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FEATURE STORY

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new reimbursement models reward clinical excellence

Pay-for-performance means that quality and revenue are no longer separate issues for healthcare providers.

AT A GLANCE

Pay-for-performance is an emerging payment model that links quality of care with the level of payment for healthcare services. While pay-for-performance programs are still in their formative stages, hospitals need to prepare by intensifying their efforts to ensure systems and processes support high-quality care.

In today's healthcare market, complex reimbursement models pose formidable obstacles to healthcare organizations and professionals alike. Further, greater public scrutiny and disclosure of clinical quality and patient safety performance standards are demanding a new, more equitable and effective reimbursement model for hospitals and physician services.

While still in its infancy, a new model that bases reimbursement on high-quality clinical performance should sweep health care within five to 10 years. Because revenues will vary according to demonstrated quality under this model, the CFO will play a new and vital leadership role in the organization's clinical quality agenda.

Are We Encouraging Poor Performance?

Everyone agrees that traditional healthcare reimbursement models are lacking. The myriad models employed throughout the country today have been more focused on trying to manage utilization through fixed payments, deep discounts, and capitation than focused on quality. What these models have in common is that they treat every provider the same regardless of clinical quality outcomes and, in fact, may have the perverse effect of rewarding poor quality performers for adverse outcomes requiring additional patient care.

"Other industries have learned to encourage superior performance by rewarding best performers more highly than average and poor performers," says Charles Peck, MD, region head for Healthcare Delivery with Aetna, responsible for the Southeast region's utilization, case, and quality management; compliance; and

regulatory affairs. "Unfortunately, in medicine we have dumbed down everyone in a particular market to the average," he adds. "Every doctor gets the same fee schedule regardless of performance. We ought to be paying providers more who operate more efficiently and achieve higher quality at lower cost."

Measurement Tools Document Clinical Quality

In 1999, the Institute of Medicine reported that as many as 98,000 lives are lost in U.S. hospitals each year as a result of preventable medical errors. Transfer those statistics to the airline industry and it's the same as a 300-passenger airplane going down daily. If the airline industry had such statistics, no one would fly. This alarming report set in motion an effort to improve the quality of hospitals and patient safety. The new frontier is to measure high-quality clinical performance and gear reimbursement models accordingly.

While everyone is rallying around the idea that hospitals can and need to do better, pay-for-performance can be a scary proposition.

Ten to 20 years ago, there was no agreed-upon methodology for measuring quality. In fact, in the 1980s and 1990s, quality was often "assumed" or based on reputations earned because of technologies or rare and complex procedures performed by certain institutions. Only recently, through evidence-based medicine, have standards been developed that are more widely agreed to be linked to better outcomes.

Although there is by no means a protocol for every illness, we now have recognized standards against which performance can be measured. A simple example of a measure would be the consistent administration of aspirin to patients who present with cardiac arrest. Aspirin has been proven to save lives and, unless there are contraindications such as allergy, should be administered to cardiac patients in 100 percent of cases, not just 80 or 90 percent. Meeting the standard is as simple a matter as writing protocols that specify when to and when not to administer aspirin. Hospitals that want to measure performance can begin by establishing guidelines for emergency departments similar to those of the airline industry as, for example, the checklist a pilot goes through when taking off or landing. Airlines know that the landing gear has to be deployed on 100 percent of the flights, not just 80 or 90 percent.
The aspirin administration protocol was one of the 10 indicators of The National Voluntary Hospital Reporting Initiative (also referred to as A Public Resource on Hospital Performance) developed by CMS. When asked by CMS to report on these quality marks voluntarily, only about 10 percent of hospitals reported. Since then, CMS has added an incentive under which hospitals that don't report will be penalized financially.

Just this year, the 10 quality measures have been incorporated into the 34 indicators of The Premier Hospital Quality Incentive Demonstration (Rewarding Superior Quality Care) developed by CMS. This three-year demonstration project is a part of the CMS Hospital Quality Initiative launched in 2003, which aims to refine and standardize hospital data, data transmission, and performance measures to create a standard set of quality measures for hospitals. It will recognize and provide financial rewards to hospitals that demonstrate high quality performance in a number of areas of acute care by increasing their payments for Medicare patients. The scores of the 278 participating hospitals will be posted at www.cms.hhs.gov for healthcare professionals.

Piloting Pay-for-Performance

In the last several years, a few pay-for-performance pilot projects involving partnerships between insurance companies and providers—both hospitals and physician organizations—have been initiated. In 2003, Anthem Blue Cross and Blue Shield, formerly Trigon, initiated a three-year program with nine participating hospitals in Virginia. It rewards the hospitals for achieving specific objectives designed to enhance patient safety and satisfaction and improve treatment outcomes. The program focuses

on creating performance goals for hospitals, helps them set up systems and procedures, and creates ways to measure performance. Participating hospitals will receive higher reimbursements for services depending on how well they meet the established standards.

In 2002, Promina Health System in Atlanta partnered with CIGNA Healthcare of Georgia to develop a three-tiered payment system that rewarded Promina physicians for meeting certain quality standards developed by CIGNA and Promina. The measurements were based on quality indicators already widely accepted by the medical community. The previous year, Promina had launched a joint patient safety initiative with The Leapfrog Group, a national consortium of Fortune 500 companies and public organizations that encourages healthcare providers to adopt a set of "leaps," such as purchasing computerized order entry systems to reduce medical errors.

Aetna's Southeast region is currently piloting a program with physician groups in high-cost specialties where the greatest opportunities exist. The insurance company also offers members a rating service via its web site that differentiates hospitals based on utilization, costs, outcomes, and other characteristics. A large pilot project is also in progress in California with the participation of multiple health plans and provider groups. Elsewhere, health plans have agreed on certain standards across the board, such as wellness standards, and are paying bonuses to organizations that have achieved the quality indicators.

In other words, investments by hospitals in quality infrastructure and quality information systems are beginning to pay off. Shouldn't health care work this way regardless of incentive? Absolutely. But the most basic things often don't get done because of the multiple and complex issues that need to be addressed and managed every day by healthcare organizations.

While competing on performance standards may be daunting at the outset, it is also an opportunity for every healthcare organization to take a leadership position in its market. There is no doubt that a philosophic agreement has been reached that is the beginning of reward for performance and payment for quality. However, as a mainstream reimbursement model, it's still a few years away.

"There's no question that it's going to be expensive for hospitals to implement measuring systems, but they can start without having a system in place," says Aetna's Peck. "Just pick one disease, for example, and gather and report data on your success in treating it. It's urgent that you begin somewhere now because in the future you will certainly be differentiated on the value you provide."

The Role of Public Scrutiny

In addition to financial incentives, public scrutiny is an enormously powerful driver of quality and performance. Just as airline service improved when on-time reports became available to travelers, so public pressure, or just the knowledge that quality-of-care information is available for public inspection, will bring a heightened awareness of healthcare performance statistics and the need to improve them.

Public scrutiny and awareness have steadily increased over the last decade. "People who have higher deductibles are going to look for information on quality and cost," says Peck. "If they need to have surgery, they will choose hospital A, which is rated A+ and lower cost, over hospital B, which rates A- at higher cost. Employers are also beginning to ask for differentiation. Our customers are asking us to identify the highest quality hospitals and doctors in a particular market and to help them design systems to direct their employees toward the highest performers. It's going to be a real partnership between employers and health plans."

While everyone is rallying around the idea that hospitals can and need to do better, pay-for-performance can be a scary proposition. "The main obstacle to implementing pay-for-performance models is fear on the part of providers," says Peck. "Obviously hospitals that are not rated highly could lose a lot of business to competitors. Some providers do not believe insurance companies have the data to make decisions about performance; others just don't want to believe the data even though it may have been validated by independent groups as in the case of the data Aetna collects from its 13+ million

LEARN MORE

"Pay for Performance: A Proposal for Physician Reimbursement" published by the Health Lawyers Association, 2004. This paper discusses a methodology for physician reimbursement based on quality measurements and performance. Go to www.hfma.org/resource/focus_areas/commercial_payment/400280.htm.

OTHER PAY-FOR-PERFORMANCE PROGRAMS

Following are several additional pay-for-performance programs developed to test the viability of this payment model.

Bridges to Excellence
Bridges to Excellence is a not-for-profit organization made up of physicians, employers, health plans, and patients dedicated to improving quality in healthcare. Their purpose is to create financial incentive programs that reward providers for improved quality in the healthcare system. The three programs currently under way are the Physician Office Link, the Diabetes Care Link, and the Cardiac Care Link. Bridges to Excellence is a grantee to the Rewarding Results program sponsored by the Robert Wood Johnson Foundation.

For more information, visit www.bridgestoexcellence.org

Integrated Healthcare Association
Integrated Healthcare Association (IHA) is a statewide health leadership group in California, consisting of physician groups, healthcare systems, and academic, consumer, purchaser, and pharmaceutical representatives. IHA's pay-for-performance program rewards physician groups for quality care based on measurements developed by IHA. The six participating health plans are Aetna, Blue Cross of California, Blue Shield of California, CIGNA Healthcare of California, Health Net, and PacifiCare. Each plan will use the common performance measurements while designing its own physician group bonus program.

For more information, visit www.iha.org/P4POVIEW.htm

Robert Wood Johnson Foundation and California Healthcare Foundation: Rewarding Results
Rewarding Results is an $8.8 million initiative of the Robert Wood Johnson (RWJ) Foundation and the California Healthcare Foundation to improve healthcare quality. The objective is to align financial incentives with high-quality health care. The overall evaluation of Rewarding Results was sponsored by the Agency for Healthcare Research and Quality and RWJ. The Leapfrop Group is currently administering the final phase of the pilot program.

Rewarding Results has seven participants: Blue Cross Blue Shield of Michigan; Blue Cross of California; Bridges to Excellence; Excellus; Integrated Healthcare Association; Rewarding Results Project–Center for Health Care Strategies; and Massachusetts Health Quality Partners. The performance criteria for creating a quality incentive are listed for each of the participants. The Rewarding Results project includes monographs and toolkits examining the implementation of physician incentives for higher quality care in specific markets.

A list of major studies and reports on the use of physician incentives is available on the Rewarding Results web site: www.leapfroggroup.org/RewardingResults.

Source: HFMA's Internet Guide to Pay for Performance Programs, www.hfma.org/resource/focus_areas/medicare/payperform.htm.

members. We cannot wait until everything is perfect. We have to make an attempt at least to begin incentivizing high performance."

CFOs who recognize it's no longer business as usual are beginning to prepare their organizations for public reporting and pay-for-performance. They are helping their organizations fine-tune clinical quality and performance improvement systems because they know that soon quality will be tied to the bottom line.

Quality for Everyone

Quality is no longer a vague concept or reputation-driven designation reserved for large and sophisticated hospitals, especially since the reporting requirements are by and large not focused on rare and extremely complex surgeries and procedures. Every hospital will have to perform on the standard measures for common yet serious illnesses (for example, diabetes, pneumonia, heart attack, heart failure), regardless of size and location. The playing field will be leveled through the adoption and application of evidence-based standards of medicine and creation of the clinical and operating systems required to better manage and monitor performance.

"Don't hide behind your data," says Aetna's Peck. "Let people see all your data on quality, cost, and effectiveness. Even if you don't have faith in other organizations that are collecting your data, you can still differentiate yourself in your community by making your data available to the public. If you have an area that needs improvement, be honest, not embarrassed."

There's no doubt that incentives are needed as catalysts to enhance performance and hospital quality.

Once the incentives are aligned, American health care will improve dramatically.

The following changes will occur:

>First and foremost, the quality of care in the community will improve.
>Hospitals will benefit greatly because doctors will cooperate to raise quality. Efficiency will increase and public reporting will look better.
>Pay-for-performance will be a boost to physicians because lives will be saved through simple systems such as the consistent administration of aspirin in emergency departments.
>Initially, insurance companies may pay a little more for performance, but in the long run, superior performance and higher quality will decrease costs.
>The insurance industry will no longer pay for mistakes.

The CFO's Role in the New Business Model

Many details of the new model's methodology remain to be worked out, and there will be much give and take as the picture unfolds over the next five to 10 years. But one thing is for certain: public reporting is now upon us, and pay-for-performance is close behind. For the CFO, here is the bottom line: if the clinical side of a healthcare organization performs well, revenues will increase. This demands that CFOs, as members of the senior leadership team, have a strong voice in matters of performance and quality. Financial managers and those who ensure clinical quality can no longer work in isolation.

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