

Quality and Financial Incentives

In this month's piece we briefly examine the efforts of health plans and employers to improve the quality of care by using financial incentives to reward providers for their performance.

The movement to measure and improve quality has become more prominent in health care over the past few years, spurred by two reports from the Institute of Medicine: "To Err Is Human: Building a Safer Health System" in 1999 and "Crossing the Quality Chasm: A New Health System for the 21st Century" in 2001. Purchasers and payers have begun promoting quality by designating funds to be paid out contingent upon meeting certain defined standards. The standards vary in different arrangements, but are comprised of a mixture of administrative services, clinical quality measures, access to services, and member satisfaction scores.

Performance incentives can overcome the limitations of financing arrangements in our health care system, which are focused on the costs of care rather than the quality of care. In risk-sharing reimbursement, including capitation, providers typically receive no reward for achieving higher quality outcomes. At the extreme, capitation can create perverse incentives to actually withhold appropriate care in order to minimize expenses. Another important factor is that some elements of quality, such as lowering cholesterol level or screening for prostate cancer, potentially generate cost savings only in the long-term; the patients may switch health plans and providers, so the current parties have little incentive to deliver these services.

Some purchasers and insurers are attempting to remedy this conundrum by developing a robust system of "pay for performance" financial incentives. They are looking at specified services and outcomes, including clinical and preventive measures drawn from Health Plan Employer Data and Information Set (HEDIS) as well as scores from patient satisfaction surveys. Perhaps the most significant factor in the success of these new "pay for performance" arrangements is that the bonuses will be large enough—up to 10% of a physician's base annual reimbursement—to truly influence physician behavior.

Employers

Employer coalitions, rather than single companies, have been at the forefront of incorporating risk in the form of performance-based targets into their contracts with health plans. Examples include the Chicago Business Group on Health, the Colorado Business Group on Health, Gateway Purchasers for Health (based in St. Louis), and the Pacific Business Group on Health. In a standard version of the contract, 2 percent of the premium or 20 percent of the administrative fee is put at risk. In essence, this arrangement creates a potential penalty for failing to meet targets, instead of rewarding health plans with additional pay for high quality outcomes. The argument is that incentives should not be given for quality care that the purchasers should reasonably expect to have provided in any event.

Still, there are some employers and coalitions that are developing financial incentives that reward providers with extra pay for achieving high-quality outcomes. In January 2001, General Motors and the University of

Michigan Health System developed a new initiative called Activecare in which GM directly reimburses providers for performing patient health risk assessments. Activecare will also reward provider groups with a year-end bonus for meeting target rates for a number of services and processes. As another example, in early 2001 the Tri-Rivers Healthcare Coalition in Dayton, Ohio, established a quality council comprised of purchasers, providers, health system representatives, and consumers to determine which provider performance areas should be targeted with newly-offered financial incentives to improve patient outcomes.

Health Plans

Defining the quality of care that a physician provides and paying them accordingly is a relatively new idea for health plans. It is difficult to implement, in part because quality incorporates such a wide-ranging list of variables, from patient satisfaction scores to clinical outcomes. Historically, health plans have focused on items that can be easily measured, such as the Health Plan Employer Data and Information Set (HEDIS) survey results and scores on access and satisfaction from patient surveys. Health plans have then attempted to incorporate these ratings into physicians' bonuses.

The methodology of factoring quality outcomes into physician payment schemas is often insufficient to achieve changes in physician behavior. However the following examples demonstrate how some health plans are striving to change physicians' behavior by offering a significant financial incentive for high-quality outcomes:

- Integrated Healthcare Association (IHA) of California, "Pay for Performance" program: Six of the largest health plans in California—Aetna, Blue Cross of

California, Blue Shield of California, Cigna, Health Net, and PacifiCare—have agreed to use a common scorecard to measure physician group performance and reward them financially. The proposed performance measures for the scorecard are comprised of the following weighting system: 50% for clinical outcomes, 40% for patient satisfaction, and 10% for information technology usage. The amount and nature of the performance award will be left to the discretion of the individual health plan, but IHA recommends significant bonuses. The Pay for Performance program is schedule to be fully operational by January 2003.

- Independent Health Association, Buffalo, New York: Independent Health has developed a quality bonus based upon five measures: patient satisfaction scores, emergency room utilization, service access, mammography rates, and colorectal cancer screening rates. Physicians can receive an additional 20 cents per member per month (PMPM) for average performance and 30 cents PMPM for high performance.
- Hawaii Medical Service Association (HMSA), Hawaii: HMSA, the state's Blue Cross and Blue Shield Plan, has offered a year-end bonus to both generalists and specialists in its preferred provider organization (PPO). The bonus can equal up to 5.5% of providers' annual billings, with a \$12,500 maximum cap. Most of the bonus—70%—is tied to a combination of clinical and patient satisfaction scores; the remaining 30% is tied to changes in administrative processes, filing electronic claims using an Internet eligibility system,

and participating in other HMSA products.

Government Agencies

Public purchasers, including the federal government and various state governments, have lagged behind in the use of financial incentives to promote quality improvement. The strict legal and financial provisions of Medicare and Medicaid legislation and difficulty in coordinating care among Medicare and Medicaid enrollees makes it extremely difficult to for public purchasers to provide extra pay for providers that are based upon high-quality outcomes.

MCOs involved in the Medicare + Choice and Medicaid programs have only recently implemented disease management programs to improve the quality of outcomes. No financial arrangements have been made between MCOs and providers within these programs to directly link outcome targets to financial reimbursement. Instead, providers are just often paid an extra amount per member per month to monitor and provide care for patients enrolled in the disease management programs.

Conclusions

As health care costs continue to climb, purchasers will increasingly look for new ways to ensure that their increased health care outlays will result in healthier patients and greater patient satisfaction. One of the most effective ways that purchasers and payers can accomplish this goal is by arranging for a portion of a provider's reimbursement to be tied to achieving high-quality outcomes. This should be done through rewards for better performance, rather than penalizing providers for not achieving certain performance targets.

Purchasers, plans, providers and patients should reach consensus on which outcomes are to be rewarded. Purchasers and payers should link financial incentives to quality

improvement efforts that will affect a large number of patients, have easily identifiable and measurable performance measures, and are feasible for providers to implement. The first wave of payment arrangements featuring performance-based financial incentives will yield lessons for the broader health care system.

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