

WHITE PAPER

PAY FOR PERFORMANCE: ASSEMBLING THE BUILDING BLOCKS OF A SUSTAINABLE PROGRAM

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DECEMBER, 2009



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PAY FOR PERFORMANCE

Almost a decade after a landmark study¹ revealed serious shortcomings in the U.S. healthcare system, problems with quality of care continue to afflict the system and costs continue to rise. Increasingly, hard-pressed stakeholders are scrambling to identify new tools to slow cost increases while improving the overall reliability and efficacy of care. One of the most promising solutions to emerge in recent years has been pay for performance (P4P), or the concept of rewarding hospitals and physicians for following clinical guidelines and achieving optimal outcomes. Proponents, including a growing number of health plans, employers, and healthcare experts, see pay for performance as perhaps the best current hope for salvaging the existing market-based payment system.

Much of P4P's appeal stems from the belief that it represents a long-overdue mechanism for realigning the financial incentives at the heart of the present healthcare system. Currently, provider reimbursement depends less on the quality of care and resulting health outcomes and more on the intensity of services delivered. Either directly or indirectly, the realignment of incentives can benefit all stakeholders. Payers, including employers and health plans, can benefit from reduced direct costs due to improved care and outcomes. Employers also can benefit from indirect cost reductions due to increased on-the-job productivity and reduced absenteeism for workers receiving better care. Physicians and hospitals can gain financial rewards and the benefits of increased visibility and recognition for performance excellence. Finally, consumers gain from greater choice and access to higher quality care.

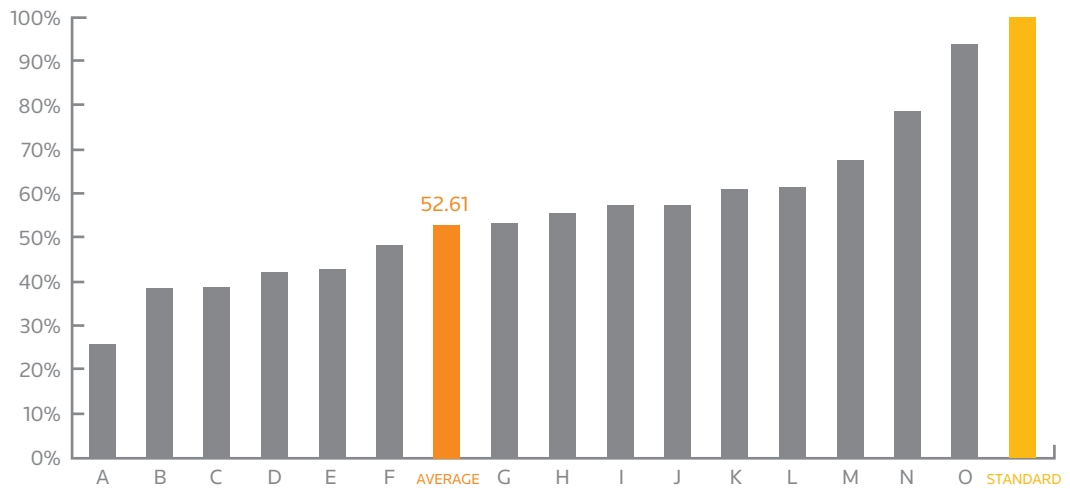
NO TURNING BACK

Dozens of health plans nationwide had implemented P4P programs encompassing about 30 million covered lives.² However, many of these programs do not meet the P4P principles we will be highlighting in this paper. The primary objective of P4P efforts has been to close the gap between established treatment guidelines and the actual manner in which care is provided.

Unfortunately, this gap is wide and deep. A study published in *New England Journal of Medicine* revealed that just over half of patients receive the benefit of consistent, evidence-based treatment practices.³ A study by the Rand Corporation published in *Annals of Internal Medicine* revealed that patients

65 and older with debilitating medical conditions receive recommended care only about one-third of the time.⁴ As a further example, an analysis of a national healthcare claims database shows that nearly 50 percent of diabetic patients fail to receive an annual A1C test, a critical intervention in diabetes management.

FIGURE 1 – Percent of Diabetic Patients Receiving Annual A1C Test (by Employer)



Source: Medstat® MarketScan® database (based on large employers included in 2001 study)

The idea of P4P in healthcare is evolving in a variety of directions, and the hard-dollar savings generated through adherence to clinical guidelines and achievement of optimal health outcomes can vary dramatically between disease states. In some cases, cost benefits may not be visible for months or even years.

Table 1 presents the business case that can be made today at each stakeholder level for participating in pay-for-performance programs.

TABLE 1 – Sample Data Elements for Commercial and Medicare Databases

Stakeholders	P4P “Investment”	Return on Investment
Consumers	<ul style="list-style-type: none"> • Self-care management • Switch to excellent providers 	<ul style="list-style-type: none"> • Improved health and productivity • Financial incentives (employer and plan option)
Employers	<ul style="list-style-type: none"> • P4P program operations • P4P physician rewards • Employee incentives for self-care and switch to excellent providers 	<ul style="list-style-type: none"> • Employee health and productivity • Healthcare cost savings • Employee retention
Health Plans	<ul style="list-style-type: none"> • P4P program operations (costs not paid by self-insured customers) • P4P physician rewards (costs not paid by self-insured customers) • Member incentives for self-care and switch to excellent providers 	<ul style="list-style-type: none"> • Reduced healthcare costs • Increased profitability • Competitive positioning/marketing
Providers	<ul style="list-style-type: none"> • Data collection and submission • Practice re-engineering 	<ul style="list-style-type: none"> • Performance rewards • Reputation for excellence • Increased patient volume

Evidence from scientific research has helped to quantify likely direct and indirect cost savings for employers and plans that can result from improved care quality and outcomes. Pay-for-performance programs are designed to ensure a return on investment that exceeds the combined costs of program operations and provider rewards. Employers and plans increasingly view such programs as wise business practice. Increased provider accountability drives improvement and reduces variation in healthcare quality, and the overall commitment to quality and excellence sends a good message to employees and members, encouraging consumer self-care management and switching to excellent providers.

“Pay for performance is here to stay,” says Jeffrey Hanson, vice president, Thomson Reuters, leading the activity in pay-for-performance initiatives. “It will evolve and change over time, but already we know that it is working and quality is improving. So to retreat to the previous system makes no sense to anyone. There is no turning back.”

Hanson is also a former president of Bridges to Excellence (BTE), one of the most ambitious P4P efforts underway in the United States. This multi-market initiative was organized by large employers and initially targeted quality improvements in diabetes care, cardiovascular care, and clinical information systems.

Like other P4P programs, BTE established a set of rigorous physician-performance measures and designed a reward system that took into account both physician performance level and each physician's patient volume associated with participating employers.

Thomson Reuters was the general contractor and program manager for BTE, with overall responsibility for managing the three-year pilot program and its various initiatives across multiple markets. In this role, Thomson Reuters worked closely with employer, health plan, and provider participants to develop detailed processes for program management, operations, and evaluation. Activities included provider communications, data retrieval and integration, reward administration, and program monitoring. These functions are at the heart of the BTE effort and took advantage of the expertise of Thomson Reuters in the areas of program design, management, and data analysis.

P4P BUILDING BLOCKS

FIGURE 2 – Elements for a Successful P4P Program

Based on its experiences with BTE and similar efforts involving other P4P initiatives nationwide, Thomson Reuters has identified the necessary elements upon which successful P4P programs are built. It is essential that these five building blocks are understood by any organization that is launching or contemplating a broad-based P4P initiative.

1. Program design must reflect the business case.
2. The performance metrics must be valid and credible.
3. The data collection and analysis must be rigorous and reliable.
4. The incentive structure must be influential and goal-aligned.
5. The program must be managed efficiently and even-handedly.

By focusing on these concepts, organizations can create a flexible and sustainable framework that allows for progressive implementation of P4P programs across an ever-increasing number of disease states.

1. Designing the program to reflect the business case

A credible pay-for-performance program must be built on a solid business case that promises a tangible return on investment for participants. Central to P4P is a growing body of evidence that shows achieving desirable clinical outcomes can reduce overall healthcare costs. As an example, a 2001 study of diabetes care published in *The Journal of the American Medical Association (JAMA)* revealed that improving glycemic control through adherence to practice guidelines improved patient health and reduced average treatment costs of diabetic patients by \$650–\$950 per year.⁵ Cost savings of this size can be significant to employers and plans.

In designing a P4P program, the measures of performance should be consistent with the relevant research evidence, and the program should be designed to enable direct translation of research findings into realistic estimates of cost savings.

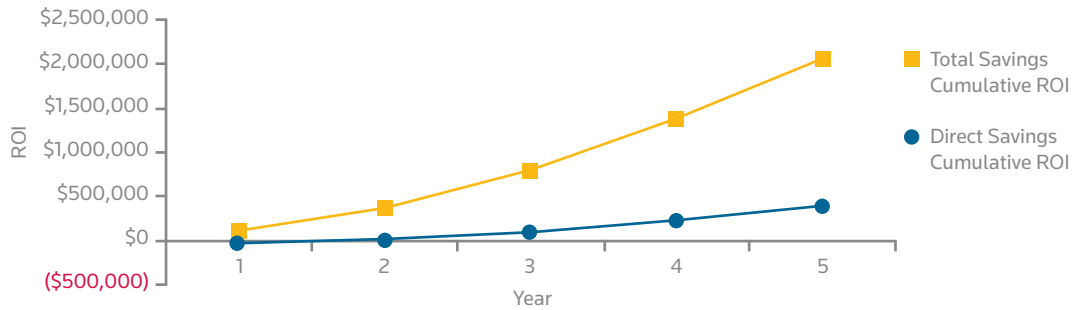
As an example, the diabetes program in BTE included clinical outcome measures that are consistent with those used in the *JAMA* study and other research studies, rewarding only those physicians who achieve performance thresholds on outcome as well as process measures.

Actuaries estimate that real-world cost savings based on these performance thresholds and the above research would range from \$300–\$350 per year for the average diabetes patient seeing a qualifying physician. BTE chose an annual physician reward level of \$80–\$100 per patient as a way for employers and plans to share their cost savings with qualifying physicians and thereby create an incentive for non-qualifying physicians to improve their healthcare processes and outcomes.

Building the program around the business case facilitates commitment by the program participants. Employers and plans faced with the decision to embark on pay for performance find it much easier to justify their own commitment when a clearly defined business case and expected return on investment have been articulated. Likewise, physician groups endorse such programs more readily when rewards represent new money, not just a redistribution of existing revenue, and when they are convinced the total rewards (financial and nonfinancial) outweigh the costs and burden of data collection.

FIGURE 3 – Sample P4P ROI Calculator

	Year 1	Year 2	Year 3	Year 4	Year 5
Patients Benefiting	970	1,843	2,629	3,336	3,972
Cost	\$149,124	\$202,064	\$254,214	\$301,134	\$343,444
Direct Savings	\$125,560	\$238,470	\$340,240	\$431,630	\$514,280
ROI	(\$23,564)	\$36,406	\$86,026	\$130,496	\$170,836
Cumulative ROI	(\$23,564)	\$12,842	\$98,868	\$229,364	\$400,200
Total Savings	\$251,120	\$476,940	\$680,480	\$863,260	\$1,028,560
ROI	\$101,995	\$274,876	\$426,266	\$562,126	\$585,116
Cumulative ROI	\$101,995	\$376,872	\$803,138	\$1,366,264	\$2,050,380



Note: *Direct Savings* is direct medical cost savings only. *Total Savings* includes both direct medical costs and indirect cost savings (e.g., reduced absenteeism).

Documenting the P4P business case is an essential first step in establishing program credibility in a local market. Tools like a P4P return on investment (ROI) calculator enable employers and plans to better understand the near-term costs and returns to their businesses. This type of tool can be useful to ensure participants have a realistic time horizon for cost savings.

Regardless of the direct financial benefits that accrue through P4P, improving care quality also produces important indirect cost savings for all involved. For employers, higher quality care results in improved employee health, which in turn leads to reduced worker absenteeism, improved productivity, and greater employee satisfaction and retention. A study reported in the *Journal of Occupational and Environmental Medicine* documents productivity costs associated with common medical conditions.⁵ For example, it is estimated that absence and disability costs associated with diabetes represent an additional 40 percent of benefit costs.

For health plans, P4P's indirect benefits include greater employer satisfaction and renewals, increased leverage in contract negotiations, stronger networks, and more efficient care management programs.

Similarly, providers who meet or exceed established clinical guidelines can anticipate additional income through performance bonuses and improved market share due to greater public awareness of clinical excellence. They also gain from enhanced patient management tools and systems.

Lastly and perhaps most importantly, consumers reap the benefits of better health, increased satisfaction with their physicians, lower costs, and the ability to select providers based on quality.

Louis Diamond, MD, vice president and medical director for Thomson Reuters and chair of the American Medical Association's Physician Consortium for Performance Improvement Planning Advisory Committee, says that creating an understanding of the business case for P4P is a straightforward proposition, even if the full extent of hard-dollar savings may not be apparent for some time to come.

“In the healthcare business, our primary product is the delivery of services. It is in our interest to deliver the highest quality care possible,” Dr. Diamond says. “We should compare our responsibility to generate optimal health outcomes with the duty of another business — say an auto mechanic. The parallel is that an auto mechanic cannot stay in business if he doesn’t deliver a high-quality service and a well-functioning car at a competitive price. We must focus on our core responsibility in healthcare the same way.”

2. Selecting valid and credible performance metrics

Metrics for tracking provider performance are at the heart of any pay-for-performance initiative. Their credibility and integrity are therefore critical to achieve maximum physician and hospital buy-in. Why are credibility and integrity so important? Many physicians and hospital executives remain highly skeptical of P4P programs. A commonly held view among providers is that P4P is simply the latest weapon used by managed care companies to drive down reimbursements and micromanage the care process.

From a practical standpoint, providers are concerned P4P programs will fail to take into account the totality of each patient’s course of illness and treatment factors beyond the physician’s control, most notably patient behavior. Finally, physicians and hospitals are worried that P4P programs will be unable to accommodate those cases in which deviation from treatment protocols is necessary. For these reasons, it is imperative that successful P4P programs begin with standardized, evidence-based measures of healthcare effectiveness (quality) developed independently of the implementing organization. Groups such as the National Quality Forum (NQF) and the National Committee for Quality Assurance (NCQA) have done considerable work to create and test clinical pathways. Initiating a P4P effort with a review of healthcare effectiveness measures freely available from these groups, as well as The Joint Commission, The Leapfrog Group, and other organizations, is a good starting point.

In addition to measuring healthcare effectiveness, P4P programs also should measure and reward healthcare efficiency. A white paper by The Leapfrog Group and BTE recommends that the primary unit of provider efficiency measurement (e.g., total healthcare costs) should be based on the “full longitudinal episode of care, comprised of all inputs associated with treating a patient with a specific disease or condition over time ... Grouping claims into clusters around standard diagnosis and procedure codes to form episodes is a common way of comparing the relative level of efficiency from one provider to another.” Data should be analyzed “using industry standard episode grouping methodologies, and applying robust case mix and severity of illness adjustments.” The white paper further encourages the use of disease-based rather than treatment-based episode groupers, since the latter may encourage the overuse of cost-inefficient treatments (e.g., surgical procedures). Fortunately, disease-based episode groupers incorporating risk-adjustments for comorbidity and case complexity are readily available.⁸

Provider effectiveness and efficiency can be measured at several different levels. The most successful P4P programs typically include a balance of three kinds of performance measures: structural measures, which gauge the availability of key systems and tools to improve care quality; process measures, which assess provider performance against evidence-based guidelines and protocols; and, outcome measures, which are focused on the patient’s progress and condition. Both the NCQA and the NQF have developed balanced scorecards for a variety of disease states that incorporate measures from each of these three categories.

TABLE 2: Three Major Types of Performance Measures (Examples)		
Structural	Process	Outcomes
<ul style="list-style-type: none"> • Disease registries • Electronic prescribing • Electronic medical records • Chronic disease management systems 	<ul style="list-style-type: none"> • Preventive screening • BP testing • Lipid testing • Smoking cessation advice • Patient education 	<ul style="list-style-type: none"> • Normal weight • Normal BP levels • Normal LDL values • Improved HbA1c levels

While process and outcome measures can be difficult to quantify, structural measures are relatively straightforward. They can include, but are not limited to, the use of clinical information systems such as disease registries, electronic prescribing systems, and electronic medical records in the physician office. Additional measures focus on the extent of physician certification or credentialing in specific disease categories and feedback from patients regarding their experiences with specific physicians.

Of course, identifying performance measures is just the first step. The process of mapping quality improvements to cost savings is necessarily complex, and handling the data and compiling it on an ongoing basis requires considerable expertise. It is therefore vital that organizations work closely with a company that has experience with other implementations. An experienced third party can help prioritize, design, and implement measures in a way that ensures maximum provider confidence and support and alignment with organizational goals and objectives.

3. Collecting and analyzing data in a rigorous and reliable manner

Because P4P programs are data intensive, success or failure frequently hinges on the systems developed for collecting and analyzing the information required to assess provider performance. Generally speaking, the simpler and more streamlined the data collection process, the greater the likelihood of an effective program.

Reliance on an experienced data contractor can ensure that necessary information is gathered efficiently and the collection burden facing hospitals and physicians is minimized. Clearly delineating what data providers will need to produce, how they can most efficiently execute the process, and the specific responsibilities of the sponsoring organizations will help to sustain provider commitment to the program.

The performance data will likely be gathered from a variety of sources, one of the most prevalent being administrative data systems — including healthcare claims and encounter data — allowing a longitudinal view of patient treatment in episodes of care and other financial and operational performance metrics. Many process-of-care measures are based on administrative data, but they also can be assembled through surveys and random chart audits. Rigorous measures of healthcare outcomes, on the other hand, often require the collection of additional data from patients' medical records. Structural data are often collected through on-site surveys at the physician office.

On the analysis side, organizations must first consider exactly how they want to categorize or compare the information. For example, data can be compared to national benchmarks, regional standards, local competitors, or all of the above. Providers also can be rewarded based on evidence of performance improvement over time.

Organizations must determine how much weight to give respective structural, process, and outcome performance measures. In BTE, each clinical module included multiple measures, each of which was defined by thresholds based on point values that reflect the weight each item has in determining overall performance. Item point values were summed to produce an overall performance score.

Retaining an experienced third party to assist in these areas not only ensures adherence to best practices, but also reinforces the key perception among providers that the process is impartial, fair, and balanced. The best partner is a company that has an intimate understanding of evidence, analysis, and research and that understands the implications of data collection and data flow.

The partner should have considerable experience working with employers, health plans, and providers in the development of metrics, collection, and analysis capabilities, as well as an understanding of the business implications associated with all P4P components.

4. Creating provider incentives that produce desired changes

One of the keys to the successful development of a P4P program is ongoing communications with providers. By apprising physicians and hospitals about the need for the program at the outset, and by conferring with them regularly about which elements the program will include, mistrust is reduced and cooperation enlisted. This will better ensure widespread support for the initiative.

Provider reactions are particularly important to consider when devising the incentive structure.

The size of the financial bonus must be meaningful to the physician and the reward timing and payment mechanism (e.g., annual fixed payment vs. percentage of ongoing reimbursements) should maximize its visibility and impact.

Other questions to consider include the role of disincentives: Will the employer or plan withhold reimbursement for providers who fail to meet performance guidelines? Or will the failure to capitalize on the financial opportunity be penalty enough?

When devising incentive structures, it is worth remembering that consumer awareness of provider performance will create an additional set of levers capable of influencing behavior. Providers who achieve specific quality benchmarks will be rewarded by an increase in market share; weaker performers will be punished with shrinking demand. Consumers themselves can be financially rewarded for shifting their care to physicians with a strong performance history.

Some P4P programs are experimenting with direct incentives designed to encourage patients to play a more effective role in their own care. In the BTE initiative, for example, diabetic patients accumulated points for meeting specific self-care guidelines. These points could be redeemed toward purchases of lifestyle products, including books on living with diabetes, glucose monitoring software, and sugar-free food.

5. Efficiently managing the program to achieve balance

Given the inherent complexity of developing, implementing, and maintaining P4P programs as well as the mistrust that frequently exists between the key constituencies, a neutral third party is critical to the development and operational implementation of a credible P4P program. If all parties understand that an unaffiliated entity is at the hub of the system, they are far more inclined to embrace the concept in theory and in practice.

It is important that each participating employer, plan, and provider organization feel the program is managed in a manner that achieves a careful balance across the interests of all stakeholders (who may otherwise be natural competitors), giving them the information needed to be successful while maintaining a level playing field.

In addition, expertise in working with multi-stakeholder initiatives becomes vital for successful program management, since P4P programs require considerable ongoing communications between the parties to be effective.

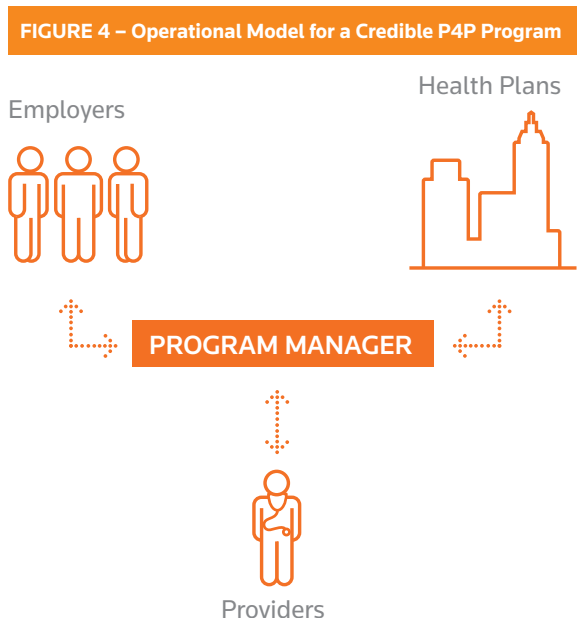
A PATH OUT OF THE MAZE

Improving performance through financial reward is certainly not a new concept. What makes it challenging in healthcare is the inherent complexity of the service provided and the multiple players involved.

By aligning financial incentives so all organizations stand to reap a reward, directly or indirectly, from improved performance and quality, P4P offers great potential for rationalizing the delivery of healthcare and extracting the system from its current situation.

Most intriguingly, P4P also offers a path for pushing greater responsibility to who needs it most — the consumer. Already, some P4P programs are using incentives to steer employees and plan members to the highest quality providers. And some day the concept may be extended to alter consumer behavior and compel healthier lifestyle choices.

As Hanson points out, “There is much yet to learn about transforming the promise of P4P into reality. Yet we have an obligation to try. The alternative — the continued slow-motion collapse of the status quo — can serve no one’s interest.”



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⁷ The Leapfrog Group and Bridges to Excellence, "Measuring Provider Efficiency", Version 1.0, 31 December 2004.

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