Pittsburgh Regional Healthcare Initiative

Reprinted from *PRHI Executive Summary*, September 2004

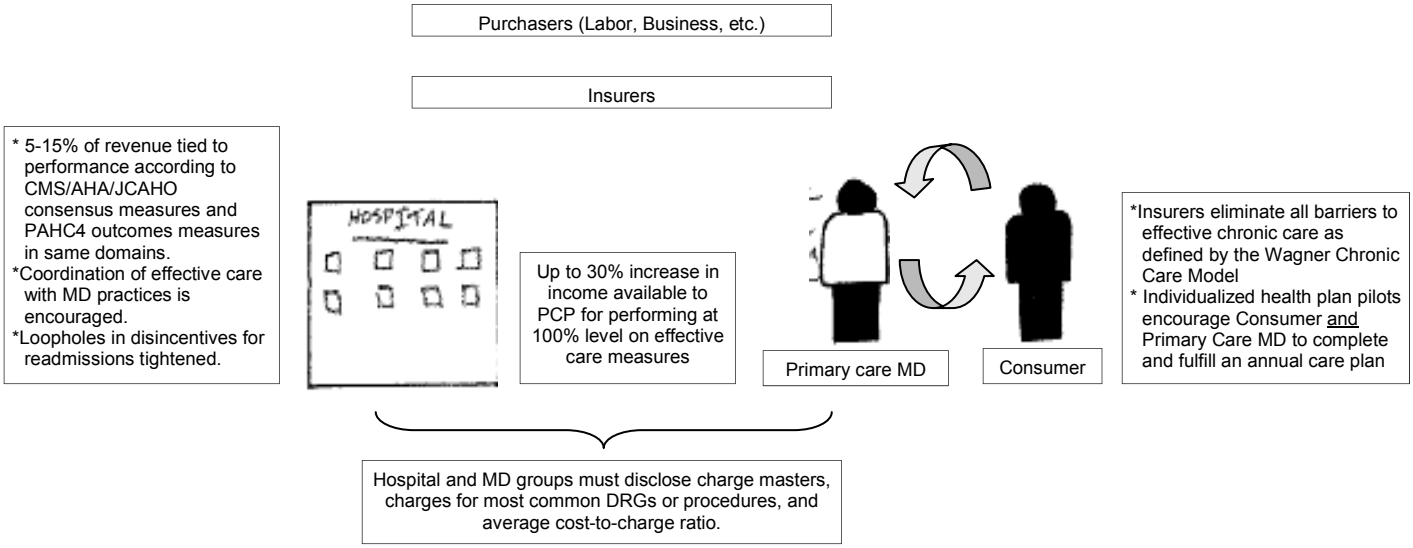
Naida Grunden, editor

Building incentives to do the right things for patients

A payment system that "first does no harm"

The May and June editions of PRHI Executive Summary *documented instances—using your examples—where the current healthcare reimbursement system rewards the wrong things. Below is a "sample discussion," the beginning of a new dialogue on the subject. Please forward your thoughts and responses to Ken Segel, PRHI Policy Director, at ksegel@prhi.org; or 412-535-0292, ext. 104.*

Health care professionals seek to promote health and healing. They participate in payment systems, however, with many barriers, or incentives that may not favor the patient. Our payment systems are also cynically complex, lack transparency, and lack adequate connection to the activities that add or detract value that occur in patient care. A previous white-paper provided specific examples of potentially dangerous payment incentives and characteristics in our community. This paper provides examples of changes to the reimbursement system locally and nationally that might speed radical improvements in health system performance. While a few encouraging experiments in payment methodology are occurring around the country and in our community, they are to date too few in number and too modest in scope to have much impact on the performance of the healthcare system.



Primary Care

Key objective(s)

Reward primary care physicians and physician groups for effective primary care (judged by both processes and outcomes) especially in the prevention and management of chronic disease, which according the Centers for Disease Control and Prevention accounts for 75% of our morbidity and cost burden.

Current condition regarding quality incentives

Most current quality incentives are not large enough or visible enough to capture physician attention. Quality incentives vary from payer to payer, further reducing their visibility and impact on behavior with physicians. Data collection remains a challenge in paper-based offices.

Sample proposal

Pay primary care physician practices and individual physicians within practices up to 30% per year bonuses or 30% higher fee schedules for providing effective primary care, especially for the

prevention and effective care of chronic disease.

It is also possible to tie significant primary care physician incentives to individualized health plans (see below). For example, for patients with chronic disease, a PCP could receive $125-$250 bonus for designing an individualized care plan with the patient and completing all necessary preventive and primary care for year.

Models / local resources

The Hill Group in California pays it's physicians up to 30% per year bonuses for providing effective primary care. To date, though they radically outperform other physician groups, they can attract only 1/3 of the amount they pay out internally in quality bonuses from insurers. The Central Florida Healthcare Coalition is implementing a plan to alter fee schedules for physicians based on annual performance against quality measures.

Several local insurers pay MD groups bonuses for attaining certain quality and finance goals. In general, the amount of resources on the table per group and physician for meeting the goals is not sufficient to encourage significant behavior change.

A Center for Medicare/Medicaid Services primary-care physician group quality incentives pilot is being implemented. It will create a shared savings pool from which to pay participating practices. Seventy percent of the bonus pool will be paid based on reduced specialty/hospital utilization (reduced cost) and 30% based on performance on process measures correlated with improved outcomes.

Bottom line re: implementation

A great deal of care is paid for at high rates, particularly on the specialty side, which the literature has shown to be ineffective. Effective care is also paid for at much higher rates in specialties than in primary care. Insurers are reluctant to make decisions to reallocate resources because of resistance from the medical and hospital communities. Will business and labor leaders provide cohesive support and pressure to make payment levels and their correlation with effectiveness more transparent, and to support alignment with the imperative to better prevent and manage chronic disease?

Hospital Care

Key objective(s):

Link payment to process and outcomes of care for patients.

Balance risks to overtreatment and undertreatment that are present in current payment methodologies.

Shift "Monday morning" activity of hospital CEOs/CFOs from looking at census and length of stay numbers toward critical process, outcome and safety indicators.

Current condition regarding quality incentives

There are still relatively few quality incentives in place for hospitals. The amount of existing quality incentives is too little to drive behavior (the average in our market is less than 1% of revenue).

Sample proposal

Tie 5% to 15% of hospital revenue (escalating each year) to uniform and escalating performance

benchmarks on new joint JCAHO/AHA/CMS core performance measures and, in our community, Pennsylvania Health Care Cost Containment Council outcome measures in the same domain. (These will not impose additional data collection on the hospitals, the process measures will be uniform across the country, and the integrity of measures will be easier to maintain with CMS/JCAHO/AHA role).

Allow hospitals and affiliated physician groups to decide where critical care processes occur and to share financial incentives tied to those processes, encouraging effective coordination. I.E. if a chronic care patient requires follow-up within 24 hours of discharge, allow the hospital that successfully facilitates that follow-up care in a PCPs office to share some reimbursement.

Close loopholes on current CMS financial disincentives to hospitals if a patient is readmitted, and expand them to cover more DRGs. Private insurers should follow CMS lead.

Consider moving all hospital care to DRG-based payments balanced by quality incentives as specified above. *Per diem* payments from commercial insurers are too subject to gaming, tacit incentives to over-treat, and non-value added administrative tussles over whether additional care days are warranted.

Models / local resources

JCAHO/AHA/CMS measures have just become de facto standards. The CMS hospital-based pay for quality pilot is intellectually credible, but in the view of leading hospital CEOs attaches too few dollars to performance. Local hospital pilot quality incentive programs are intellectually credible, but need to be a larger percentage of revenue and be made more uniform regarding measures.

Bottom line re: implementation

Hospital leaders state their desire to be paid for providing better quality care, but sometimes resist participating in actual proposed incentive pilot programs. Will insurers, business and labor leaders provide cohesive support to significantly expand portion of revenue tied to quality performance, and to make those measures more uniform across the community?

Pricing Transparency

Key objective(s)

Create clarity regarding actual prices charged and expected reimbursement for healthcare services, which in conjunction with quality measures can help consumers and purchasers make better decisions re: purchasing "high value" care. Will also reduce corrosive effect on health system participants of living with a "shell game" pricing/reimbursement system that shifts costs among players rather than creating value.

Current condition re: movement toward pricing transparency

The Pennsylvania Health Care Cost Containment Council publishes annual average cost-to-charge ratio for hospitals. (Pennsylvania hospitals received 30 cents in payments for every dollar they "charged" in 2003).

Insurers/providers in Pennsylvania and throughout most of the country have resisted any disclosure of contractual payment terms (actual reimbursement levels).

Sample proposal

Require health system providers (hospitals, physician practices, other health care delivery organizations) to publicly disclose their charge master (retail price list) and average cost-to-charge ratio (average amount of charges they actually receive from payers) on a single statewide web site, and to any payer or consumer who inquires. Require same providers to provide charges and average cost-to-charge ratio for 10 most common procedures to each patient. These steps would provide meaningful pricing information to payers and consumers, without requiring the disclosure of specific contract terms.

Models / local resources

A new law in California requires hospitals to disclose charge masters, although that information is unlikely to be very visible.

Bottom line re: implementation:

Pricing transparency will likely be resisted by providers and insurers. Federal, and state policymakers, purchasers, labor and consumer groups will need to provide strong support for rapid implementation of pricing transparency requirements.

Insurance Coverage That Customizes Care

Key objective(s)

Ensure that insurance coverage fully supports effective chronic care.

Tie insurance coverage directly to health care needed by consumer.

Current condition

Customized health insurance products accommodate consumer preference, but aren't tied directly to an individual consumer's health condition or needed care. They also don't directly involve the health care provider.

Sample proposal

Insurers provide full and generous reimbursement, without co-pays, for all chronic care recommended in the Wagner chronic care model.

Implement aggressive pilots of health plans that require and provide incentive for individualized care plans for each consumer, especially those with or at risk for chronic diseases. Consumers and their primary physician would create the plan at the beginning of the year. The health plan would provide incentives to both providers (such as a fee for creating the plan and bonuses of $150-$250 for completing the care) and consumers (such as eliminating co-pays or reducing premiums) to fulfill the plan.

Models / local resources

A consortium of payers in Dayton, OH plan to introduce a customized health plan pilot project during 2004-5.

Bottom line re: implementation

Will require health plan, purchaser, union and provider group leadership to construct strong pilot programs.

Centre City Tower
650 Smithfield Street, Suite 2150
Pittsburgh, PA 15222

Phone: 412-535-0292
Fax: 412-535-0295
Website: ***w w w . p r h i . o r g***