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From the Editor

Pay For Performance

In this issue of Value Based Purchasing, we spotlight the Pay for Performance (P4P) movement. In broad terms, P4P is a system which rewards health care providers based on the quality and cost-effectiveness of care they provide. While "pay" generally means increased financial reimbursement, P4P programs also can reward performance through public recognition and/or steering increased business toward higher-performing providers. Numerous questions have been raised about P4P, including:

- If high-quality care is expected, is it necessary to pay bonuses based on actual performance?
- Will the relatively modest levels of incentives offered by many P4P programs be enough to stimulate providers to change behaviors, revise office systems, and invest in IT and other technologies needed to improve performance?
- Do we know enough about how to measure performance to have some degree of assurance that the quality indicators being measured are associated with better care and better outcomes?
- Do P4P programs end up rewarding those providers who already are providing higher-quality care, and not have an impact on improving performance among a broader array of providers?

Reports in the published literature on the impact of P4P programs are limited, and the evidence of their impact is mixed.

Despite these questions, the P4P movement is gathering steam. In December of 2006, Congress passed legislation, subsequently signed by President Bush, maintaining Medicare physician payment rates at their present levels for 2007, and canceling a scheduled 5% reduction. This benefit was linked, however, with a mandate for a 1.5% bonus system to be established for physicians participating in CMS' quality-reporting system. The Physician Voluntary Reporting Program (PVRP) relies on physicians using a new set of billing codes. Known as G-codes, these codes capture information on whether quality indicators, which are not ordinarily captured through billing codes (CPT codes), were met.

Among the 16 current PVRP quality indicators, the majority are relevant to inpatient care. Outpatient quality indicators include diabetes care, prevention of falls, pharmacotherapy for patients with heart disease, and treatment for major depression. Although the G-code system is complicated (some say it's downright crazy), it speaks to government's newfound commitment to physician P4P, following on CMS' recent efforts to implement P4P for hospitals.

It is doubtful that the federal government would have arrived at this level of commitment to paying for performance, were it not for the P4P demonstration and advocacy efforts of employers (e.g. Bridges to Excellence, Pacific Business Group on Health, Leapfrog Rewards). Whether or not the P4P movement ultimately leads to improved quality and safety in health care, it stands as evidence that the work of employers who are engaged in value-based purchasing can impact national health policy and stimulate innovation to address a troubled health care system.

Neil Goldfarb, Editor
Value-Based Purchasing

VBP Interview with Dr. Arnold Milstein

Janice L. Clarke, Managing Editor, VBP

Arnold Milstein, MD, MPH, is the Medical Director of the Pacific Business Group on Health (PBGH), the largest employer health care purchasing coalition in the United States. He is also the U.S. Health Care Thought Leader at Mercer Health & Benefits. His work and publications focus on private and public sector health care purchasing strategy, clinical performance measurement, and the psychology of clinical performance improvement.

A co-founder of both The Leapfrog Group and the Consumer-Purchaser Disclosure Project, Dr. Milstein heads performance measurement activities for both initiatives. The New England Journal of Medicine's series on employer sponsored health insurance described him as a "pioneer" in efforts to advance quality of care. In 2004 and 2005, he received the highest annual award of World-at-Work, the largest global organization of human resource managers, and of the National Business Group on Health (NBGH). The NBGH award cited nationally recognized innovation and implementation success in health care cost reduction and quality gains. In 2006, he was the first private sector purchaser specialist to be elected to the Institute of Medicine.

Dr. Milstein was educated at Harvard (BA-Economics), Tufts (MD) and UC-Berkeley MPH-Health Services Evaluation and Planning).

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VBP: *You have a unique perspective on eliminating waste in the U.S. heathcare system. Would you give us the "nutshell" version?*

AM: In the broad context, we are experiencing upward creep in the unaffordability of health insurance…an average policy for a family of four has grown from 15% to over 100% of annual minimum wage earnings. This reflects health care spending that steadily outgrows our Gross Domestic Product (GDP) and income, mostly due to the net cost additive effect of reliable treatment innovations. This annual cost-additive effect presents an increasing challenge because higher-income Americans are not stepping forward to ease the burden for others. Given this scenario, we need to do two jobs:

1. Eliminate the current level of waste or "fat"
2. Annually capture new efficiencies that are equal to the cost-additive effect of valuable treatment innovations.

How much of our current spending is "waste"? Spending could be cut by 50% without any adverse impact on the health care system (evidence from the Dartmouth Atlas). If all American physicians practiced with the same conservative resource use as the most conservative and high quality physician groups in the top performing regions (e.g., Seattle, Minneapolis), 30-40% of current spending could be eliminated without loss of quality or patient satisfaction. Another 20-30% of spending could be eliminated if the remaining services were delivered at benchmark levels of cost per service.

VBP: *What do you see as the broad, systemic changes necessary for eliminating waste?*

AM: We can eliminate >50% of the waste in the system by taking the following sequential steps:

1. Reduce service volume by 30% by emulating the resource use patterns of the best performing physician groups in the best performing regions.
2. Once service volume is brought under control, work toward lowering unit prices for services to the level of those in the lowest cost, highest quality delivery systems.

Note that, after eliminating all baseline waste, each year of biomedical "miracles" adds 2-4% to health care spending. This means that reengineering must deliver a perpetual 2-4% annual efficiency capture in order to prevent, rather than simply postpone, affordability problems.

VBP: *We keep hearing that electronic medical records (EMR) are part of the solution. Where do they fit in your theory?*

AM: EMRs play an important role. Just taking the paper out of health care by adopting free-standing EMRs will eliminate 3-4% of the waste in the system. If EMRs become fully interoperable (i.e., each provider's system able to share patient information with other providers' systems) an additional 3-4% of "fat" can be shaved.

But EMR's are not a panacea. Like any industry that aspires to world class levels of quality, reliability and efficiency, health care needs an electronic platform to test and rapidly implement performance-enhancing service innovations.

The interesting question is, "Is there sufficient management and IT expertise in health care to enable robust and perpetual performance gains?" World class, or even elementary, process engineering skills are not taught substantively in most medical or nursing schools.

In manufacturing and advanced service companies, an electronic platform is used to design process improvements, implement the improvements, monitor the effects of the improvements, and rapidly standardize to the new process when it has been improved. Health care needs to begin to work this way. Without a well designed electronic platform, rapid cycle testing and adoption of many simultaneous service innovations is not possible.

Currently, only a handful of health care systems (about 2% of the nation's systems) "get it." A few examples are Inter-Mountain Healthcare System, Virginia Mason, Mayo, Kaiser Permanente, Vanderbilt, Duke, and Partners' in Boston.

VBP: *What role does the consumer play?*

AM: Consumers can have a powerful effect on any industry. Weak assertion of customer values makes for poor performing industries. American customers need to be educated on how to say "no" to high prices without corresponding evidence of superior quality and lower total longitudinal cost of care.

VBP: *How can employers/purchasers of health care influence the health care industry to make the necessary changes?*

AM: Focus on creating a "performance-sensitive" market where the most leverage is – with individual physicians. Physicians are the only ones who are legally empowered to write orders for all categories of health care resources, and they heavily influence patient behavior. Even more important, no one has greater ability to insist upon integration of IT-enabled process engineering in hospitals and all other facets of care delivery. Employers should support only those insurers and/or business coalitions that will deliver, report and incentivize improvement in two measures for each physician.

1. An aggregate quality metric, i.e., a single specialty-relevant statistic for each physician.
2. An average total spending metric (i.e., average, case severity mix-adjusted, total cost per episode-of-care and year-of-chronic-care) for patients primarily managed by each physician.

Such a performance-sensitive market could catalyze health industry transformation.

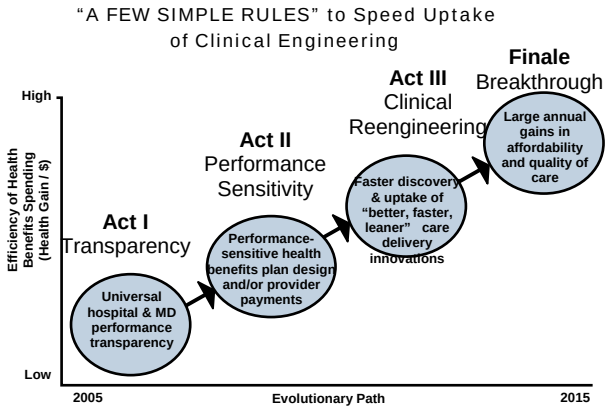
VBP: *Is there evidence that these strategies will be successful?*

AM: The large Las Vegas gaming companies and their union improved quality and reduced health care spending by 10% relative to the insurance trend over a 2-year period through such an approach; and even greater progress is likely to occur in their next phase.

Another example is Massachusetts State employees. Unlike Las Vegas, the state employees are distributed over six different health plans. The state persuaded health plans to merge their claims data to enable more reliable physician performance assessments, and each plan was permitted to use its judgment with regard to strategy(ies), i.e., tiering the network, limiting the network, and/or P4P. In partnership with the Massachusetts Medical Society and state performance improvement leaders such as MHQP, continuous refinements are underway.

VBP: *Your work has been described as "motivating physicians to lead health industry performance breakthrough." How do you represent your model for such changes graphically?*

AM:



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Value of Business Coalitions in Implementing Bridges to Excellence Programs

Adapted from an article by ***Andrew Webber****, president and chief executive officer of the National Business Coalition on Health in Washington, D.C. NBCH (at www.nbch.org) has a membership of nearly 90 employer-led coalitions in the United States, representing more than 7,000 employers and 34 million employees and their dependents.*

In April of 2006, eight employers in Colorado Springs (CO), representing 50,000 lives, announced that they are participating in a Bridges to Excellence (BTE) program (www.bridgestoexcellence.org), a pay for performance program that rewards physicians who provide top quality care to patients. This program is focused on helping to control the cost of diabetes for employees and their dependents while increasing the overall quality of health care for the participants.

The eight employers are members of the Colorado Business Group on Health (CBGH), a non-profit coalition based in Denver (www.coloradohealthonline.org). They include the City of Colorado Springs, Colorado College, Colorado Springs School District #11, Colorado Springs Utilities, El Paso County, Intel, Memorial Health System, and Penrose-St. Francis Health Services. David Lord, director of special projects for Colorado College and chair of the CBGH diabetes program, credits CBGH with the successful launch of the program. "A large group

such as CBGH gives employers more leverage in negotiating with healthcare providers, insurance companies, and health plans."

In 2004, CBGH (a member of the National Business Coalition on Health) worked with its employer members to develop a program that focused on diabetes among employees and their dependents. The program goals included increasing the rate of early detection of diabetes, improving the amount and quality of diabetes education offered, and improving benefit designs for those with diabetes.

The diabetes BTE program recently implemented in Colorado Springs will reward physicians who meet the standards for diabetes care from the National Committee for Quality Assurance. These standards encourage physicians to work in collaboration with their patients to avoid the serious complications that can result when diabetes is not managed appropriately. Physicians who treat employees and/or their dependents with diabetes will be eligible for as much as $100 per patient per year if standards are met.

The diabetes BTE program will also include incentives for employees and their family members with diabetes. For instance, beneficiaries may earn up to $200 in cash for participating in wellness activities such as joining a gym or completing a health risk assessment.

Donna Marshall, executive director of CBGH, says the BTE program demonstrates what employers can accomplish by working together. "The eight employers in this diabetes BTE program are expecting to see improvements in costs and quality in the years to come. They also recognize that we have to embrace a wide range of initiatives to get the outcomes we need in terms of lower costs and better health care."

Colorado College is one example of an employer that uses a combination of strategies to contain healthcare costs. Three years ago, the college started a self-funded insurance program for its 600 employees and 1,500 covered lives. In subsequent years the college added wellness and illness prevention initiatives. As a result of this multi-faceted approach, the college anticipates a 4% rise in its healthcare costs for the coming academic year – a significant decrease from the 15% to 18% annual increases the college experienced previously.

CBHG affords its members the opportunity to discuss the problem of increasing healthcare costs with other employers and to share successful solutions. Lord says, "As a member of CBGH, we can share best practices, review educational materials used by other employers and buy services for health screenings in bulk. It would be much more difficult to accomplish these things as an individual employer."

BTE programs combined with wellness initiatives can help to change the healthcare system from one that reacts to illness to one that rewards healthy behaviors. CBHG believes that this is the best way to control healthcare costs in the long-term.

P4P "Primer"

Valerie Pracilio, BS and Janice Clarke, RN, BBA

Pay for performance (P4P) is a strategy that rewards healthcare providers for improving the quality and cost-effectiveness of care they deliver to patients. P4P is viewed by many as a solution to soaring healthcare costs, rising malpractice fees and growing quality concerns. An increasingly popular concept among businesses and health plans, the Federal government is also beginning to implement P4P initiatives via the Centers for Medicare and Medicaid Services (CMS).

P4P is defined by the Leapfrog Group as "incentive programs designated to overcome the limitations of current reimbursement arrangements by aligning financial rewards with improved outcomes."[1] P4P programs set expectations, measure performance, and present rewards based on the results.[2] The three primary objectives of P4P are:

- Creating a fair payment system,

- Creating financial incentives for improved outcomes, and
- Encouraging providers to add efficiency by stretching financial resources.[3]

The key players in P4P are providers, payers and the federal government. Commercial health plan and government P4P programs exert pressure on providers (i.e., physicians and specialists) to perform well with respect to quality benchmarks and to share their quality scores or rankings publicly in order to receive financial incentive payments.

According to Kaveh Safavi of Solucient (an information products company that serves the healthcare industry and maintains the nation's largest healthcare database), providers are most concerned about the fairness of P4P payment methods. Some payers (ie, healthcare insurance companies) provide the P4P incentive payments to physicians based on the magnitude of improvement in performance on certain measures. Physicians argue that providers who demonstrate high quality pre- and post-implementation of P4P receive less of an incentive than those whose performance went from poor to good.

In an article for Physician Executive, Lawrence Fink describes P4P as a program that "disvalues medical ethics." He writes that P4P is driving providers out of the system and leading to the establishment of concierge service medicine.[4] While Fink believes that the ethical components of beneficence and non-maleficence are lacking in P4P programs, others believe that there is nothing unethical about offering incentives to physicians to encourage good quality.

Although the U.S. healthcare system is more advanced than other nations', its considerable resources are being used inefficiently. Among the current initiatives to improve efficiency in health care are:

- Rules of engagement for efficiency, established by a collaborative effort among the Agency for Healthcare Research and Quality (AHRQ), Bridges to Excellence and The Leapfrog Group.[5]
- Health Plan Employer Data and Information Set (HEDIS) measures for payers scheduled to be introduced in 2008 by the National Committee for Quality Assurance (NCQA.)
- Cost-efficiency improvements envisioned by the Medicare Payment Advisory Commission (MedPAC), a Federal government initiative.

In its recommendation to the Congress, MedPAC asked that a portion of Medicare payments be made to hospitals, physicians, home health agencies, providers of dialysis patients, and Medicare Advantage (MA) patients based on quality.[6] Another government agency, the United States Department of Health and Human Services, provides data sharing and a reporting mechanism for hospital quality indicators.

Medicare should, at minimum, get the best value possible for the dollars spent.[6] The rate set aside by Medicare for P4P initiatives is 1-2% of current payments per provider. Pay-for-performance will alleviate one of Medicare's historic problems – the system makes equal payment to providers regardless of the quality of care they deliver.[1] Under a P4P program, provider payments will be based on their ratings on a set of quality indicators.

Summary: P4P is a strategy aimed at aligning healthcare provider payments with the efficiency and quality of care delivered. Specific quality standards are set by the CMS, JCAHO, and NCQA/HEDIS. Ongoing evaluation of P4P programs will determine their effectiveness in changing patterns of healthcare delivery and improving quality.

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Program Schedule

This e-journal, *Value Based Purchasing*, is a product of The College for Advanced Management of Health Benefits, a unique training program designed to help employee benefit managers meet the growing challenges of providing high quality health benefits and managing rising benefit costs. The College offers a practical, intensive program that focuses on benefits purchasing techniques and skills that emphasize improving the value, quality-cost ratio, and effectiveness of health care services purchased on behalf of employees. The program is a collaboration between the HealthCare21 Business Coalition in Tennessee, the National Business Coalition on Health, and the Department of Health Policy of Thomas Jefferson University.

Three College sessions are currently planned for 2007:

March 19-21 in Las Vegas, NV
June 4-6 in Nashville, TN
September 24-26 in Columbus, OH

For more information, or registration materials, please contact Jeannine Kinney, Program Coordinator, at jeannine.kinney@jefferson.edu, or 215-955-1709.

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