

MERCER

Human Resource Consulting

A Private Sector Perspective on Pay-for-Performance in Health Care

Arnold Milstein MD, MPH

U.S. House Ways and Means Committee

March 18, 2004

I am Dr. Arnold Milstein, a physician at Mercer Human Resource Consulting and Medical Director of the Pacific Business Group on Health (PBGH). PBGH is California's coalition of large employer health care purchasers and also supports the health benefits needs of more than 9,000 small California employers.

I have helped to develop, and currently participate in the governance of, three private sector programs to pay American doctors and/or hospitals for superior performance: the Leapfrog Group, Bridges to Excellence, and the Integrated Healthcare Association's (IHA) Pay-for-Performance Program. The IHA program is projected to pay over \$100 million to better performing California physician groups in 2004. My comments today on health care pay-for-performance programs are not intended to represent these five organizations.

A more detailed review of U.S. health care pay-for-performance programs will be published on the Commonwealth Foundation's website in April. It is based on a paper commissioned by the Foundation that I prepared for the Foundation's International Health Care Leadership Colloquium at Bagshot, England in July of 2003.

- 1. The American health care industry is severely underperforming.** Compared to other developed countries, we spend substantially more of our GDP on health care. In return, we get easier access to advanced biomedical innovations, but poor health care industry adherence to evidence-based treatment guidelines, patient safety standards, and efficient care delivery methods. Current scientific estimates (specified in my testimony to the Joint Economic Committee on February 25 and Senate HELP Committee on January 28) by Rand, the Institute of Medicine, and nationally respected health services researchers at Dartmouth, Harvard and Intermountain Health Care, give us an approximately 50% national score on exposing Americans to substandard quality of care and preventable treatment complications and a 40% national score on wasting their health benefits spending via services with undetectable health benefit and/or inefficient service delivery methods. Though the health care industry is making effort to improve, the level of effort is not yet scaled to the magnitude of the problem.
- 2. One root cause of this unintended equilibrium is toxic payment incentives that do not reward doctors, hospitals, managed care organizations, or treatment innovators for superior quality and superior total cost efficiency over the longitudinal course of an acute or chronic illness.** As Tom Scully frequently observed, it is insanity to pay the same

price for any service without regard to differences in performance. Other such as Dr. Brent James at Intermountain Health Care have detailed how improvements in longitudinal cost-efficiency and quality are often penalized under today's *performance-insensitive* payment systems. Why would we expect that quality and longitudinal cost efficiency would flourish under such an incentive system?

3. **Payment incentives can be effective in improving health industry performance.** While the evidence to support this statement is based as much on anecdote as on scientific evidence, most private sector purchasers regard it as self-evident, based on all other American markets for products and services. I've attached a thoughtful recent synopsis by researchers at the Harvard School of Public Health of experience to date in 37 recent U.S. programs to pay doctors and/or hospitals for higher performance. Its most important message is that it will be difficult to measure or maximize the effectiveness of doctor and hospital pay-for-performance programs, until they affect a much larger fraction of physician and hospital total income.
4. **Performance-based payment incentives for doctors, hospitals, and managed care organizations are an increasing private sector trend.** Few of the 36 private sector incentive programs included in the Harvard study existed five years ago.
5. **Payment incentives are not the only market levers for lifting clinical performance.** "Sunshine" created by the public release of easily understandable, credible, and comparable performance measures of quality such as death rates, complication rates, and rates of adherence to clinical guidelines, has been shown to motivate a 3X increase in provider improvement effort (J.Hibbard, *Health Affairs*, January 2003) and improved clinical results (E. Hannan, *Medical Care*, January 2004). Other powerful private sector market levers on provider performance include substantial loss of patient volume from insurance plans that exclude or reduce insurance coverage for less well performing physicians, hospitals, and/or treatment options.
6. **Market based payment incentives are more effective when combined with other performance drivers.** Among the most important are physician and hospital access to and training in two generic tools of modern performance management of complex, high risk consumer service industries such as commercial airlines: (1) electronic, interoperable information systems that allow continuous prompting of professionals and/or service users whenever opportunities exist to improve a plan of services or prevent service implementation errors; and (2) greater use of operations engineering expertise in managing performance over the entire course of a consumer's period of service need. Almost sixty years of post World War II progress in biomedical technology has transformed American health care from a menu of relatively simple, ineffective, low-risk, and inexpensive services to a highly complex, potentially very effective, dangerous, and expensive service menu. However, our clinical information systems continue to depend on handwriting, paper documents, and highly fallible human memory; and advanced expertise in operations engineering is wholly

absent in the clinical work of most hospitals and physician offices. Early performance exemplars such as Intermountain Health Care in Salt Lake City and Theta Care in Appleton, Wisconsin have shown that insertion of these two modern industrial tools into the DNA of American health care delivery can generate very large quality increases and/or efficiency capture. Multiple new private sector programs to incentivize physician and/or hospital performance breakthrough (such as the Leapfrog Group, the Integrated Health Care Association, and Bridges to Excellence) recognize the importance of these two management tools and have directed a substantial fraction of their incentives at provider adoption of them, in addition to incentivizing high performance.

7. **There are budget-neutral opportunities for Congress to much more vigorously reinforce private sector momentum to incentivize longitudinal cost-efficiency and quality among doctors and hospitals.** These include:
 - A. **Encourage CMS to speed and significantly expand its current laudable efforts to (1) make publicly available quantified measures of hospital and physician quality, clinical information system adoption, and clinical management capabilities (for example, achieving NCQA's certification in physician office systems); and (2) coordinate its physician and hospital incentives with large national private sector incentive programs such as the Leapfrog Group; and (3) prepare to implement promptly recommendations for CMS provider incentives, expected in 2005 from the Institute of Medicine.**
 - B. **Reprioritize NIH spending in favor of AHRQ, especially for efforts to (a) test and refine comparable measures of performance of physicians, hospitals, and treatment options; and (b) accelerate physician and hospital use of clinical information systems and operations engineering tools to improve their performance.** NIH biomedical research is America's health care muscle; AHRQ health services research is America's health care brain. We currently allocate NIH funds in an approximate ratio of 99% muscle to 1% brain. The result is an American A+ on treatment discovery and an American C- on efficient, high quality delivery of these treatments.
 - C. **Within CMS and AHRQ efforts to compare and improve American clinical performance, much more heavily prioritize measures of longitudinal cost-efficiency for doctors, hospitals, and treatment options.** Given the crisis of health care affordability in both the private and public sectors and evidence of roughly 40% uncaptured efficiencies in the American health industry, this facet of performance measurement and incentivization deserves higher prioritization within CMS and AHRQ. Recently enacted Medicare demonstration projects are directionally favorable, but more broadly applicable near-term provider incentives for longitudinal cost-efficiency are warranted.

D. While fully protecting Medicare beneficiary privacy rights under the Privacy Act and HIPAA, allow private sector health plans continuous access to the beneficiary de-identified, full Medicare claims database. Almost no private sector purchasers or health insurers have enough claims experience in any one location to measure precisely the longitudinal cost-efficiency and quality of most individual physicians and specific hospital service lines, such as knee replacement surgery. Access to the Medicare claims database would allow private sector health benefit plans to more precisely measure and therefore reward more robustly physicians and hospitals for superior quality and longitudinal cost-efficiency. In addition, expansion of billing data required of hospitals and doctors for Medicare payment would greatly improve the cost and precision of performance measurement. Such an expansion is illustrated by recent recommendations of the Quality Work Group of the National Committee on Vital and Health Statistics.

Rapid improvement in performance measurement would help emancipate America's doctors, hospitals, and treatment innovators from the tyranny and irrationality of public and private health benefit plans that primarily reward the cheapest unit prices and often unintentionally punish them for improvements in quality and longitudinal cost efficiency.

America's current movement to use consumer-directed health benefit plans to incentivize Americans to select more efficient, higher quality health care options, including improved health behaviors, can provide half of the horsepower required for breakthroughs in the affordability and quality of our health care. The rest must come from reformed public and private sector payment systems that make an irresistible business case to our health care industry to take up modern tools of performance management and use them to continuously optimize the quality and longitudinal cost-efficiency of our national health care spending.