
The National Institute of Health Policy's
Medical Arms Race Syndrome (MARS) series

Aligning Incentives to Redirect the Medical Arms Race: *Value Based Purchasing*

featuring keynote speaker, Jack Rowe, MD,
retired chairman and CEO of Aetna, Inc.

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THE NATIONAL INSTITUTE OF HEALTH POLICY
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Dr. Jack Rowe led Aetna through a major strategic turnaround, taking it from losses of \$365 million in 2001 to operating earnings of \$2.7 billion when he left in 2006. At Aetna Dr. Rowe was in a unique perspective to understand and influence payment systems to affect larger changes in health care. Dr. Rowe is also well known for his work in medicine and academic medicine. His ability to understand the healthcare system from different perspectives makes him a unique leader in health care.



Dr. Jack Rowe addresses health care leaders at the University of St. Thomas on September 20, 2007

On September 20, Dr. Rowe came to the NIHP at The University of St. Thomas to share his perspectives and experiences with a number of health care leaders from the Upper Midwest. Dr. Rowe has been in a position to implement change and his insights into the challenges of re-aligning incentives to redirect the Medical Arms Race are important to understand. His key message was that we need to change the incentives in the payment system and move to value based purchasing and this realignment, as much as anything else, will help to end the Medical Arms Race. Dr. Rowe outlined some distinct challenges we face in moving to value based purchasing and re-aligned incentives, but he also thinks we may have gathered the momentum we need for substantial progress in the near future.

Public Reporting of Performance in Health Care: Is it Useful?

Setting aside the larger question of redirecting the medical arms race with payment and other incentives, Dr. Rowe stated the discussion with a more basic question. “Is any of this information about performance even useful?” And the answer, of course, is maybe. There still is not compelling evidence that patients and the general public change their behavior based on performance data. Even for the few patients who look at quality data for providers, only a fraction of those individuals actually make a change based on the data.

So we still seem to be at a point where individual patients and their families are not using health quality data available to them to make provider or care decisions. This might not matter when it comes to improving performance. The simple act of public reporting may have an impact on improving quality whether or not the data is accessed by consumers. According to Dr. Rowe, the real question is not *whether* or not we should have public reporting of quality data, but *who* will establish the standards and make the measurements.

Is Pay for Performance Effective?

Dr. Rowe highlighted some of the key characteristics of good pay for performance systems. Some of the design considerations for successful pay for performance include: covering a sig-



nificant proportion of the provider's patient population, larger provider groups, moving away from fee-for-service to more global or capitated payments and ensuring that the providers have a reasonable chance to get the results they need from their population of patients.

"Paying for performance is a logical idea. We do it in every other walk of life."

- Jack Rowe

Dr. Rowe listed several options regarding *who* should get paid – the physician, hospital, disease management entity or the patient – and *which outcome* to incent – patient satisfaction, health care processes, health outcomes or health inputs. Finally, the *type of incentive* is an important consideration – cash, reputation, reduced administration or clinical volume. In each instance some of these characteristics are easier build in to payment systems than others and each yields different results and unintended consequences.

Gaming the System

Even after careful consideration of all of the elements of a good payment system, can these value based payment systems be gamed? "You bet", according to Dr. Rowe. As an example he highlighted the experience of the British National Health System and their "amazing" results rewarding physicians for improvement. In a very short time the quality improvements far exceeded the original expectations. One explanation for this could have been that the expectations were set too low. This is probably part of the result, but more significant was the ability for the providers to exclude numerous patients from the results based on loose and provider driven criteria.

Pockets of Innovation

Overcoming the challenges in designing a P4P program and the potential problems of gaming the system once it is implemented has been done and Dr. Rowe highlighted several examples of paying for value that hold great promise.



"Medicare is moving at 'blinding speed' with respect to payment reform."
-Jack Rowe

Medicare has done some important work on measuring improvement and paying for performance in the last few years. Notably, the *New England Journal of Medicine* recently published the results of two years experience with the "Premier Demo". And while the NEJM editors characterized the impact of P4P on hospital performance as trivial, Dr. Rowe, with his years of health care experience, thought the improvements represented very significant change.

Another example of innovation highlighted by Dr. Rowe was the Geisinger Health System approach. Geisinger has a "guaranteed episode of care" strategy with respect to cardiac artery bypass graft (CABG) surgery. Every patient undergoing an elective CABG at Geisinger will receive the 40 "benchmark" processes required for the procedure and will pay a flat rate with no additional charges for any complications occurring within 90 days after surgery. Dr. Rowe emphasized in a response to a question that



this approach is possible for integrated systems like Geisinger or maybe Kaiser, but a less integrated system would not be able to take advantage of this innovative approach.

Role of Health Plans

Dr. Rowe also provided a unique insight into the level at which today's health insurance plans actually compete. Many health plans have not quite figured out their role in helping to transform incentives to align with value. Dr. Rowe is convinced that a long-standing problem health plans have in not being able to protect intellectual capital when it comes to plan innovation could actually be an advantage and contribute to the spread of innovative value-based purchasing ideas. Innovation in health plan products spreads extremely fast. According to Dr. Rowe, he and his leadership team could discuss a good idea for product innovation while they were getting on to the elevator on the 10th floor of their offices and by the time they got off on the first floor, all of their big competitors would be implementing the same idea.

Bottom Line: Promise of P4P Will Take Time

Dr. Rowe admits that it is disappointing that value based payment are taking such a long time to evolve. And he acknowledges that the challenges of the MAR present us with a significant challenge that will test value based purchasing systems, at least in the near term. Dr. Rowe noted that large device and technology companies are very good at developing and delivering new technologies to the market. One of the biggest problems in trying to address the Medical Arms Race with changes in payment policies is that technology spreads so quickly, it is almost impossible for policy changes to keep pace with changes in technology.

Notwithstanding these challenges, however, Dr. Rowe holds out hope that we will see real innovation and improvement in the very near future. The sheer number of pay for performance programs has increased from 39 such programs in 2003 to over 148 pay for performance programs in 2007 according to an August 2007 MedVantage survey. The good news about this proliferation is that we are learning more quickly what does and does not work and have identified some potential areas for improvement such as; efforts to measure *efficiency* not just quality, increased transparency in public reporting, and more focus on interoperable IT systems to capture data more easily. The bad news is that with so many systems we may be diluting the impact of any one incentive and further confusing and frustrating both providers and patients.

Dr. Rowe concluded by encouraging us to learn from the value-based purchasing experience we have accumulated so far and to design payment systems that align incentives to get better value from the health care system. We need to move forward, to be courageous and not let the perfect be the enemy of the good when it comes to innovative payment reform.

To follow the MARS discussion, please visit the NIHP website at www.nihp.org, where we will continue to track the issue in addition to providing information and updates on NIHP events.