Bonus programs for hospitals, MDs are gaining momentum

Will your facility be paid more if it has quality outcomes and lower costs? Medicare and some big health plans are setting up bonus plans that reward doctors and hospitals for controlling costs and improving quality. Some are giving physicians incentives to use lower-cost settings like ambulatory surgery centers (ASCs).

Policy makers see these new “pay for performance” plans as the best hope to help control health costs. Hospitals are a target because they account for a major chunk of health care spending.

“Surf’s up. I think we’ll see more not less of these plans, perhaps with Medicare in the lead,” Don Berwick, MD, quality improvement guru with the Institute for Healthcare Improvement, Boston, said in an audioconference April 27.

Though your facility may not be affected yet, it’s a good reason to keep focused on cost management and quality.

Medicare is rolling out programs that pay physicians and hospitals more for better results. On May 3, Medicare reported early findings on a 3-year demo with the health care alliance Premier Inc that will pay a small group of hospitals more if they have better outcomes than peers.

In at least 2 states, California and Minnesota, health plans are creating tiers of hospitals based on quality and cost. And the California Public Employees Retirement System, known as Calpers, which provides insurance for 1.2 million workers, wants to know why some hospitals have higher “sticker prices” than others.

Big health plans like UnitedHealth-care are introducing pilots that designate physicians who provide higher-quality, low-cost care, according to its criteria—and kicking up controversy.

Here’s a look at the trends.

The affordability crisis

Health costs have been charging upward, and hospital costs are leading the way.

“We’re seeing an affordability crisis in health care,” said David Ormerod, MD, of Blue Shield of California, who traced trends at the American Association of Ambulatory Surgery Centers (AAASC) meeting in March in Reno, Nev.

Health care costs have been climbing by about 5% a year since 1997 after slowing in the mid-1990s.

“Because hospitals account for so much of the health care dollar, that’s really where the concern is,” Dr Ormerod said. Physicians’ costs are rising, too, but are a smaller percentage of the expense. Prescription drug cost growth has been consistent (chart).

As costs rise, fewer people can afford insurance, and the healthiest tend to be the ones who drop their coverage. That leaves the insured population with a larger percentage of sick patients, which boosts costs and premiums further.

Paying for better results

In April, Medicare introduced Hospital Compare, where the public can see data on nearly 4,200 hospitals for 3 conditions—acute myocardial infarction, heart failure, and pneumonia. (www. hospitalcompare.hhs.gov or www. medicare.gov). Hospitals that don’t report are docked 0.4% in their annual Medicare update. In all, 98% of eligible hospitals are participating.

The early returns from Medicare’s 3-year demo with Premier found the 274 participating hospitals improved their quality significantly during the project’s first year, Centers for Medicare and Medicaid Services administrator Mark McClellan, MD, PhD, announced in May. The project tracks hospital performance on 34 indica-
tors for 5 conditions (www.cms.hhs.gov/researchers/demos/phqi/default.asp). Two conditions involve surgery—coronary artery bypass graft (CABG) and hip and knee replacement. Hospitals are being rated on indicators such as using the internal mammary artery for CABG and starting and stopping prophylactic antibiotics on time.

During the first year, median performance was up 7.5%, indicating “financial incentives to reward better quality care work,” Dr McClellan said.

When data analysis is complete, hospitals scoring in the top 10% will receive a 2% bonus over their DRG payments for patients with the relevant conditions. Hospitals in the next 10% will receive an extra 1%. In the third year, hospitals that don’t meet a quality target will have their payments reduced. Medicare is expected to pay out $21 million in bonuses over the 3 years.

Hackensack University Medical Center in New Jersey is one of the pilot participants. In looking at its practices, the hospital noted a couple of problem areas, such as the use of antibiotics after total joint surgery, according to an article in The New York Times (April 15). Under guidelines based on clinical trials, antibiotics are to be discontinued 24 hours after surgery. Evidence has shown that giving them longer is not effective and can contribute to antibiotic resistance. Yet the hospital found a quarter of surgical patients were kept on antibiotics for more than 24 hours. The surgeons solved the problem by issuing a standing order to stop IV antibiotics after 24 hours.

“Within a week, 94% of patients had their antibiotics withdrawn on time,” the article said.

To surgeons who protested, the chairman of the department of orthopedic surgery would say, “You’re entitled to your opinion, but there’s no validity to it.”

Bonuses for physicians

A Medicare pilot involving 10 large physician groups covering about 200,000 patients will pay bonuses to MDs who improve care for patients with chronic diseases like congestive heart failure, cardiac disease, and diabetes. About 100 such programs have been created by other insurers and employers, The Times noted. The Medicare Payment Advisory Commission (MedPAC) recommends that Medicare start paying all physicians differently based on how they perform.

A UnitedHealthcare (UHC) pilot “performance program” has elicited strong reactions from physicians and hospital systems. Underway in 13 areas, the pilot designates physicians who UHC says provide higher-quality, lower-cost care, according to its criteria. Some self-insured employers such as General Motors and Daimler Chrysler are giving employees incentives, such as lower copayments, to use these physicians, The Wall Street Journal reported (March 29). In the St Louis area, the pilot applies to about 1.5% of the 900,000 people UHC covers.

Doctors and hospitals are pushing back, saying the pilot is ill-conceived and unfair. BJC Healthcare, a 10-hospital system, is threatening to terminate its UHC contract, saying just 18% of its physicians and only a handful of doctors at Washington University would qualify for the performance network. Patients would be forced to pay higher out-of-network rates if they wanted to continue to see these physicians. Officials of another system, St John’s Mercy Health Care, called the plan “ill-conceived, poorly planned, and hurriedly implemented,” according to the St Louis Business Journal. The Medical Group Management Association (MGMA) asked UHC to stop the program, saying it had “serious design flaws,” which made it “unethical” and “misleading to consumers.”

Patients pay more at costlier hospitals

Blue Shield of California made headlines in 2003 when it set up 2 tiers of hospitals based on quality and cost. Hospitals in the first tier are considered “preferred,” with higher quality and lower cost, according to Blue Shield’s criteria.

Patients who choose second-tier hospitals pay more—sometimes significantly more. A patient who had a $1,000 copay in a first-tier hospital might pay twice as much out of pocket to use a second-tier hospital. The program applies only to elective admissions, not emergencies. The program has saved Blue Shield about 3%.
Blue Cross and Blue Shield of Minnesota is rolling out a 2-tier hospital plan for one of its networks, set to go into effect in January. The tiering is based on both cost and quality measures. As in California, patients in the network will pay higher co-pays to use second-tier hospitals.

**Pushing hospitals on cost and quality**

Calpers, the nation’s third largest purchaser of health care benefits, is pushing hospitals on cost in California. Last spring, Calpers voted to exclude 38 hospitals from its Blue Shield network. Some later rejoined, but 23 are still out.

“Premium increases exceeding 50% in the past 3 years are simply unsustainable. Almost half of the cost increases are driven by hospital charges,” Calpers’s board president said.

Calpers spokesman Clark McKinley told OR Manager, “There’s a wide disparity in the ‘sticker prices’ in hospital chargemasters, and it doesn’t seem to make much sense. You might see a $14,000 charge for a surgery at one hospital and half that at another.

“We know hospitals have to make their margin, and we want them to be healthy, but we believe there has to be a more sensible way to reimburse them for their costs.”

Calpers is forming a coalition to look at hospital pricing and quality measures and expects to have a plan in place next year.

**Encouraging use of surgery centers**

Some insurers have incentives to encourage physicians and patients to use less expensive ambulatory surgery centers (ASCs) instead of hospital outpatient departments. But payers expect to see a significant difference in cost. Without a big cost differential, insurers are unlikely to choose ASCs based only their claim of higher quality, Dr Ormerod said.

Some pilots pay physicians higher fees for taking their procedures to ASCs, he notes. Though the success of these programs is not yet clear, more insurers may consider such arrangements if they are successful.

Another incentive is to give medical groups a target for what percentage of their surgical procedures, say 33%, are appropriate for an ASC versus a hospital.

“And we’ve been getting this information out to physician groups to see how they compare with this benchmark,” Dr Ormerod said.

Physicians get detailed reports about the cost difference between the 2 types of facilities.

A study by the Moran Company commissioned by the Federated Ambulatory Surgery Association found that, on average, Medicare paid $320 more for a claim in a hospital outpatient department than in an ASC.

When physicians see the cost difference, Dr Ormerod said, “the light goes on, and they say, ‘Gee, maybe we should start to shift some of our services there.’ We can actually drill down to the procedure level and begin working with them to channel more of their procedures to the cost-effective settings.”

Patients might be rewarded as well. Their copay might be $500 in a hospital but $200 or $300 in a surgery center. The difficulty is that for many patients, the decision about where to have surgery is already made before they are aware there is a difference in the copay. ✤