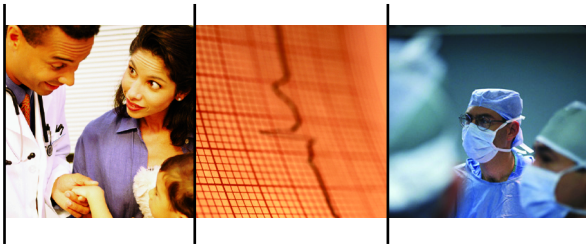
Issue Brief
Findings from HSC



PAYING FOR QUALITY: HEALTH PLANS TRY CARROTS INSTEAD OF STICKS

by Bradley C. Strunk and Robert E. Hurley

Growing national attention to improving quality and patient safety is spurring development of quality-based financial incentives for physicians and hospitals. Health plans in particular are driving these pay-for-performance initiatives, according to findings from the Center for Studying Health System Change's (HSC) 2002-03 site visits to 12 nationally representative communities. For now, there is little standardization across plans in how quality improvement is measured, and incentive payments typically are modest in comparison with providers' total revenue. Nevertheless, today's nascent efforts can provide a foundation on which to build. Support from major plans and public and private purchasers, sufficiently large financial incentives properly aligned with base provider payment systems, and improvements in quality measurement can all help foster widespread provider acceptance and, ultimately, improvements in health care quality.

Quality Incentives Gain Favor

Across the country, health plans are experimenting with provider payment arrangements that offer financial rewards to providers meeting quality-related goals, according to findings from HSC's 2002-03 site visits to 12 nationally representative communities (see Data Source). While plans have long used payment policies to try to influence provider behavior, past models typically promoted greater awareness of health care service utilization and cost.

For example, some models tied a portion of a provider's compensation or a bonus payment to the provider's ability to keep patient utilization or costs below agreed-upon targets. Capitation, or plans' use of fixed per-member, per-month payments regardless of the amount of care provided, was another payment method used widely in the early to mid-1990s to promote cost-conscious provider behavior. However, utilization- or cost-based financial incentives and capitation have fallen out of favor because of concerns that they create perverse incentives for providers to stint on needed care and do not systematically promote quality improvement.

Two landmark Institute of Medicine reports—*To Err Is Human* in 1999 and *Crossing the Quality Chasm* in 2001—put health care quality and patient safety issues squarely on the public policy agenda. Together, the reports drew attention to significant quality and patient-safety shortcomings in the American health care system. A key recommendation in *Crossing the Quality Chasm* was to align payment policies with quality improvement.

Incentive Program Snapshot

Health plan-based quality incentive programs exist in seven of the 12 HSC communities. Notably, most programs are sponsored by major health plans—those with large market share and, therefore, significant influence over providers. Each program varied on three key design features: quality

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Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. HSC researchers interviewed representatives of health plans, providers, employers, policy makers and other stakeholders about current approaches to provider payment and quality incentive programs in local health care markets.

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measurement, incentive payment structure and incentive size.

- Plans are using a variety of methods to measure quality with little standardization from one program to the next. Plans commonly use indicators of patient satisfaction and preventive care use, since these data can be collected easily. More sophisticated process measures of care delivery, such as the specific care a patient receives for a given diagnosis, and health outcomes are less common, but their use is growing along with advances in evidence-based medicine and risk adjustment applications to measure differences in patient acuity. Patient safety-related indicators also are becoming more prevalent.
- Although incentive payments take a variety of forms, two designs are common. The first is a bonus payment paid at regular intervals—yearly or quarterly, for example. Alternatively, some plans condition a specified portion of a provider's payment rate increase over a multi-year contract to the provider's performance on a quality scorecard. Regardless of how they are paid, incentives almost always represent "upside" risk to providers. In other words, the providers risk losing extra revenue, but base payment rates are not threatened.
- The size of incentive payments typically is modest compared with a provider's total revenue from a given plan—usually about 1 percent to 5 percent of total payments. Plans acknowledged they do not yet know how large incentives should be to achieve desired changes in clinical practice.

Incentives in Action

The following examples of quality incentive programs—one targeting physicians in California and the other targeting hospitals in Michigan—represent some of the most innovative approaches observed during HSC's 2002-03 site visits.[1]

Physician incentives. California's Integrated Healthcare Association (IHA) launched Pay for Performance (P4P) in January 2002. Under P4P, six major California health plans agreed to develop individual quality incentive programs for capitated medical groups and independent practice associations in health maintenance organizations (HMOs)—the dominant model of health care delivery in southern California—using a common set of performance measures. The six health plans account for about 8 million HMO enrollees statewide.

The IHA quality scorecard covers three broad categories: clinical quality, patient satisfaction and information technology (IT) investment. The clinical quality area, which accounts for 40 percent of the total physician group score, includes measures of preventive care—for example, childhood immunizations, breast cancer screening and cervical cancer screening—and measures related to the management of such chronic conditions as asthma and diabetes. Patient satisfaction accounts for 40 percent of the total score and includes satisfaction with doctor communication, specialty care received and timeliness of care. The IT component accounts for 20 percent of the total score and is based on demonstrated investment in technology enabling clinical data integration at the point of care.

The first incentive payments—annual bonuses in most cases—are due to be paid in mid-2004. Five of the six California plans participating in the P4P initiative will pay maximum incentives ranging from about $2 to $4.50 per member per month, which is typically about 5 percent of total capitation rates, but could be as high as about 10 percent. Another plan will pay an incentive payment of up to 3.5 percent of the capitation rate.[2]

Hospital incentives. Blue Cross and Blue Shield (BCBS) of Michigan, the dominant health plan in Lansing and throughout the state, launched the Participating Hospital Agreement Incentive Program in 2000. This program pays incentives based on how well a hospital scores on a quality scorecard.

The BCBS quality scorecard has three components: clinical quality (50% of the total score), patient safety (40%) and implementation of a community health project (10%). The clinical quality area includes a variety of process of care indicators for patients with acute myocardial infraction, congestive heart failure and community-acquired pneumonia, as well as indicators of surgical infection prevention for selected procedures. Hospital performance on patient safety is based on

certification of a hospital board-approved patient safety plan, compliance with a defined list of medication and patient safety practices, and implementation of technology that can improve patient safety, such as a computerized physician order entry system. The program is notable for its use of indicators developed by outside organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Quality Forum, that command significant standing with providers.

The program uses bonus payments calculated on a "pay-per-measure" basis, and participating hospitals in Lansing and throughout the state are eligible for incentive payments of up to 4 percent of inpatient payments in 2004.

The Incentive for Incentives

Interviews with plans, providers and purchasers suggest that plans have been the prime movers behind incorporating quality incentives into provider payment systems. A key motivation is a general belief in promoting the practice of evidence-based medicine and quality improvement throughout the health care system. Ideally, incentive programs can enable plans to use their role as payer to pursue goals that are shared by both purchasers and providers.

Plans also perceive a business case for paying for quality. A few argue that the business case for paying for quality hinges on its potential to reduce unnecessary follow-up care and improve efficiency, thereby generating cost savings that can be passed on to purchasers through lower premium increases. However, there is little empirical evidence to date to support such claims. Other plans use quality incentives because they believe they can promote better performance for a given level of cost or payment rate increase—and that purchasers will see the value added through gains in provider performance. In other words, these plans view quality incentives as a way to assure purchasers they are getting more for what they pay for in terms of health benefits.

Quality incentives also are attractive to plans for other reasons. During the past few years, providers in many markets have sought to shed capitated payments and return to payment models such as fee-for-service that involve little or no financial risk and can create incentives for overuse of services. Some plans view quality incentives as preserving some financial risk for providers in a more acceptable way than capitation. Other plans have adopted quality incentives to defuse tense provider contract negotiations and repair relations damaged during the contentious contracting environment of the last few years.

With a few exceptions, providers have not been driving forces behind quality incentives, and many remain cautious about incentive program designs and measures. But some are willing to participate and, like plans, view quality incentives as a way to promote the practice of evidence-based medicine. They also value the monetary and other rewards tied to performance improvement—both because they appreciate recognition and financial incentives help to offset infrastructure investments to support quality improvement. Finally, providers' motivation to support pay-for-performance is shaped in part by sensitivity to community perceptions, which could be harmed if providers publicly oppose credible efforts to improve quality.

In general, purchasers have played limited roles in leading efforts to advance quality incentives across most of the 12 communities. Nevertheless, there are notable exceptions, one of which is the Bridges to Excellence program, spearheaded by a coalition of purchasers, plans and providers. Operating in Boston and a few other markets, Bridges to Excellence makes incentive payments to physicians who show improvements in diabetic and cardiac care and invest in information systems and care management tools. This type of program allows purchasers to make direct investments in quality improvement rather than using plans as agents of change.

Prospects for Success

Plans and providers are still experimenting with payment arrangements that use quality-based financial incentives. Over the longer term, the success of these programs will be judged by their ability to attract greater participation from both providers and plans and alter provider behavior in a way that promotes system-wide quality improvement. A number of factors will influence whether or not incentive programs significantly improve quality.

Incentive design. The size of incentives, along with the proportion of a provider's patient panel enrolled in a plan sponsoring an incentive program, determines the total amount of extra revenue a provider can earn. Although most current initiatives have begun with small-scale incentives relative to total provider payments, plans expect to increase the size of incentives to ensure they have an impact on provider behavior. At the same time, some providers are concerned that incentive programs will end up being financed largely by shifting dollars from some providers to others, creating winners and losers. Plans are under pressure to prove otherwise and show their commitment to adequate funding for quality incentives for the long term.

Larger incentives alone will not necessarily alter provider behavior in ways that promote quality improvement. Plans also will need to consider the relationship between quality incentives and the underlying financial incentives of the base payment system. If quality incentives are not carefully aligned with the base payment system—if the two reward providers for opposing behaviors—they are unlikely to have much of an effect even if they are large by today's standards.

Support from major plans. Incentive programs from plans with large market share are more likely to succeed than efforts by smaller plans. First, major plans account for a large share of a given provider's total revenue, and incentive programs from such plans could translate into significant extra provider revenue, even if the unit incentive payment is small. The extra revenue a provider can earn will be important in motivating changes in providers' clinical decision-making behavior and an important funding source for improved information technology infrastructure.

Second, incentive programs from major plans could help accelerate standardization

Policy makers can act through Medicare and Medicaid to promote quality incentives as a customary method for paying providers.

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of criteria used to award incentives, which will be key to minimizing providers' reporting burden. In markets with several major plans, this could be accomplished through collaborative efforts, as exemplified in California by the P4P initiative. In markets such as Lansing with a dominant health plan, the criteria used by the plan could become a *de facto* standard.

Quality measurement. For quality incentive programs to succeed, they will have to overcome significant skepticism among providers about how quality is measured. A few programs have made strides to incorporate more sophisticated measures of care processes and outcomes, particularly those developed by reputable organizations trusted by providers. Equally important will be developing the permanent infrastructure to support care process and outcome measurement, such as clinical guidelines and best practices developed through evidence-based clinical research. The Bridges to Excellence program, through its incentives to providers who invest in IT and care management tools, is particularly attentive to this concern.

Purchasers' role. Ultimately, purchasers will play a vital role in the success or failure of quality incentive programs. Many plans appear to have little evidence or faith that quality incentives will prove to be an effective tool to control health care costs. At this stage, plans largely are betting that purchasers will value quality improvement enough to pay for it. The efforts of some large and proactive purchasers, such as those involved in The Leapfrog Group and the Bridges to Excellence program, suggest that could be the case. However, interviews with a broader and more diverse set of purchasers often reveal that quality improvement is a lower priority than controlling costs, particularly in today's climate of rapidly rising insurance premiums. Without broader willingness among purchasers to pay for quality, plans will be hard pressed to sustain a business case for their efforts over the longer term.

Policy Implications

The Institute of Medicine presented extensive evidence in *Crossing the Quality Chasm* that "health care is plagued today by a serious quality gap." That report illustrated that quality improvement must be addressed on multiple fronts, just one of which is finding a way to build financial rewards for quality improvement into health care financing. Many plans and providers indicate a willingness to pursue such changes, but their efforts will depend on the support and commitment of the ultimate financiers of health care—government and private employers.

Policy makers can play an important role in the development of private-sector quality initiatives. Continuing support for evidence-based effectiveness research and clinical guideline development will be critical to advancing best practices, devising more sophisticated tools to measure quality and attracting providers to the cause of quality improvement. Investment in information technology will be equally important to enabling better data collection and analysis and the widespread adoption of evidence-based practice.

Finally, as others have argued,[3] policy makers can act through Medicare and Medicaid to help advance standardization of criteria for awarding incentives and, more generally, promote quality incentives as a customary method for paying providers. The recently enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 included a number of quality incentive programs and demonstrations, a sign that policy makers are serious about paying for improved quality. ●

Notes

1. Both of these programs are being studied in greater depth as part of the Rewarding Results program; see *www.leapfroggroup.org/RewardingResults/*.
2. Each participating health plan has released the details of its individualized incentive program; for a comparison chart, *see www.iha.org/p4psum09.pdf*. For more general information on the P4P initiative, see *www.iha.org/Ihaproj.htm*.
3. Berwick, Donald M., et al. "Paying for Performance: Medicare Should Lead," *Health Affairs*, Vol. 22, No. 6 (November/December 2003).

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