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*May 2005*

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## Will Pay-for-Performance Relieve Payment Woes?

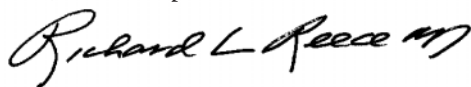
Over the next five years, Medicare's formula for paying doctors will reduce physician reimbursement by 30%. Recognizing that such cuts will have far-reaching implications, the federal Centers for Medicare & Medicaid Services is testing a pay-for-performance program to reward high-performing physicians with increased pay. By the end of this year, more than 600,000 Medicare recipients will be in demonstration programs in which doctors will get bonuses for measurably improving results for patients with common chronic diseases, such as congestive heart failure, coronary artery disease, diabetes, and high blood pressure.

Among the many questions physicians have about pay for performance is: Will it be fair? Edward Hill, MD, president-elect of the American Medical Association, says pay-for-performance systems are difficult to install and are dangerous. "The main problem is that if pay-for-performance simply drives down costs, it will not work, and it will not improve quality," he comments. "If it's truly going to be fair, evidence-based, really for quality care for patients, then of course, that's a good thing. But it's very, very risky and difficult. It's going to be difficult to implement as well." The AMA ([www.ama-assn.org](http://www.ama-assn.org)) recently published guidelines for pay-for-performance programs.

Joseph Antos, a scholar at the American Enterprise Institute, says, "Regardless of whether pay-for-performance is fair, physicians should prepare for such programs because Medicare wields significant clout in the health care market." In fact, Antos says, Medicare essentially runs the U.S. health system because 100% of hospitals and 95% of doctors must follow Medicare rules, and insurers typically mimic Medicare payment schedules.

"The cards are definitely stacked against doctors," Antos comments. "The cuts are built into the law, and Congress will have a hard time changing anything about these Medicare cuts. What the AMA and other physician groups are saying is: 'One, you have to give us an increase next year and not a cut; and two, you cannot institute pay-for-performance until you've given us an increase.' I'm not convinced any pay-for-performance system will be the answer. Over the next three years, doctors will find that some percentage of their Medicare fees will be determined on how well they meet certain government standards. That may get them a minor increase next year. However, it's a temporizing move."

William Jessee, MD, president and CEO of the Medical Group Management Association, observes that since Medicare is developing pay-for-performance systems, both Medicare and private insurers will be able to pay less to physicians who do not meet these performance standards. "In academia, the rule is publish or perish," he adds. "For hospitals and physicians, it may be perform, publish your data, or not be paid."



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# P4P Improves Outcomes, Reimbursement

**C**ardiologists in Michigan have proven what many health care industry experts have been asserting in recent years: that pay for performance can help improve the quality of care physicians deliver.

The pay for performance program, which was supported by cardiologists at the University of Michigan Health System in Ann Arbor, is sponsored by Blue Cross Blue Shield of Michigan. BCBSM facilitated the development of a consortium of the state's cardiologists that would collect data on outcomes and improve care based on that information.

## An Unusual Approach

"Initially, the consortium's success was based solely on supporting hospitals' and cardiologists' efforts to rigorously define optimal angioplasty care and use the information to systematically improve care throughout the state," says Thomas L. Simmer, MD, BCBSM's senior vice president for medical affairs and chief medical officer. "At the outset, the project did not include a pay for performance component."

The idea of pay for performance in cardiology is relatively new, Simmer continues. "Most pay for performance programs have been directed toward primary care," he says. "The collaborative program supported by BCBSM may not be revolutionary, but it is certainly different than many approaches to pay for performance, such as the publication of quality 'report cards.'"

The cardiology specialty lends itself to pay for performance initiatives. "Cardiologists perform certain procedures, such as angioplasty and placement of coronary stents, that have proven to be good subjects for evaluating performance and rewarding physicians accordingly," Simmer explains. "Medical evidence indi-

cates that a large number of these procedures result in complications or must be performed again within six months, and that performance varies by physician. BCBSM wanted to recognize those physicians who were performing well, but we could not accurately determine care quality differentials solely on the basis of information in our claims database."

But pay for performance is more than just giving providers a report card and rewarding them for high grades, Simmer asserts. "Rather, pay for performance should be viewed as a way to prompt physicians to work together to understand how care can be improved, and then to improve

direction, a group of cardiologists at the University of Michigan Health System coordinate the program and collect the data.

"Quality improvement requires access to a large amount of data and the ability to use these data to benchmark and compare performance and processes of care with others," says Moscucci. "These requirements prompted the University of Michigan cardiologists to propose the creation of a cardiovascular consortium that would collect data on coronary interventions, provide feedback on processes of care and outcomes, permit benchmarking, and facilitate the exchange of infor-

**"A collaborative initiative run by physicians is much more likely to achieve that goal than a report card system imposed by a health plan or outside organization."**

**—Thomas Simmer, MD, BCBSM**

it," he says. "A collaborative initiative run by physicians is much more likely to achieve that goal than a report card system imposed by a health plan or outside organization."

Mauro Moscucci, MD, director of the cardiac catheterization laboratory at the University of Michigan Health System, believes all physicians want to pursue high quality, but says a consistent focus on quality takes time and an investment of resources. "Pay for performance represents a financial incentive to maintain this focus and overcome obstacles to high quality," he adds, "rather than just continue with 'business as usual.'"

The BCBSM Cardiovascular Consortium was formed in 1997 and represents collaboration among 18 centers in Michigan. Under Moscucci's

mation among participating institutions, thereby prompting improvements in care."

To reduce complications such as unplanned bypass surgery, heart attack, kidney failure, and in-hospital death, the consortium embarked on a five-year study to identify best practices in angioplasty, including optimal medication use. BCBSM funded the data collection at participating hospitals. Using the data, the cardiologists identified the care processes that optimized angioplasty outcomes and determined how to evaluate each patient's risk for complications effectively.

"BCBSM facilitates and supports the consortium, but participating cardiologists are independent of the health plan," Simmer notes.

*(Continued on page 4)*

(Continued from page 3)

“Unquestionably, improvements in care should be driven by the people who are delivering that care. Program coordination by the University of Michigan means that the physicians, rather than the health plan, are in control.”

### Overcoming Mistrust

The consortium currently includes almost 200 cardiologists who perform about 80% of the percutaneous transluminal coronary interventions in Michigan. The members are cardiologists in community practice and in academic medical centers.

For all participating physicians, the consortium collects data on patient risk factors, processes of care and outcomes of all the PCTI-angioplasties, with or without stent placement. The consortium also collects data on other standard measures of cardiac care, such as the use of ACE inhibitors in congestive heart failure patients and the use of aspirin in acute myocardial infarction patients who undergo angioplasty. This year, the data collection effort is being expanded to include cardiac surgical procedures by a consortium of heart surgeons.

In order to facilitate physician participation, BCBSM had to overcome what Simmer calls certain “trust issues.” First, cardiologists were concerned about sharing information with other cardiologists. “After all, these cardiologists were competitors who were now working together,” Simmer acknowledges. “They were concerned that the program was going to reveal information that would embarrass them or strengthen their competitor’s market advantage.”

Moscucci explains that the first response among physicians was one of concern. “They asked: ‘Why

should we give our data to you? Who will own the data? Will these data be used for public reporting?’ In early meetings with physicians from other institutions, I shared University of Michigan data revealing that we, too, could improve in certain areas,” he says. “This built trust among other physicians, who were then less reluctant to share their own data.”

BCBSM agreed that the data would be confidential. Identifiable data are provided only to each individual hospital, and sources of comparative data are not disclosed.

Another factor enhancing trust was the accuracy and integrity of the data collection effort. “For example, on-site audits were performed to ensure that every patient receiving care in these centers was included in data collection,” Simmer says. “This promoted trust among participating cardiologists, since if centers omitted patients with high morbidity they could have skewed the results in their favor.”

### Improved Outcomes

By working together, the Michigan cardiologists learned how to deliver care more safely and less expensively.

“Eventually, the cardiologists were able to amass sufficient information to reveal how they could avoid several complications associated with angioplasty,” says Simmer. “The cardiologists have reduced mortality rates associated with the procedures. Furthermore, by preventing complications, they achieved a large cost savings.”

An analysis of 25,245 artery-clearing angioplasties performed between July 1997 and September 2002 at five participating centers revealed that practice improvements significantly reduced complications (see table).

The biggest cost savings resulted from an enhanced ability to avoid kidney failure as a consequence of excessive use of contrast dye during angiography. “Certain patients are at a very high risk of kidney failure as a result of the use of contrast dye,” Simmer explains. “The average patient suffering renal failure following angiography spent 30 days in the hospital, and 40% of these patients did not survive. After seeing the outcomes data, the cardiologists realized that they must identify those at higher risk of kidney failure in advance of the procedure and dose the contrast carefully in these patients. As a result, they reduced the number of angiography patients who suffered kidney failure by about two-thirds. Systematic changes in practice in this high-risk group resulted in a reduced number of renal failure hospitalizations, avoided costly kidney dialysis, and saved the lives of many patients.”

### Optimal Approaches

Interestingly, this improvement was not specifically related to the improved performance of the cardiovascular procedure itself, Simmer points out. “We knew angiography was a high-risk procedure, but we did not know when we started the program exactly which outcomes would be improved,” he says. The results reveal an important lesson for hospitals, cardiologists, and payers that might develop a similar program: “have faith.” “Physicians who work together to collect data will identify important areas for quality improvement, even if those areas are not initially defined or targeted,” he explains. “This is especially true in highly technical areas of care, which are rapidly evolving and for which optimal

**“Pay-for-performance represents a financial incentive to overcome obstacles to high quality rather than just continue with ‘business as usual.’”**

**–Mauro Moscucci, MD, University of Michigan Health System**

approaches are not yet fully defined. Whatever particular improvements are achieved will benefit patients, physicians, and payers.”

Another common target for the consortium participants was pre-procedure aspirin use. “Interventional cardiologists know that aspirin should be given to patients prior to a percutaneous coronary intervention in order to prevent complications,” Moscucci says. “But in 1999, the data revealed that only 89% of patients received aspirin prior to the procedure. After a focused quality improvement effort centering on system change, the percentage has risen to 98%.” Moscucci explains that in the majority of institutions, schedulers, and nurses now ensure that the patient has received aspirin prior to the procedure.

Not surprisingly, the quality benefits achieved through the program have translated into better care for all cardiac patients in Michigan, not just BCBSM enrollees. “The cardiologists were adamant that they did not want to focus on improving quality for only one segment of their patient base,” Simmer says. “They wanted to improve care for all their patients, regardless of coverage. That made sense to BCBSM; so we agreed that performance measures would be reported as ‘all-payer.’ We could not have improved the care of BCBSM members without a narrow focus.”

Also, BCBSM saves approximately \$2.5 million a year as a result of this program, while additional millions are saved in hospitals statewide for non-Blue patients, Simmer adds.

### Reimbursement

The success of the data collection effort and associated quality improvements led to the institution of a pay for performance incentive program last year. “When we started this initiative in 1997, we did not offer financial rewards because we did not yet know what the data would reveal,” Simmer notes. “Initially, the consortium was focused only on data

## Complications Decline

<u>Kidney failure requiring dialysis</u>	<u>-57%</u>
<u>Heart attack incidence</u>	<u>-19%</u>
<u>Unplanned coronary artery bypass</u>	<u>-22%</u>
<u>In-hospital deaths following angioplasty</u>	<u>-27%</u>

Source: Blue Cross Blue Shield of Michigan

collection. BCBSM supported the costs of that data collection, but we did not offer any incentives until the program established the ability to distinguish among centers regarding performance. At that point, we implemented a reward mechanism in order to share cost savings with the participating physicians.”

BCBSM gives better-performing centers a 1% increase in reimbursement for cardiovascular procedures. Eligible hospitals must voluntarily share information demonstrating consistently high performance across a wide array of performance indicators pertaining to cardiac care, not just angioplasty. “BCBSM’s arrangement with the centers does not allow us to know what they do with the extra reimbursement,” Simmer says. “Presumably, some money is used to build cardiac program infrastructure to ensure that quality gains continue, while other funds contribute to the financial viability of the hospital.”

The reward system was not necessarily an encouragement to participate, but was a byproduct of the project’s success, a way for BCBSM to share the financial benefits of the program. “However, there are centers who did not participate initially but who joined the consortium once we implemented the reward system,” Simmer notes. “So certainly, pay for performance is a meaningful and reasonable incentive for quality improvement.”

Pay for performance also could be used in the treatment of patients

with chronic cardiac conditions, such as congestive heart failure, Simmer adds. In fact, at the end of last year, BCBSM instituted a physician group incentive program in which it said it would reward 10 physician groups representing more than 2,900 Michigan physicians for improving quality of care and generating health care cost savings. The program promotes quality improvement in numerous areas but specifically targets treatment for four chronic conditions: congestive heart failure, coronary heart disease, persistent asthma, and diabetes mellitus.

While there is a role for pay for performance as an incentive to individual cardiologists, Moscucci believes that quality improvement depends largely on improving systems of care. “Physicians need the support of the system to provide high quality of care,” he says. “Individuals may find it difficult to change practice patterns or may face obstacles to providing optimal care. Consider, for example, pre-procedure aspirin use: The rate can be improved by asking all physicians to remember to remind the patient to take an aspirin before the procedure, or by building that reminder into the patient scheduling system. A system change shifts the responsibility for modifying the process of care from the physician to the system.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 8).

# Program Boosts Billing Accountability

By Ted Sullivan and Linda Roy

In physician offices that outsource their billing, staff might start to finger point and play the “blame game” when claims don’t get paid or charges are lost. But doing so doesn’t resolve problems or improve the process to prevent the same mistakes from happening again.

Lack of control over the billing process also makes it difficult for staff to assume responsibility and take pride in their work because they can’t see the end result: the claims getting paid. At Miami Pediatrics, a seven-physician, three-location general pediatrics practice in Miami, we noticed staff in the three clinics were developing an “us versus them” attitude, especially when errors occurred.

## Assigning Blame

When our formerly hospital-owned practice went private in June 2000, we used an in-house billing program but found we didn’t have the time and resources to bill effectively. We switched to an outsourced billing company but this system only compounded the finger pointing.

At Winchester Physician Associates (WPA), a 19-office group in Winchester, Mass., we noticed the same problem. We used to have an outsourced billing company and whenever something went wrong with claim payments, staff would place the blame on the billing service. Staff also felt little desire to learn more about how the billing process works because they relied on the service exclusively.

*Ted Sullivan is the director of physician services for Winchester Hospital, in Winchester, Mass., and Linda Roy is the practice administrator for Miami Pediatrics, in Miami.*

**In the past if the billing service noticed a problem with a claim, the service would call the practice and ask the physicians or office staff to correct the problem. As a result, the staff never learned from its mistakes.**

For example, if the billing service noticed a problem with a claim, the service would call our practice and ask the physicians or office staff to correct the problem. It was turning into a daily negative phone call, and the billing service started trying to correct problems on its own. The problem was that our staff never learned from its mistakes.

We wanted to improve our billing and collection processes, and like Miami Pediatrics, signed on as clients of athenahealth, Inc., a company in Waltham, Mass., that provides an online revenue-cycle management solution. athenahealth improved our collection rates but we discovered we could also use the system as a teaching tool to improve staff accountability.

## Improving the Culture

To create a culture of accountability, we had to develop a new way of thinking at WPA. We had several goals. We wanted staff to fix the mistakes and learn from them, we wanted a system that would clearly show how everyone on staff performs, and we wanted to develop a culture of collecting payments at the time of service.

At WPA, physician compensation is tied directly to the amount of cash

we collect. Therefore, we encourage our physicians to be decision makers, and they in turn ask us to adopt better technology and tools to increase cash flow and reduce costs.

## New Technology

Once new technology is in place, we have to monitor staff performance and how well the new technology performs. Staff members appreciate having the tools to help them do their jobs more effectively, and, as a result, take more pride in their work. We recognize and reward staff members’ efforts, which is the final step in creating a culture of accountability. Then, since the physician compensation increases because of improved cash flow, they keep encouraging staff to improve performance and learn how to make the most out of the technology.

After WPA switched to athenahealth, we experienced a 20-day drop in days in accounts receivable and have sustained a 6% increase in collections. For us, that translates into a net cash increase of \$1 million per year.

## Learning From Mistakes

Before WPA switched to athenahealth, we wanted to investigate why claims from our practice were not get-

ting paid in a timely manner and why there was a large outstanding self-pay balance. Initially, we thought the problem might have been equally split between our staff and the billing service. But we also wondered if the billing service actually was responsible for a majority of the errors.

### **Finding the Source**

Instead, we learned that most of the errors came from our practice staff. There were errors in coding, failure to check patient eligibility, and neglecting to collect co-payments. These errors occurred regularly, preventing us from maximizing revenue. Once we started using the new system, it became easier to correct these problems. The system prompts staff when an incorrect code is entered and puts incomplete or inaccurate claims in “hold buckets” where staff can easily see the inaccuracies or identify problem trends. Once staff can see the problems and then fix them, they become accountable for their work.

Using such systems, it is also easy to track which staff member registered a particular patient and find if he or she collected a co-payment, and checked the patient’s insurance eligibility. It is much easier to collect payments up front than to call patients who have outstanding balances and ask them to make payments. At WPA, we developed a number of strategies to help us collect payments at the time of service.

The office managers now use the system to identify staff members who do not collect co-payments and work with them to correct the situation. The office manager can educate staff about the importance of reminding patients prior to their visits about any outstanding balances.

Office managers also use the system to learn why there are outstanding balances. For example, an office manager can see if a staff member did not properly check a patient’s insurance and then can explain how to prevent such denials in the future.

### **Back Office Problems**

At Miami Pediatrics, we had similar problems but because we corrected billing and coding problems behind the scenes, staff members never learned from their mistakes. Now, if a claim is posted incorrectly, we can e-mail the staff member who handled the claim, identify the problem, and have the staff member correct the mistake. Office managers frequently use athenahealth as a teaching tool, either for individuals or system-wide, and as a result, staff members have a greater sense of responsibility and accountability for their work. Also, we have found that for the first time, staff are interested in coding and want to learn more about the process. In fact, various staff members compete with each other to see which office can work through its hold buckets fastest. When one office learns a new way to handle

claims or eliminate problems, staff will share that knowledge with those at other clinics.

At WPA, staff are willing to accept responsibility for their jobs, because they have the tools to do their jobs properly and to succeed at them. Now that staff have a tool that prompts them to enter the correct codes on claims and know how to sort claims on hold by denial reason, they have started to focus on developing creative solutions to other problems. When we outsourced our billing, staff didn’t worry if there was a problem collecting payments or sending claims. Since they are held accountable for their actions, they care more about the problems and are developing new ways to solve problems.

Recognizing these efforts, we let staff know how much we appreciate their work through praise and rewards. For example, at the end of each month, we go over our days in accounts receivable and other results and praise staff in our monthly financial reports for good performances. Some practices have developed incentives for reducing the days in accounts receivable (AR). One office manager created a “daysies” award for the best results compared with established benchmarks for days in AR and self-pay percentage of AR.

In addition, practice managers have better access to information. Physicians often ask practice managers about the financial details of their work. In the past, the practice managers used systems that did not allow them to run proper reports quickly or easily. When the practice managers could not access the necessary information, they were left feeling incompetent in how they did their jobs. Now they have a tool that provides answers to such questions within minutes.

—More information on physician practice strategies is available on our Web site (see page 8).

**After installing a new revenue cycle management system, Winchester Physician Associates had a 20-day drop in days in accounts receivable and has sustained a 6% increase in collections, increasing net cash by \$1 million per year.**

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