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A Change for Healthcare:

Why more and more businesses are turning to incentive programs to rein in soaring costs for employee healthcare

By Karen Pallarito

Physician A. O'tayo Lalude is an apostle of rigorous diabetes management. When patients come to his Louisville, Ky., office, they get the works--a battery of preventive measures ranging from blood sugar, cholesterol, and urine tests to counseling on diet, exercise, and how to quit smoking.

While better versed than many of his primary-care peers in the finer points of managing the chronic disease, even Lalude admits his attention to detail has improved since joining Bridges to Excellence, a voluntary "pay for performance" initiative that singles out and rewards physicians who achieve quality-of-care goals.

These days Lalude (rhymes with holiday) keeps a checklist with every diabetic patient's chart reminding him to order necessary lab tests and specialist referrals. He used to assume that patients would keep their appointments for diabetic eye-care screenings. Now he checks with the ophthalmologist for no-shows.

Trend du jour. Earlier this year, he joined an elite class of Bridges physicians recognized for delivering high-quality diabetes care. For his efforts, he'll receive a $700 bonus, or $100 per Bridges patient he treated in 2004. That's small change in the whole scheme of running a medical practice, but his earnings could swell in future years as program sponsors begin encouraging patients to switch to better doctors by offering coupons good for discounts on, say, diabetic supplies. "I knew I was doing a good job," he says, "but I wanted my peers to see what I was doing."

Basing provider payments on quality was a nascent concept when General Electric, Procter & Gamble, Ford, UPS, Verizon Communications, and others launched Bridges in 2002. Today, it is the trend du jour in healthcare. More than 100 performance-based programs are in place across the United States, nearly triple the number up and running in 2003, according to Med-Vantage, a healthcare software firm in San Francisco. Today, most large health insurers have some sort of provider incentive program. Medicare alone has demonstrations in the works at 10 sites.

It's not hard to see why purchasers and payers are fiddling with provider payments. The average premium for a family of four is approaching $10,000 a year, according to a Kaiser Family Foundation/Health Research and Educational Trust survey.

Foisting onerous managed-care constraints upon resistant doctors and patients, a common practice of the mid-1990s, did not solve the nation's healthcare problems. So employers are taking a different tack. By demanding higher quality, they hope to rid the healthcare system of costly errors and inefficiencies. "We didn't get into this to save money; we got into this to improve value," insists Robert Galvin, GE's director of global healthcare.

To the average consumer, paying doctors and hospitals to do what they ought to be doing anyway might seem a bit cockeyed. "I think that Joe and Jane on the street are very wary of this whole thing and appropriately so, because one could ask the question, 'Haven't we always

done this?' " observes David Nash, professor and chairman of health policy at Jefferson Medical College in Philadelphia.

But the modern healthcare system pays doctors and hospitals fees for delivering services without consideration for the quality of care or patient satisfaction. And medical treatments proven to save lives often fail to reach patients. A 2003 Rand Health study highlights the widespread under use of recommended services: Only one quarter of diabetic patients had their blood sugar measured regularly, just 45 percent of heart-attack patients received beta blocker drugs to avoid future heart attacks, and a mere 38 percent of adults were screened for colorectal cancer. Overall, patients received only 55 percent of recommended care, and that's "a rather optimistic view," says study author Elizabeth McGlynn, Rand's associate director. While the study measured which treatment the doctors prescribed and took into account explicit patient refusals of care, it did not reflect patients who simply ignored their doctor's advice.

"We're paying for care whether it's good or bad, free or full of mistakes," says Suzanne Delbanco, CEO of the Leapfrog Group, an employer group that seeks to improve healthcare quality and affordability.

Bridges, which operates in Louisville, Cincinnati, Massachusetts, and upstate New York, is rather unusual among incentive-based programs. Doctors can earn bonuses ranging from $50 to $160 a patient if they meet specified quality targets in three areas: diabetes, cardiac care, and patient-care-management systems. Since its inception, the sponsors have handed out more than $1.5 million in awards.

Other programs divvy up existing reimbursements based on how hospitals or doctors score on various quality measures. Beginning early next year, Horizon Blue Cross Blue Shield of New Jersey will begin paying a majority of its 18,000 network physicians differing amounts based on their historical quality-of-care track record. Better doctors will earn more, midlevel performers will take home standard fees, and the lowest performers will get a pay cut. Every year or two, Horizon will recalculate doctors' performance and restructure their payments accordingly.

As pay for performance evolves, the next logical step is to offer consumers a *Zagat* -style shopping guide with information about the cost and quality of their providers, says Geof Baker, president and CEO of Med-Vantage. Currently, only 15 programs are publicly reporting results of doctors, but in five years, as many as 50 to 60 will do so, he predicts. Horizon Blue Cross Blue Shield expects to begin releasing physician results to the public by mid-2006."Making this transparent to the consumer may be equal or may be potentially more of a motivation for improvement than tinkering with reimbursement," says Nicholas Bonvicino, the company's senior medical director for clinical network management.

Better bottom line. Because these incentive programs are still new, there's little quantitative information to show if they work. But early findings from Bridges' diabetes program are encouraging. Doctors recognized as quality providers delivered services at 15 to 20 percent below the cost for nonparticipating doctors, Galvin says. While their office visit costs were slightly higher, the doctors had sharply lower hospitalization and emergency room costs.

At PacifiCare Health Systems, a large Cypress, Calif., insurer, there has been a 30 percent reduction in hospitalizations in one year for coronary-care patients since the implementation of pay for performance and other disease management programs, says Sam Ho, chief medical officer.

As for what the future of pay for performance holds, "We don't know yet," admits Donald Berwick, head of the Institute for Healthcare Improvement in Cambridge, Mass. He worries that rewarding doctors for focusing on independent procedures instead of taking a holistic

approach could lead to unintended consequences. "You don't necessarily get wholly proper care," he says. The American Medical Association, meanwhile, favors voluntary programs.

In Louisville, Bridges to Excellence has been received with mixed responses from physicians. Some doctors felt it was "shoved down" their throats, says Fred A. Williams Jr., president of the Jefferson County Medical Society and an endocrinologist who has earned recognition as a quality diabetes provider under the program.

As for Lalude, he says the program is reinforcing what he considers his correct approach to treating diabetes. "GE did not write the medical literature," he reasons. "What GE's saying is . . . why don't you control it? And we'll pay you to keep your nose out of trouble and your eye on the shop."