellence,[4] which is active in several states on the East Coast and in the central region of the country. Bridges To Excellence (BTE) is a not-for-profit organization that designs and creates programs that encourage physicians and physician practices to deliver safer, more effective and efficient care by giving them financial and other incentives to do so.

Lessons Learned in P4P

BTE's most important lessons learned during its initial pilots (which lasted three years), all of which have been presented to members of the Institute of Medicine's Subcommittee on Pay for Performance, presented to members of Congress through hearings and published in a number of journals and articles, are that:

1. **Incentives matter and the size of the incentive has a relationship to a physician's decision to participate in care process improvement.** In general, incentives must be greater than or equal to the cost of change, or, at the very least, sufficient to significantly contribute to the cost of change. For example, a multi-specialty group practice in Albany, N.Y., was able to defray about a quarter of the $1 million investment in a new clinical information system due to the financial incentives received through BTE. The practices, whose care processes were re-engineered, achieved significant improvements in the management of patients with chronic conditions. Exhibit 1 illustrates both points: (1) overall there is a statistically significant difference between the mean rewards available for

François de Brantes is the national coordinator for Bridges To Excellence (BTE), an organization focused on rewarding physicians for better quality care. In that capacity, he is responsible for creating and developing new programs for BTE and for supervising the implementation of BTE programs in different regions in the country. Mr. de Brantes can be reached at **Francois.deBrantes@bridgestoexcellence.org**.

Exhibit 1 Mean Patient Counts for Recognized and Nonrecognized Physicians

Market & Program	t-value	p-level (0.1=sign)	Nonrecognized Physician Mean Patient Count	Recognized Physician Mean Patient Count
Cincinnati Diabetes	4.33	<.0001	5.2	10.0
Louisville Diabetes	3.35	.0021	5.2	17.9
Boston Diabetes	2.47	.0166	2.2	4.1
Boston HIT Systems	13.10	<.0001	10.7	31.9
NY Cap. Reg. HIT Systems	8.68	<.0001	18.9	82.8

recognized physicians and nonrecognized physicians in each pilot region (size patient count is a proxy for size of bonus); (2) there is a significant difference between the mean patient count for physicians recognized for adopting new systems of care and the patient count for physicians being recognized for diabetes excellence only. With respect to this second point, the average investment for a practice of three physicians to adopt new clinical information and patient management systems is $50,000.

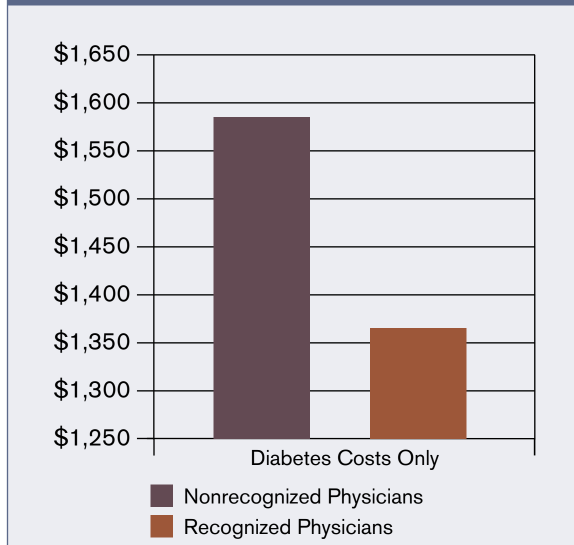
2. **The costs and benefits of participating in an incentive program must be known up front.** Practices – or individual physicians who are asked to invest both time and money in that practice to improve their performance – must have a good estimate of the benefits they will derive from that effort.[5] For example, a group of physicians in Delaware decided not to participate in a BTE implementation because they estimated that the benefits of meeting the threshold for the required performance measures exceeded the initial investment they would have to make to allow them to meet the performance measures.
3. **Self-assessment of performance and its validation by an independent third party is a very powerful agent of change.** Physicians and physician practices that are asked to participate in a BTE implementation must perform a self-audit of their current performance. This effort, while time-consuming, creates the road map for change. For example, Dr. Lalude discovered through his self-assessment that his compliance with good standards of care for his patients with diabetes was 45 percent; far below the 80 percent threshold required for incentives. This discovery motivated him even more than the financial rewards to re-engineer his practice of care for those patients, and the improvements achieved in under a year were significant both in terms of quality of care for the patients and the cost of care. Additionally, instead of having his performance assessed by a payer who would only look at a portion of his patient panel, Dr. Lalude's performance was assessed by the NCQA via a representative sample of his entire panel.
4. **High-quality care can be cost-effective care.** While there is clearly no correlation today between quality and cost of care, BTE's analyses of claims data comparing patients that are seen by BTE-recognized physicians and those that go to nonrecognized physicians show conclusively that their average severity-adjusted cost of care is lower by about 10 to 15 percent. For example, patients with diabetes have average yearly costs of about $1,600 (see Exhibit 2.) Patients going to recognized physicians have costs of about $1,400.[6] The difference comes from lower rates of avoidable hospitalizations or visits to the emergency room, which is a result of more frequent physician office visits. This is a clear sign that the care the physician is delivering is more proactive and improves the consistency of care being delivered to patients. These findings are in line with a number of studies that evaluated the actuarial impact of meeting certain performance thresholds.[7] In these studies, the ability for the physician to demonstrate good control of intermediate outcomes, such as blood pressure and cholesterol, resulted in significant savings.

Exhibit 3 indicates the actuarial value of controlling intermediate outcomes for patients with diabetes.[7] The average savings estimates are not fully additive.

Best Practices in P4P

Both BTE and the IHA have common elements that are responsible for their success: (1) they use standard performance measures; (2) they represent multistakeholder efforts that bring together a large group of payers and purchasers to make rewards meaningful to physicians; (3) they use independent third-party organizations to measure the performance of the physicians; (4) they provide physicians with clearly defined benefits which helps the physicians determine the value of participating; and (5) they encourage physicians to adopt better systems of care, including health information technology, to systematically improve the delivery of care.

Exhibit 2 Average Episode Cost for Patients Seen by Physicians Recognized for Excellence in Diabetes Care Compared With Patients Seen by Nonrecognized Physicians



In every industry sector, organizations are rewarded when they improve the value of the services they deliver or products they make. This is not the case in healthcare. In healthcare, for the most part, only the volume of transactions is rewarded irrespective of the quality of the care delivered. In fact, in many instances, generating a higher volume of expensive services can implicitly reward poor quality.[8] Pay for performance is an attempt to change that dynamic by introducing a countering incentive. Its impact depends on the factors listed above, mainly the size of the incentive relative to a physician's or hospital's total revenues. The smaller the incentive (in percentage terms), the lower the impact. While no formal studies have yet clearly answered this issue, there is a lot of empirical data that suggest that physicians will strongly respond to incentives that represent 5 percent or more of their total revenues.[9] This is because change is difficult and maintaining the status quo is, for the most part, easy. Change can only occur if the benefit of that change is greater than the benefit of the status quo, or if the status quo is so uncomfortable that it makes the prospect of change more appealing. Today, the status quo is uncomfortable for employers, which makes the prospect of experimenting with changes in payment appealing. Yet for many physicians the status quo, while not ideal, is not so uncomfortable as to overcome the perceived risk of change.

We can all continue to pay for volume and become ever more uncomfortable, or we can start recognizing that physicians and hospitals are like any other economic entity in the economy: They respond to incentives, and the ones we have now are quite poor. BTE's and the IHA's P4P programs have shown us we can do better, but we can and should go a giant step further: all the way to comprehensive payment reform. It is upon this concept that PROMETHEUS was developed.

PROMETHEUS: Beyond P4P

Rather than replacing the two main payment models prevalent in the United States – fee for service and capitation – PROMETHEUS Payment[10] addresses their shortcomings. The model attempts to create a payment environment where doing the right things for the patient helps providers and insurers also do well for themselves. This is accomplished by paying providers for the quantity of care that is recommended by well-established guidelines and evidence.

Overall, PROMETHEUS is not an entirely new concept. Case rates and global fees, which are its central elements, have been around for decades. But there are three important innovations included in PROMETHEUS that clearly differentiate it from prior models:

1. The basis for the case rates is evidence-based guidelines and includes adjustments for patient severity of disease. Exemplary performers can get more than 100 percent of the case rate.
2. Clinical integration around the care of the whole patient – not just parts – is explicitly encouraged and rewarded through a comprehensive scorecard that includes measures of clinical process and outcomes of care, patient experience with care received, and in many instances, cost-efficiency.
3. It is designed to accommodate a wide range of physician specialties, hospitals, other healthcare providers and the many ways they are organized to deliver care – from large integrated delivery networks to individual practitioners.

A team of experts in healthcare economics, law, policy, plan operations and performance measurement carefully designed these innovations in an effort to help plans and purchasers respond to one of the main challenges set forth by the Institute of Medicine's series of reports on the quality of care in America[11]: to reform a toxic payment system. One purpose of PROMETHEUS is to create a setting that improves the work environment for providers and improves quality of care for patients.

That reform can only occur by (1) understanding the root causes for the failure of the current payment models *and* (2) designing processes that will mitigate their effects while encouraging the right behaviors. For example, broad-based capitation shifts insurance risk from insurers to providers. PROMETHEUS specifically avoids holding providers accountable for insurance risk. It does hold them accountable for their ability to provide excellent care. Similarly, fee for service shifts the responsibility for prudent and wise use of resources from providers to insurers. PROMETHEUS holds providers accountable for the efficient use of resources, but it frees them to manage those resources in any way they see fit and removes current artificial barriers to innovate.

Exhibit 3 Actuarial Value of Controlling Intermediate Outcomes for Diabetes Patients

Clinical Measure		Annual Savings Per Diabetic Patient	Max
HbA1c control	Poor Control Good Control	$177 $96	$279
Blood pressure control	<140/90 mm Hg <130/80 mm Hg	$166 $230	$494
LDL control	<130 mg/dl <100 mg/dl	$149 $251	$369
Nephropathy assessment		$77	
Eye examination		$1	
Notation of smoking status and cessation advice or treatment		$1	
Completion of lipid profile		$0	
Foot examination		$0	

Self-assessment of performance and its validation by an independent third party is a very powerful agent of change.

Implementing PROMETHEUS Payment will require creating an operational infrastructure (an "engine") that can bolt on to existing plan claims payment systems to perform the following five tasks:

- Establish severity-adjusted evidence-based case rates (ECRs);
- Determine the appropriate allocation of those case rates across different types of providers treating the same patient;
- Track the performance of all providers caring for the patient covered by the ECR;
- Reconcile all payments to reward good performance; and
- Create a scorecard to report and pay for quality and efficiency.

There are significant complexities contained within each of these five tasks and it will take a substantial amount of effort to make each operational, and this effort is well under way. Several organizations have committed to creating the critical components of the engine. In addition, members of medical professional societies are contributing to building out ECRs and several regions are designing implementation programs to test PROMETHEUS.

Although there are clear limitations to what can be covered under the scope of ECRs today, specialty societies and other medical professional organizations will likely rise to a new challenge if the validity of the model is proven: to develop additional clinical practice guidelines that take into account this application and can form the basis for case rates covering the majority of conditions and procedures.

Powering Up Consumer-Directed Healthcare

Health benefits reform without payment reform, or payment reform without health benefits reform, is only half of the solution. We need both to be in place. Today we are in a situation where benefits reform has moved much faster than payment reform, and so payment reform needs to catch up.

Health benefits reform has changed the level of sensitivity consumers have toward the cost of care by increasing consumers' responsibility for meeting deductibles and making high co-insurance payments. A 2006 healthcare cost survey shows that more than 5 percent of all health plan enrollees of large companies are in a high-deductible plan, and a Forrester Research survey estimated that close to 6 million Americans would be in a consumer-directed health plan (CDHP) in 2006.[12] As a result, consumers are eagerly searching for comparative information on the cost and quality of care they are increasingly paying for, but can only sometimes find relevant information on quality, and very seldom on cost.[13]

In response to this situation, policy makers from the president to members of Congress have asked that prices of units of care services be made public, and there are a number of efforts to publish rates for radiology services or office visits.[14] However, because care is mostly paid for after the services have been

delivered and there is a very high degree of variation in the quantity of services delivered to a patient, consumers can only estimate their total anticipated costs of care. Not only is it an estimated cost, but to gather the necessary information is very difficult. For all intents and purposes, there is no relevant "price" for consumers to look at and from which to estimate their expected costs of care.

We can and should go a giant step further: all the way to comprehensive payment reform.

Take Sally Jones, who has recently been diagnosed with Stage 1 breast cancer. What are the estimated costs of her care? Her oncologist may publish office visit costs, but that will not include the cost of any adjuvant therapy. The reality is that the current mode of paying for physician services, hospital stays, prescription drugs, diagnostic studies and any other healthcare service is not designed for pricing transparency. It was designed to work in the current fee-for-service and capitation payment system, which itself is a reflection of current prevailing forms of healthcare insurance plans.

ECRs should provide consumers with the price transparency that they really need. By having access to case rates that encompass all the care required to treat their condition, a consumer can truly compare the cost of care from one provider to another. Armed with robust data on both the financial and quality performances of physicians and hospitals, consumers can become the arbiters of their care in much the same way they have become the arbiters for all other purchasing decisions.

Let's take Sally Jones again. As soon as the diagnosis of Stage 1 breast cancer has been confirmed, Sally is advised of the ECR for her condition and she can look up the case rates that are published by her plan for each of the providers in the plan's network. She can determine up front what her total expenses will be, and budget accordingly. Tied to quality information on each provider, Sally can now make a decision as a real consumer, as she does in all other aspects of her life.

Creating a market in healthcare that will deliver consistent value to all its participants cannot be done in the current payment and benefits environment. Movement toward health benefits that encourage patients to act more like consumers *and* movement toward a payment system that encourages the continuous pursuit of quality and cost-effectiveness must be the twin goals of all employers and health plan administrators. Many have already embraced these goals; many more should. ■

Endnotes

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