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## Literature Review

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# Literature Review

Joshua J. Gagne, PharmD

*Each issue of Value-Based Purchasing will provide a summary of recent articles from the published VBP literature. In this issue, we spotlight several recent publications regarding pay-for-performance programs and financial incentives for quality care.*

**“Early Experience With Pay-for-Performance: From Concept to Practice” (JAMA. 2005;294(14):1788-1793, by Meredith B. Rosenthal, PhD, Richard G. Frank, PhD, Zhonghe Li, MA, and Arnold M. Epstein, MD, MA**

The concept of paying for performance is becoming increasingly popular in health care. Stakeholders who demand more for their money are rewarding providers who practice better quality care or who demonstrate improvements in such. The underlying objective of paying for quality is to realign reimbursement policies to promote better quality care. As a result, more than 100 incentive-based programs have spawned across the country, driven mainly by purchasers and payers such as the government, health care insurers, employers, and employer groups. To date, little is known about the impact of these nascent initiatives.

A study from the Harvard School of Public Health calls into question the true impact of incentive-based programs. The researchers evaluated a prototypical pay-for-performance program on the quality of care provided to patients of a California-based health plan. The results were compared to those of patients receiving care from a separate California physician group in which no pay-for-performance scheme was in place. Among the three indicators of quality examined, the pay-for-performance group demonstrated substantially greater improvements on only one of the measures. In light of the results, the researchers suggest that perhaps the incentives were too modest to warrant serious changes to provider behavior, or that the true impact of pay-for-performance would be seen more long term and was not captured in this study. As pay-for-performance programs mature, additional studies like this one will help elucidate whether paying for better quality is truly increasing value in health care purchasing.

**“Minimally Invasive: Minimally Reimbursed? An Examination of Six Laparoscopic Surgical Procedures” (Surgical Innovation. 2005;12(3):261-287), by Adam R. Roumm, MSPH, Laura Pizzi, PharmD, MPH, Neil I. Goldfarb, and Herbert Cohn, MD**

The need to realign payment policies to promote higher quality health care and better outcomes for patients has been illuminated in a number of studies. Researchers in the Department of Health Policy at Thomas Jefferson University sought to determine if reimbursement rates for different types of surgery encouraged the use of best practices and promoted high quality care. The researchers systematically reviewed studies of six types of surgery that may be performed as traditional, open surgical procedures, or as laparoscopic procedures, which are forms of minimally invasive surgery (MIS). Clinical and economic outcomes of the open procedures were compared to those of the corresponding minimally invasive procedures. The researchers then considered the level of reimbursement provided by Medicare for each type of surgery to determine if procedures producing the best outcomes were also receiving the highest rates of reimbursement.

The investigators concluded that minimally invasive procedures lead to better outcomes as compared to the open procedures. MIS was associated with decreased length of hospital stay, decreased hospital costs, and faster return to work or other activities. Average Medicare reimbursement for these procedures, however, was generally lower. This suggests that providers are being paid more for procedures that do not promote the best outcomes for their patients, leading to higher expenses for payers and longer periods of time away from work. This study

underscores the need to realign incentives to not only promote better quality care but also to reduce health care expenditures.

**“Partnering with payers to improve surgical quality: The Michigan plan” (*Surgery*. 2005;138(5):815-820), by Nancy J. O. Birkmeyer, PhD, David Share, MD, MPH, Darrell A. Campbell Jr, MD, Richard L. Prager, MD, Mauro Moscucci, MD, and John D. Birkmeyer, MD**

Many pay-for-performance strategies have evolved from the multitude of initiatives that have emerged over the past few years. One approach for improving quality in surgical interventions comes from a single large private payer in Michigan. Birkmeyer and colleagues describe the Blue Cross Blue Shield of Michigan and Blue Care Network (BCBSM) program not as a “pay-for-performance” initiative but rather a “pay-for-participation” model which compensates providers for simply collecting data and implementing quality improvement initiatives. BCBSM is providing incentives for participation in three surgical quality improvement initiatives in various areas of surgery.

The program strives to foster collaboration among hospitals and surgeons, identify areas for improvement, and implement and evaluate improvement activities. Proponents anticipate quality improvement and cost savings in surgical care. The authors suggest that, “Michigan is particularly fertile ground for payer-sponsored quality improvement initiatives,” since it, “is home to several very large employers with a long history of seeking value for the health care that they purchase.” They go on to describe some of the challenges in implementing such a program. The main challenges include achieving buy-in and maintaining participation from surgeons, and of course funding. Despite these challenges, the project is moving forward and the impact of such a program design is anticipated.

**“Surgeon compensation: ‘Pay for performance,’ the American College of Surgeons National Surgical Quality Improvement Program, the Surgical Care Improvement Program, and other considerations” (*Surgery*. 2005;138(5):829-836), by R. Scott Jones, MD, FACS, Cynthia Brown, and Frank Opelka, MD, FACS**

As the paradigm shift to pay-for-performance transpires, Jones and colleagues offer a framework for surgical quality improvement that integrates an incentive-based scheme. The three-phase outline emphasizes the need to align fiscal incentives with high quality care and optimal outcomes. The authors note, “the primary goal of pay-for-performance programs must be improving health quality and safety.” In doing so, health care purchasers and payers also expect to get more for their dollar.

The first phase of the plan involves implementing a “pay for reporting” system promoting collection and reporting of administrative surgical data. The second phase extends to a “pay for participation” program, similar in theory to the program in Michigan. Surgeons will be rewarded for reporting on a broad set of performance measures, regardless of outcomes. The third phase of the system ties in a Medicare pay-for-performance piece to reward physicians who achieve the best outcomes. The authors set forth a series of principles for which Medicare should incorporate to ensure fair incentives for all surgeons across various specialties and practice settings. Of note, such a system should include a positive reward system rather than a punitive reimbursement policy to ensure accuracy of data, and recommends that surgeons be involved in the design of measures and payment policies.

As we have seen, pay-for-performance is a hot topic in health care, but it is not limited to surgery. Stemming increases in health care spending is a formidable task, but health care purchasers are in a unique position to demand more value for their health care dollars. Pay-for-performance is attempting to do just that by realigning payments with better outcomes and higher quality. Though the results have been mixed to date, much more will be learned about the impact of these programs as they develop.