PBGH
PACIFIC BUSINESS GROUP ON HEALTH

Six Strategies to Get Better Value From Specialty Services in Health Care

ISSUE BRIEF

Introduction

Health care costs continue to rise, in part because many patients receive care that is unwarranted, particularly in the areas of high cost specialty care. For example, several experts believe many of the stents implanted in patients to treat coronary artery disease may be unnecessary, and complex and expensive back surgeries have increased 15-fold in the past decade without a clear clinical justification.[1]

Sometimes, as is often the case with caesarean sections, the patient advocates for the procedure because they do not have enough information to make the best decision; many c-sections are performed when a vaginal birth would be safer and less expensive.

In today's environment, it is difficult for purchasers, including PBGH members, to ensure they are buying the right care at the right price for their employees. While there is no silver bullet to guarantee every patient gets high quality care at the right cost, there is an array of tools that can work together to change how expensive, specialty services are delivered. We can think of tools as six "dials" or levers that can be adjusted—either individually or in tandem— to drive the health system towards producing better value. Some of these dials can be moved directly by large employers; others require the cooperation of health plans, professional societies and other stakeholders. This *Issue Brief* provides an overview of six tools that purchasers need to understand, advocate for, and manage in order to improve the value of specialty health services.

Outcomes Measurement

Purchasers are interested in paying for health care that improves and extends people's lives, not in prescribing specific approaches to care. Well-designed, well-executed measurement systems can help us to discern which doctors and treatments lead to better health outcomes. When these are in place we can recognize and reward high-performing physicians and health systems and steer patients towards the best care options. Purchasers can take a number of steps to support the appropriate measurement of outcomes. We can:

A. Insist upon health plan and provider measures that reflect health outcomes in addition to clinical processes wherever possible.

B. In Pay-for-Performance (P4P) and recognition programs, instead of evaluating processes, as the transient state of technology or clinical knowledge limits our ability to evaluate these, we should insist upon robust and durable measures looking at outcomes, such as patient-reported care experiences.

C. Design benefits and support payment reforms to reward providers who report data regarding outcomes.

PBGH EFFORT TO MEASURE OUTCOMES:
Consumer-Purchaser Disclosure Project

The Consumer-Purchaser Disclosure Project and PBGH are advocating that the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum, and the Integrated Healthcare Association rapidly shift to requiring outcomes reporting. PBGH is also collecting clinical and patient reported outcomes data for joint replacement procedures for the California Joint Replacement Registry, described below.

Provider Feedback

Fewer than 20 percent of providers have electronic health record systems in their offices; many are making decisions in environments that lack a formal data structure that is able to provide feedback about their performance and their patients' long-term health outcomes.

Electronic health records and related tools can bring the latest medical knowledge to the patient's bedside and enable health professionals to understand their own performance, compare it to that of others', and make continual improvements. These systems also allow providers to pool their data with colleagues, look at coordination across the continuum of care, and collect information directly from patients. Where new technologies are in use, registries—robust, longitudinal data collection of patients' treatment and outcomes—also facilitate timely discovery of safety or performance problems. We need to imagine an information-rich care environment, where patients and providers are able to look together at what works, look at data about patients like them, and engage in continual learning. To support these endeavors, purchasers can:

A. Publicly recognize providers who participate in registries. They can also make registry participation a requirement for preferred provider programs.

B. In Pay-for-Performance (P4P) and related programs, require performance measures that reflect patient outcome and care coordination across the continuum, and reward providers for participating in registries.

PBGH EFFORT TO SUPPORT PROVIDER FEEDBACK:
California Joint Replacement Registry

Hip and knee replacements are increasing in volume and contributing to the rise in health care costs. PBGH has supported the California Joint Replacement Registry (CJRR), a pilot project designed to collect and share data that provides credible feedback to orthopaedic surgeons, hospitals, and patients about treatment decisions, quality of care, and patient outcomes. The long-term goals are to improve treatment decisions and care delivery for patients receiving joint replacements. The CJRR is a joint undertaking by PBGH, California HealthCare Foundation and the California Orthopaedic Association. The CJRR will be piloted at three sites during early 2011, with plans for expansion later in 2011.

Payment Reform

Most purchasers do not directly contract with or set payment rates for the doctors and hospitals that serve their employees. But they can insist on payment practices that reward value and not volume. For example, purchasers can:

A. Work with plans or contract directly with providers to develop episode-based payments. Rather than paying for each unit of service delivered, these bundled payments can pay for an episode of care. For example, a bundled payment may cover a total hip replacement from initial diagnostic workup until

postoperative physical rehabilitation is complete. Payments can also be linked to registry participation and reporting.

B. Ask health plans to create payment incentives for appropriate care. Where professional standards for appropriate use exist, those providers that show patterns of care that conform to the accepted standards should be recognized. Those who continue to make treatment decisions that are inconsistent with those standards should not receive full payment.

C. Put pressure on payers, both public (such as Medicare) and private (insurance plans). Generally, payers should be expected to make an increasing proportion of total payment based on quality performance rather than volume of services. Payers should be asked to document the percentage of total provider payments tied to quality.

PBGH EFFORT IN PAYMENT REFORM: AICU: Intensive Primary Care for Complex Patients

Patients with chronic illness are the most expensive and most difficult to treat in our health care system today. Emerging models demonstrate that intensive primary care support and care coordination for the population with multiple chronic conditions can reduce unnecessary medical services and create savings in total cost of care up to 20 percent. PBGH's AICU: Intensive Primary Care for Complex Patients project targets high-risk, high-cost patients, where savings from coordination of care are expected to be significant. The pilot project will focus on approximately 2,000 patients who reside in the LA/Orange County and Humboldt areas and are employed through CalPERS, Boeing, PG&E and other PBGH members.

Consumer Incentives

Purchasers should not only ensure that payments reward providers for the delivery of high-value care, but should also use economic incentives to encourage their employees to seek out that care and the providers most likely to provide it. To do this, purchasers can:

A. Create benefit designs that encourage employees to choose the best performing providers. This can be accomplished through creating different "tiers" of providers and hospitals. Employees may have higher cost sharing for selecting a provider or hospital that is not in the high-value tier.

B. Use reference pricing. For most services, there are very wide variations in prices for common procedures, despite their similar levels of quality. In California, we see prices vary by as much as eight times. Employers can set a "reference price" which indicates the price that is eligible for full benefit coverage; if a consumer chooses to get care from a higher-priced provider, they will be exposed to the full cost difference above the reference price.

PBGH EFFORT IN CONSUMER INCENTIVES: Hospital Value Initiative

In today's health care system, a consumer has little incentive to choose a hospital based on its value. A hospital visit would likely cost a consumer the same amount whether the service delivered was high quality, or low quality, and regardless of the price charged to the employer or health plan. Some companies are working in select regions to create "tiered networks" of hospitals based on value. These tiers would encourage consumers to seek their care at those hospitals that offer quality services at the best prices.

Consumer Education

Most employees have little information on how quality and price vary among the providers available to them, and little understanding that significant variation even exists. Consumers need general education about the variability in the health system, the economic and personal risk created by that variation, and the concept that higher prices do not necessarily equate to higher quality. They need to understand that the out-of-control increase in health care costs is accelerated when they choose a high-priced provider over a lower-cost one. They need to learn that their well-being is put at risk when they go to a hospital or doctor with a second-rate quality or safety record.

A. Purchasers can support programs that help consumers fully understand their treatment options and the various trade-offs that each option provides, as well as the expected outcomes and costs. This can be accomplished through educational campaigns and also through a more formal process called Shared Decision Making. Shared Decision Making techniques provide patients the opportunity to better understand their illness, treatment options, and expected outcomes.

PBGH EFFORT IN CONSUMER EDUCATION:
Better Maternity Care Project

PBGH is partnering with California Health Care Foundation and the California Maternal Quality Care Collaborative to build a statewide data repository that can improve quality in maternity care. Almost 30 percent of the births in U.S. each year are c-sections, and we know that the outcomes for babies and mothers in medically unnecessary c-sections are inferior to outcomes for vaginal deliveries. With this data, we can look for opportunities to design quality improvement projects and patient education campaigns.

Professional Standards

In every field, there is a vast literature of scientific research assessing the effectiveness of various treatments for different types of patients. Many professional societies have published practice guidelines to help doctors make clinical decisions that reflect the body of evidence available today. Some societies have proceeded to define quality performance measures, and encouraged P4P and other programs to use these physician endorsed measures. A handful of medical societies have even taken the step of defining inappropriate care—saying that the evidence does not support use of certain treatments for certain patient types—because the risks (and costs) outweigh the benefits. It is important to encourage the continued development of such measures and appropriate use criteria and to show that purchasers and payers are willing to use them in incentive and recognition programs. Purchasers should support these efforts and:

A. Work with professional societies to define performance measures and appropriate use criteria that reflect both the evidence base and the information requirements of consumers and purchasers.

B. Make use of available appropriate use criteria in all suitable markets, particularly by publicizing data on inappropriate use patterns and creating financial disincentives for patterns of inappropriate care.

PBGH EFFORT IN PROFESSIONAL STANDARDS: Working With the California Orthopaedic Association

PBGH has played an instrumental role in helping the California Orthopaedic Association develop an Orthopaedic Quality Institute. The Institute will help decide appropriate care criteria for orthopaedists.

Next Steps

In many cases, purchasers will have greater ability to move these dials when they work collaboratively with other stakeholders. For example, purchasers can have a lot of influence moving the **payment reform** and **outcomes measure** dials when they partner with consumer advocates. The Consumer-Purchaser Disclosure Project, a coalition of consumers, labor and purchasers led by PBGH, is a good example.

Often purchasers can work with health plans to move the **payment reform** and **provider feedback** dials by creating tiered networks, encouraging registry participation, and recognizing and rewarding high-performing providers. For example, PBGH used the California Physician Performance Initiative to supply data about physician performance to Blue Shield, who in turn created a "Blue Ribbon Recognition Program" on its website to recognize the best performing providers. The next step might be for purchasers to work with Shield to encourage their own employees to seek out those providers.

PBGH also has had great success partnering with professional societies, like the California Orthopaedic Association, to move the **professional standards** dial. PBGH members don't have the medical skills needed to decide what appropriate care looks like, but they can support professional societies' efforts to do just that. Professional societies can also help move the **consumer education** dial by supporting Shared Decision Making initiatives and developing approved patient education materials that emphasize risk-benefit trade-offs and informed decision making.

Through many different avenues, including working groups, meetings with health plan senior leadership, advocacy efforts, and PBGH summits and board meetings, PBGH continues to offer its members opportunities to meet with these critical partners and emphasize the importance of bending the cost curve by encouraging appropriate use.

Endnotes

1. Leonhardt, D. (2010, April 8). Saying No to Back Surgery. *New York Times* and Tom Pope, "Hard to Curb Overuse of Drug-Eluting Stents," *Managed Care*, June, 2006.

About the Pacific Business Group on Health

Founded in 1989, Pacific Business Group on Health (PBGH) is one of the nation's leading non-profit business coalitions focused on health care. We help leverage the power of our 50 large purchaser members who spend 12 billion dollars annually to provide health care coverage to more than 3 million employees, retirees and dependents in California alone. PBGH works on many fronts to improve the quality and affordability of health care, often in close partnership with health insurance plans, physician groups, consumer organizations, and others concerned about our health care system. To learn more please visit www.pbgh.org.

PBGH
PACIFIC BUSINESS GROUP ON HEALTH