

## Paying For Performance – The Business Case

With health care premiums skyrocketing 59% since 2000, purchasers have a right to ask whether the quality of care is improving correspondingly. Studies have estimated that as much as 30 percent of all medical expenditures are wasted on poor quality care. Medical errors, hospital-acquired infections, and readmissions for complications are not only adversely affecting patients' health, but are resulting in higher costs to the health care system. Plus, there are regional variations in treatment in the nation that also impact outcomes. One way to promote health care quality is by "Paying for Performance," an innovative concept which links performance to payment and rewards health care providers that meet quality standards.

The goal of paying for performance is to "change the status quo by stimulating both immediate and long-term improvements in performance." (Epstein et al). The idea is not to reward 'good' physicians or punish 'bad' physicians, according to a January *New England Journal of Medicine* article. "If you remove the financial disincentives and add new rewards, provider performance may improve over time," said Dr. Karen Feinstein, Chairperson of the Pittsburgh Regional Healthcare Initiative at a PHC4-hosted meeting of purchasers in Harrisburg in 2003. Pay-for-performance incentives may include bonus programs, awards for improvement projects, fee schedules based on performance, at-risk contracting, and cost differentials (savings) for consumers, according to the American Hospital Association.

Paying for performance in health care makes both business and medical sense, said Cliff Shannon, President of SMC Business Councils and Chair of the PHC4 Education Committee, speaking to a group of business and labor leaders in Pittsburgh in September 2004

at a meeting jointly hosted by SMC and PHC4. Mr. Shannon called on purchasers to work together on needed health care reforms, including pay for performance. He advocated paying more for perfectly delivered health care, and paying less for health care services that produce poor results. Typically, providers are paid for the services they perform, regardless of the outcome of treatment.

**Better Care Costs Less** – Better quality care should cost less in the long run, because, theoretically, the need for higher-cost services should be reduced. Francois de Brantes, Program Leader of Health for General Electric and a leader of the "Bridges to Excellence" pay-for-performance program says, "If we eliminate inefficient care, we'll reduce costs to the entire system."

Approximately 35 health plans representing 30 million members nationwide offer some form of pay-for-performance programs (Endsley). For example, in Pennsylvania Independence Blue Cross (IBC) included performance clauses in contracts with four hospitals and health systems in 2002; additional hospitals have agreed to participate since then. These hospitals can earn bonuses based upon existing quality measures from recognized sources such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Agency for Healthcare Research and Quality (AHRQ). IBC has used PHC4 data to incorporate recognized quality indicators such as readmission rates, mortality rates and morbidity rates. PHC4 data can also be used to examine in-hospital lengths of stay (LOS), complications, and readmissions. All of these measures can affect the bottom-line.

Minnesota's third largest health plan has announced that beginning January 1, 2005 it will stop paying for certain procedures that go wrong. The plan, Health-

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Partners, says it will stop paying for a list of 27 adverse events compiled by the National Quality Forum, including surgery performed on the wrong body part or on the wrong patient, and leaving a foreign object in a patient after surgery. HealthPartners has 630,000 members and a network of physicians and hospitals, including clinics.

**Developing Standards for Care** – Standardizing care using scientific evidence to determine the most effective treatments for improved patient outcomes could reduce or eliminate variations in care and result in increased quality, according to Dr. John Wennberg, Director, Center for Evaluative Clinical Sciences, Dartmouth Medical School, a noted expert in evidence-based medicine. The pay-for-performance concept requires purchasers, health plans and providers to develop and agree on standards for quality care. Once standards are agreed upon, paying for performance would also include measuring performance and rewarding results either financially or through other incentive systems.

### Ways to Look at Paying for Performance

**Hospital-acquired Infections** – Hospital-acquired infections can result in longer hospital stays and higher costs. It is estimated that two million Americans contract a hospital-acquired infection each year and that these events are associated with approximately 90,000 deaths and cost about \$5 billion. If hospitals could reduce or eliminate avoidable hospital-acquired infections, costs could be reduced. In early 2004, PHC4 became the first state agency to begin collecting information on hospital-acquired infections.

**Readmissions from Complications** – Readmissions are cases where patients must return to the hospital after discharge for additional treatment. Complications or infection were the cause of 12,917 readmissions to Pennsylvania hospitals for the 19 treatment categories where readmissions were reported, according to PHC4's September 2004 *Hospital Performance Report (HPR)*. These readmissions added 98,000 hospital days and \$530 million in charges. The October 2003 HPR found readmissions for complications or infection amounted to more than \$410 million in charges and more than

93,000 hospital days. In the December 2002 *Hospital Performance Report*, \$100 million of hospital charges might have been avoided if all hospitals which had higher than expected readmission rates related to complications and infections had performed at their expected (better) levels of effectiveness.

**"Misadventures"** – According to PHC4 data, in Calendar Year 2003, 3.4 out of every 1,000 admissions to Pennsylvania hospitals had a coded "misadventure" – a medical term for accidental cuts, punctures or hemorrhages; foreign objects left in the body; failure of sterile precautions during procedures; contaminated or infected blood; and other similar occurrences during surgical and medical care. These misadventures accounted for nearly \$64 million in additional charges and approximately 8,000 additional hospital days.

**Preventive Care** – Disease management and preventive care could offer opportunities for cost containment, particularly as a means to avoid inpatient hospitalizations. Some preventive measures include appropriate monitoring and testing for diabetes, comprehensive drug therapy to treat asthma, monitoring of high blood pressure, and use of beta-blockers after a heart attack were important measures for purchasers. A longer-term example of preventive care is a weight management program that promotes improved nutrition and exercise to deal with obesity, perhaps reducing the need for bariatric surgeries.

**Conclusion** – "The business case is a strong one; paying for performance can improve patient care and save money," remarked Marc P. Volavka, Executive Director of PHC4. He said that PHC4 data clearly makes the case that hundreds of millions of dollars can be saved each year in Pennsylvania alone.

PHC4 data is a valuable source of information on health care quality. By becoming familiar with performance-oriented measurements, i.e., readmissions from complications or infection, etc., purchasers and other stakeholders can pose informed questions to insurers during contract negotiations with hospitals and other providers.

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