Pay for Performance in the Individual Physician World

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AGENDA

- Introduction
- History of P4P at Blue Cross of California
- PPO Physician Quality and Incentive Program Version 1
- Disparities in Quality
- Challenges and Changes Version 2
- Summary & The Future

Physician Incentive Programs

"There are three ways to pay a physician - fee for service, capitation and salary, and they are all bad".

James Robinson. UC Berkeley, 2000

Influencing Physician Practice (Behavior)

How to influence physician behavior

- Not effective
  - Lectures, review articles, grand rounds
- Partially effective
  - Practitioner feedback
  - Physician leader education-one on one Patient incentives and reminders
- Very Effective
  - System changes-Nursing Assistants to do preventive health, dedicated clinics
- Promising but limited data
  - Above plus physician incentives

Stone EG et al. Interventions that increase …Ann Intern Med 2002; 136:641-51

What Do Physicians Think of Incentives?

- Many physician organizations use a variety of financial incentives for Primary Care Physicians to influence behavior
- Incentives that limit referrals and incentives to increase productivity have a potential negative influence that could compromise quality of care
- Incentives to improve quality and those linked to patient satisfaction are more tightly linked to greater PCP satisfaction

Grumbach K et al New Engl J Med 1998;229:1516-21

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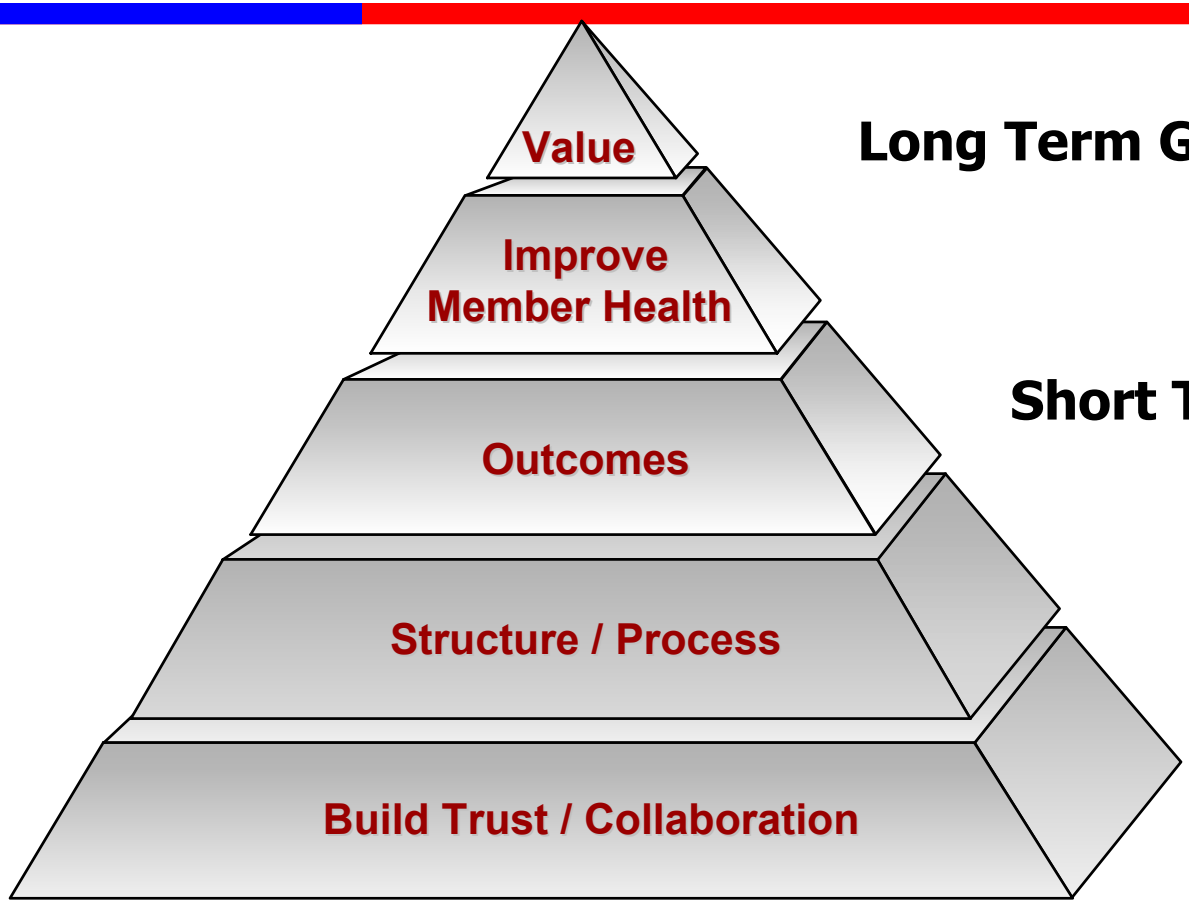
History of P4P at BCC

- 1994 HMO Report Card
- 1995 Incentive added for top performers
- 1997 Incentive for 80% of network
- 2001 Incentive increased to mean > $2.00 pmpm - $66m awarded in 2005
- 2002 Incentive Program for PPO – awardee of RWJF “Rewarding Results”

Alignment of Health Plan and Physician Goals



Quality broadens the dialogue beyond fees to building a foundation of trust

Quality Score Card HMO
Physician Internal Program

- 99% of membership in delegated groups
- Incentive paid to group management
- Introduced scoring for incentive paid to practitioners
  - Scoring System 20 points
  - Member Satisfaction - 5 points
  - HEDIS or at least one chronic disease (e.g. MS, CC, asthma) 5 points
  - Physician Profile - 5 points
  - Physician Bonus - 5 points

Internal Bonus Trends

Internal Bonus		2002	2003	2004
		Overall (N=180)		
Satisfaction w/ PCP	**5**	**112**	**115**	**133**
	2.5	10	14	20
	0	34	22	19
Clinical Measures	**5**	**101**	**106**	**146**
	2.5	10	11	**9**
	0	45	34	**18**
PCP Feedback	**5**	**71**	**67**	**104**
	2.5	26	15	**28**
	0	59	60	**40**
Incentive Program	**5**	**39**	**67**	**114**
	2.5	5	12	**2**
	0	112	72	**57**

Bold = sign. Pr<0.05

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Physician Quality Incentive Program Goals

- **Improve the quality of care delivered to members**
- **Create a more transparent health care system**
- **Improve affordability through generic prescribing and quality of care improvements**
- **Reduce costs through simplified and timely transactions**

PQIP Program Ver 1.0

- PPO Physician Scorecard available on-line
  - Physicians can compare performance to peers
- Physician Recognition Program
  - Financial reward based on Scorecard results
  - Introduced in pilot area in October 2002
  - First payout in 1st Quarter 2004
  - New fee schedule introduced in July 2005

Clinical Measures Goal 1. Improve Care

- ACE Inhibitor use in CHF
- Breast cancer screening
- Cervical cancer screening
- Childhood immunizations: MMR
- Childhood immunizations: VZV
- Long-term control drugs for asthma
- Compliance with lipid lowering drugs
- Diabetes: retinal exam
- Diabetes: HbA1c measured
- Follow-up after ER visit for asthma
- Lipid panel for stroke
- Colorectal cancer screening
- Follow-up after mental illness hospitalization
- Major depression acute phase treatment
- Major depression optimal contacts
- Major depression continuation phase treatment

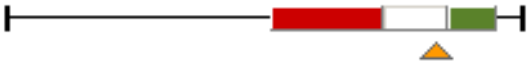
To change your comparison, select another specialty, county, or zip code.

Earn bonus points and rewards for improving your performance profile click here

BCC Physician | Regional Benchmarks | National Benchmarks

Percentiles: 10 - 25th 25 - 75th 75 - 90th
Your Rate:

Specialty: FAMILY PRACTICE County: ALL COUNTIES Compare

Clinical Indicator	Primary/ Secondary	Your Rate	Average Rate	How You Compare 0% 100%
ACE Inhibitor use in CHF	Primary	100%	N/A	
Cervical cancer screening	Primary	82%	78%	
Colorectal cancer screening	Primary	29%	20%	
Compliance with lipid lowering drugs	Primary	82%	89%	
Diabetic retinal exam	Primary	21%	21%	
Follow-up after Emergency Department visit for asthma	Primary	0%	2%	

Goal 2: Improve access to physician of choice

- **MEASURES**
  - **Practice open to new patients**
  - **Length of time provider has contracted with BCC's PPO**
  - **Provider contracts with other BCC products**
  - **Board certification**

Goal 3: Improve affordability through generic prescribing

- Generic prescribing rates for:
  - Antibiotics
  - Antidepressants
  - Hypercholesterolemia
  - Hypertension
  - NSAIDs
  - Ulcer medications

Goal 4: Reduce costs through simplified and timely transactions

- **MEASURES**
  - **Proportion of claims submitted electronically**
  - **ProviderAccess participation**
  - **Timely response to re-credentialing materials**

Distribution of Eligible Physicians

CRITERIA	# of MDs
• Contract with BCC PPO	45,000
• Targeted specialties	20,000
• Score for 1 or more "key" clinical measure	12,281
• Practice in Bay Area	1,984
• $12,000 or more in BCC paid claims	~1,700

Payment

Incentive Program Ver 1.0

Score	Reward
< 40	1 year subscription to SKOLAR MD
41-60	2% of Paid Claims, up to $2,000 + 1 year subscription to SKOLAR MD
61-80	4% of Paid Claims, up to $3,000 + 1 year subscription to SKOLAR MD
81-90	7% of Paid Claims, up to $4,000 + 1 year subscription to SKOLAR MD
91-100	10% of Paid Claims, up to $5,000 + 1 year subscription to SKOLAR MD

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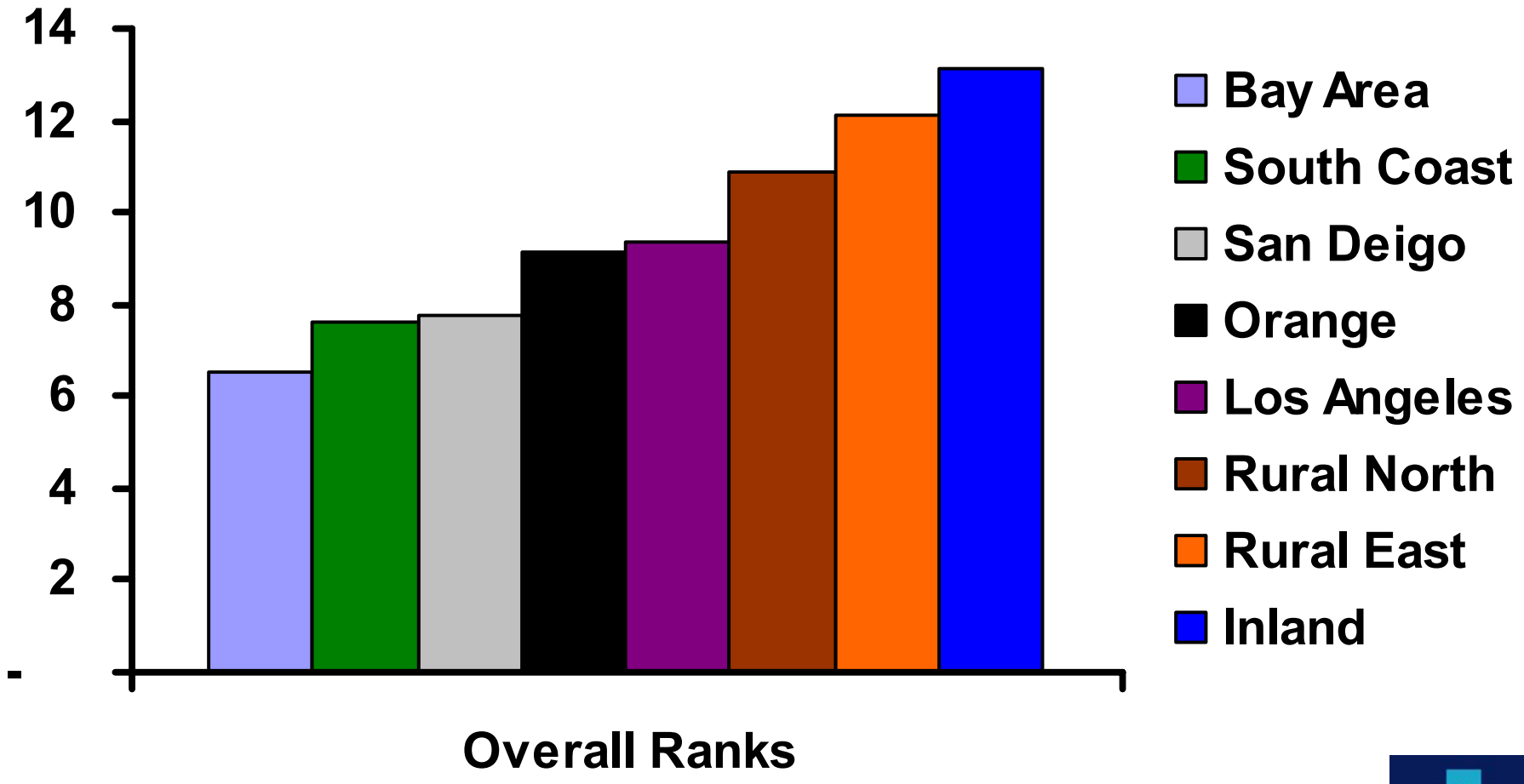
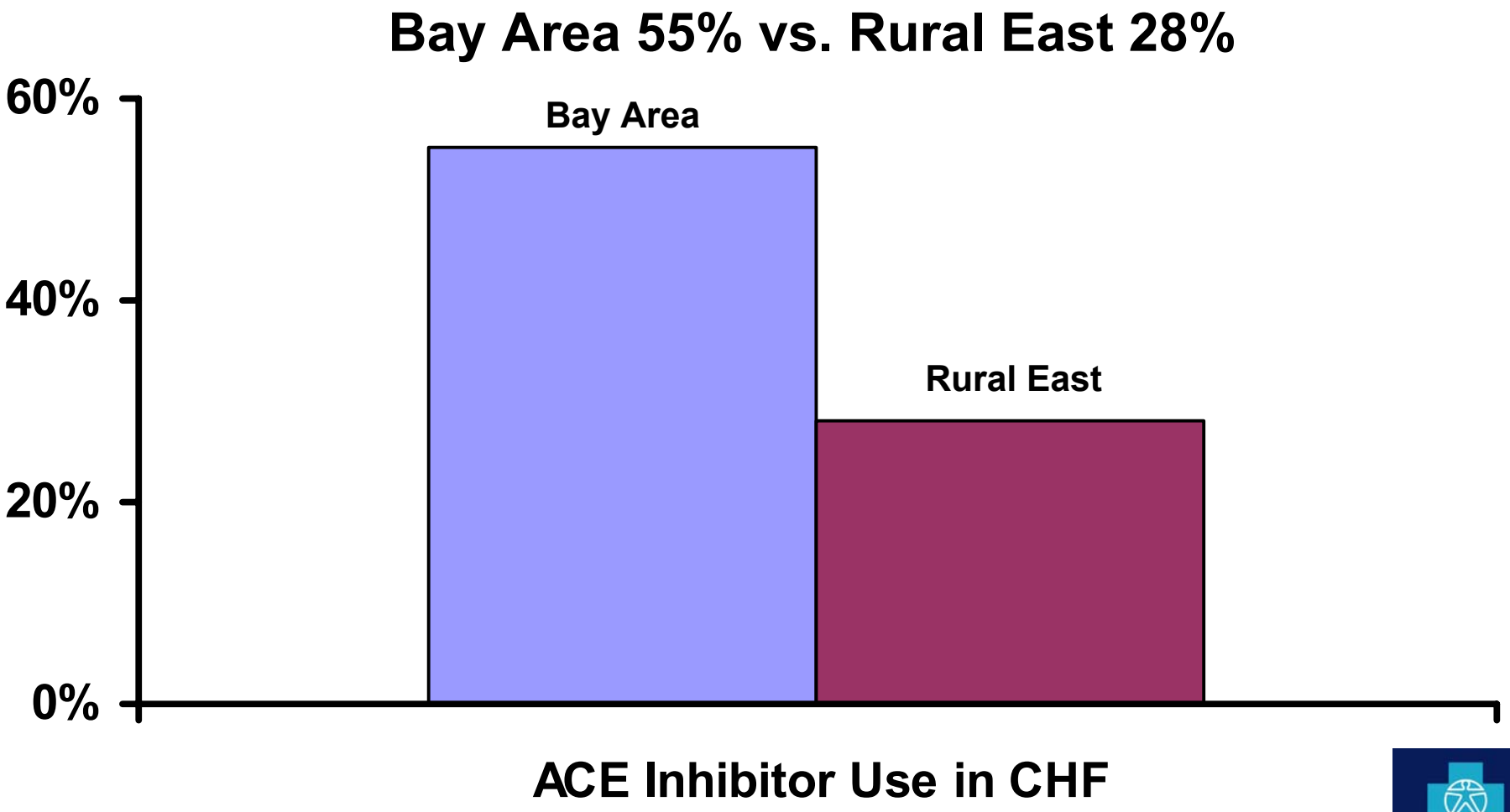
Corporate Region Classification

- RURAL EAST
- RURAL NORTH
- INLAND
- ORANGE
- SOUTH COAST
- SAN DIEGO
- LOS ANGELES
- BAY AREA

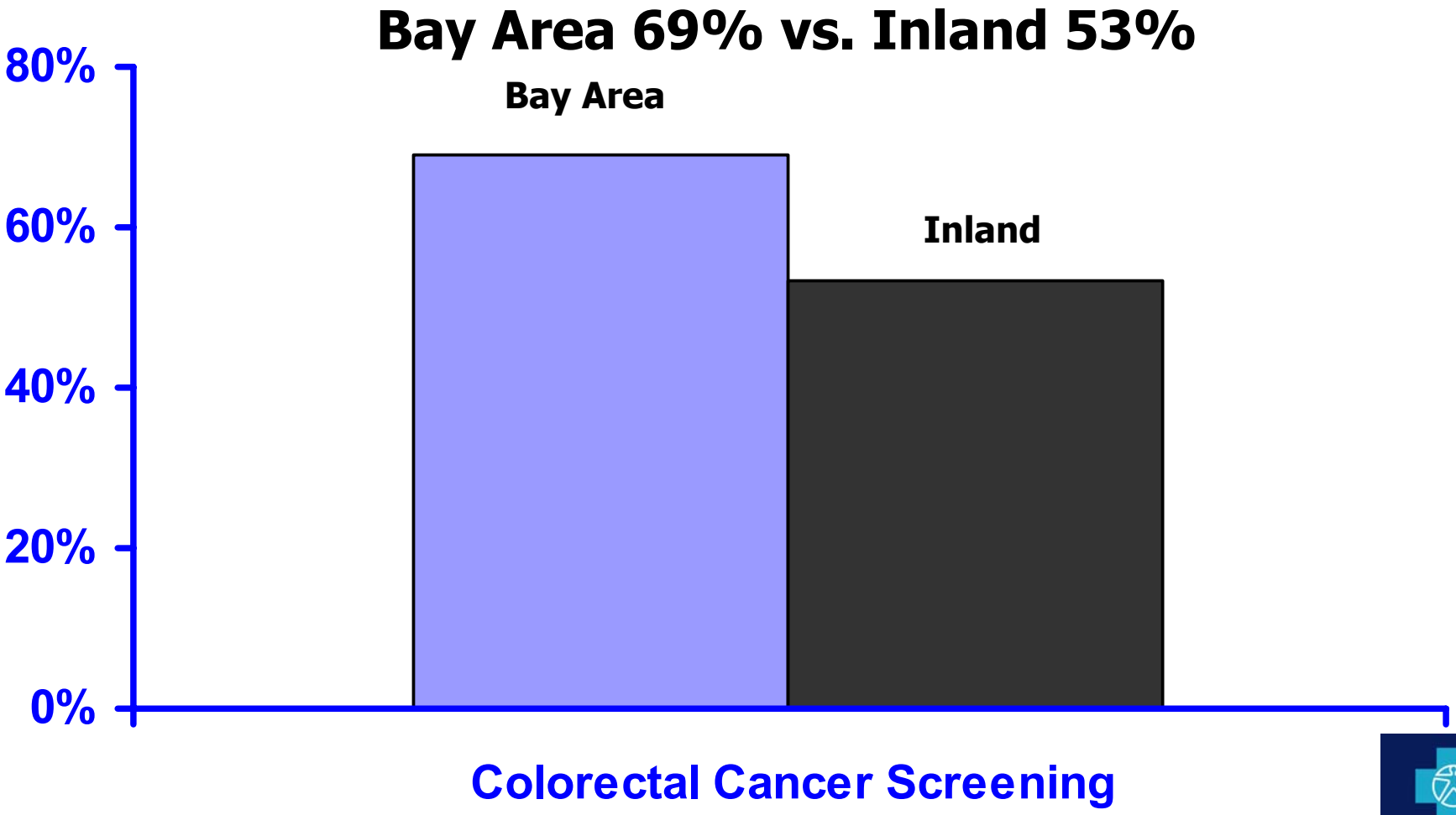
PPO Clinical Trends 2004: Regions



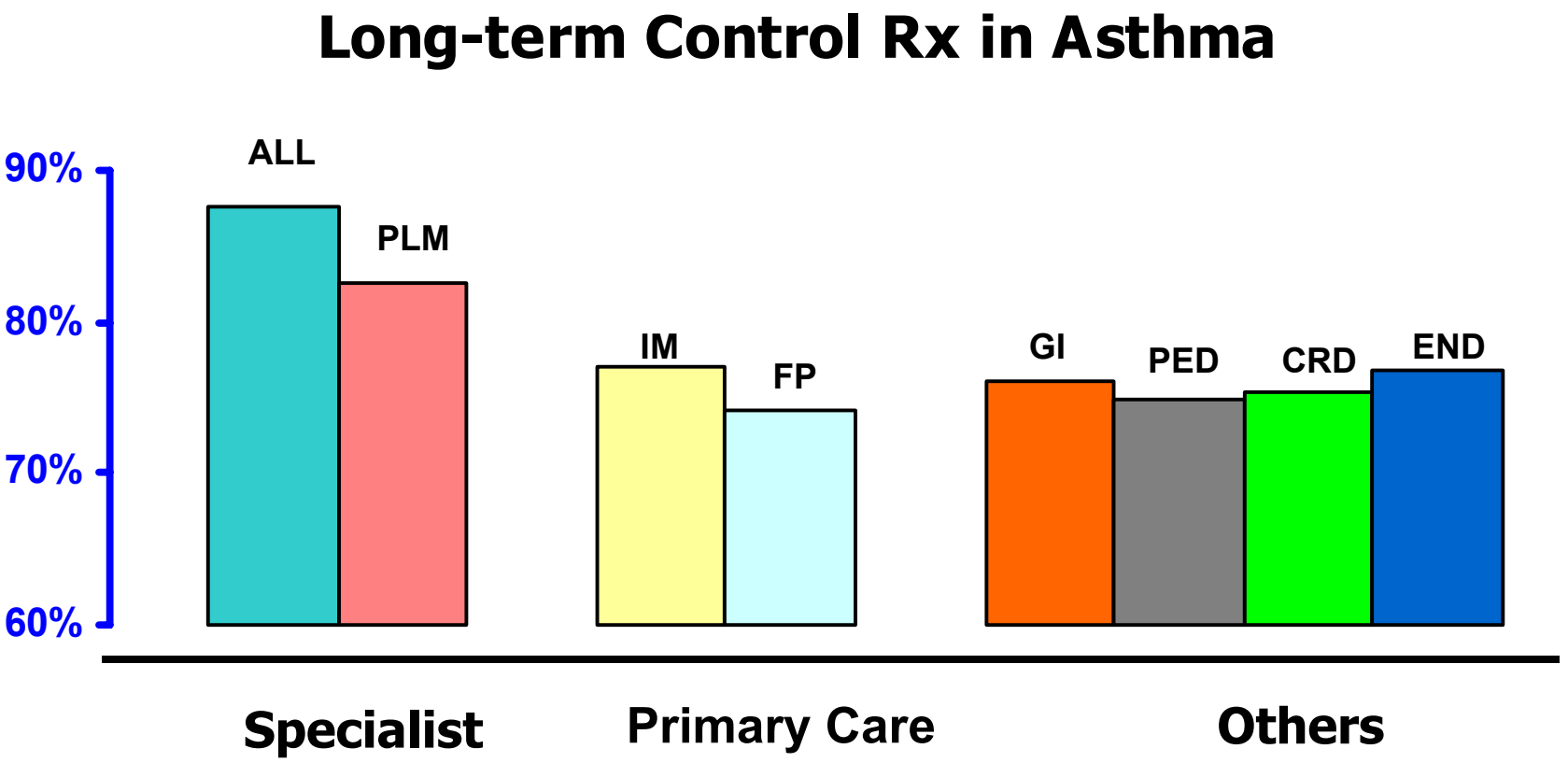
PPO Clinical Trends 2004



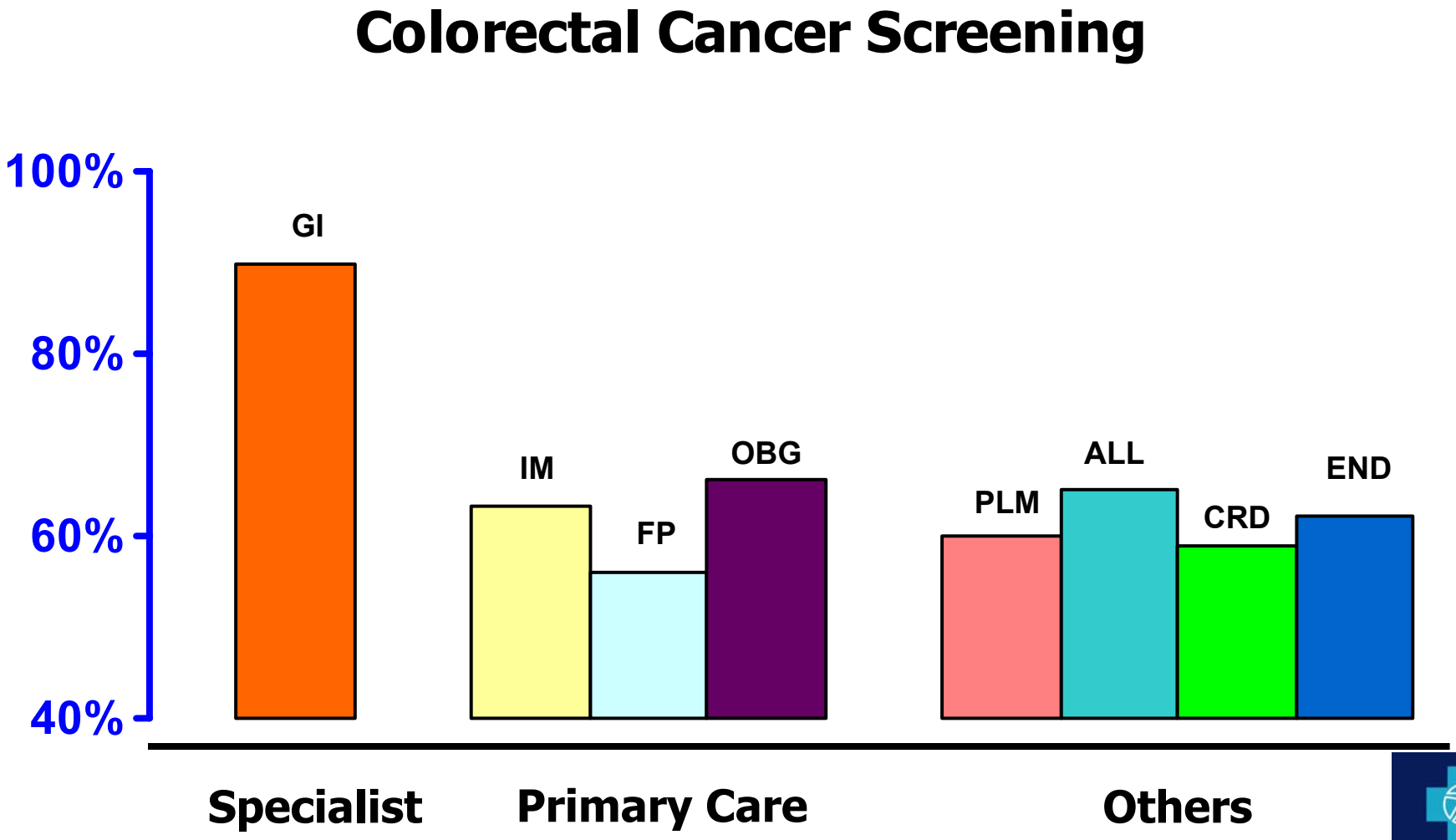
PPO Clinical Trends 2004



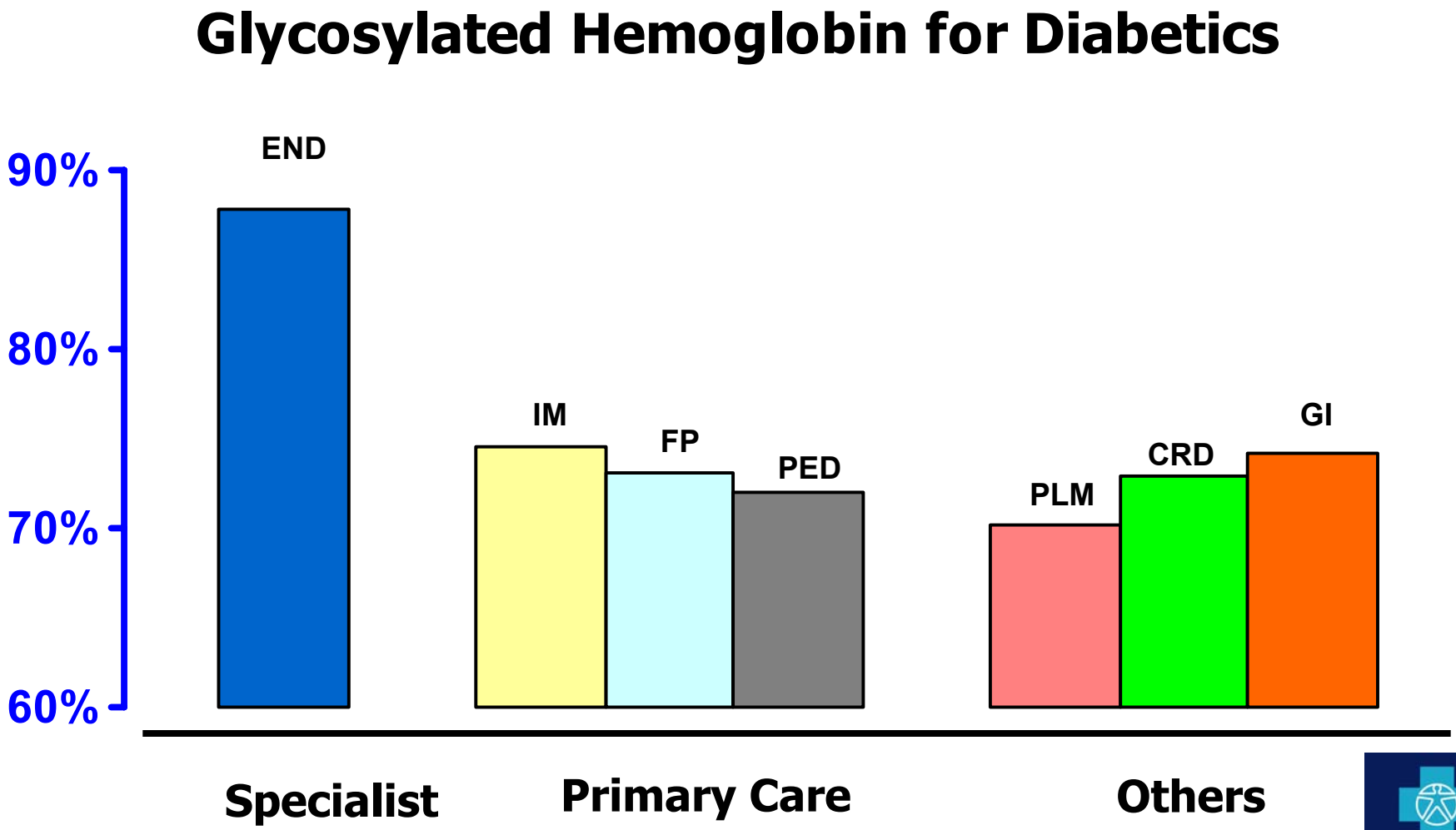
PPO Clinical Trends 2004



PPO Clinical Trends 2004

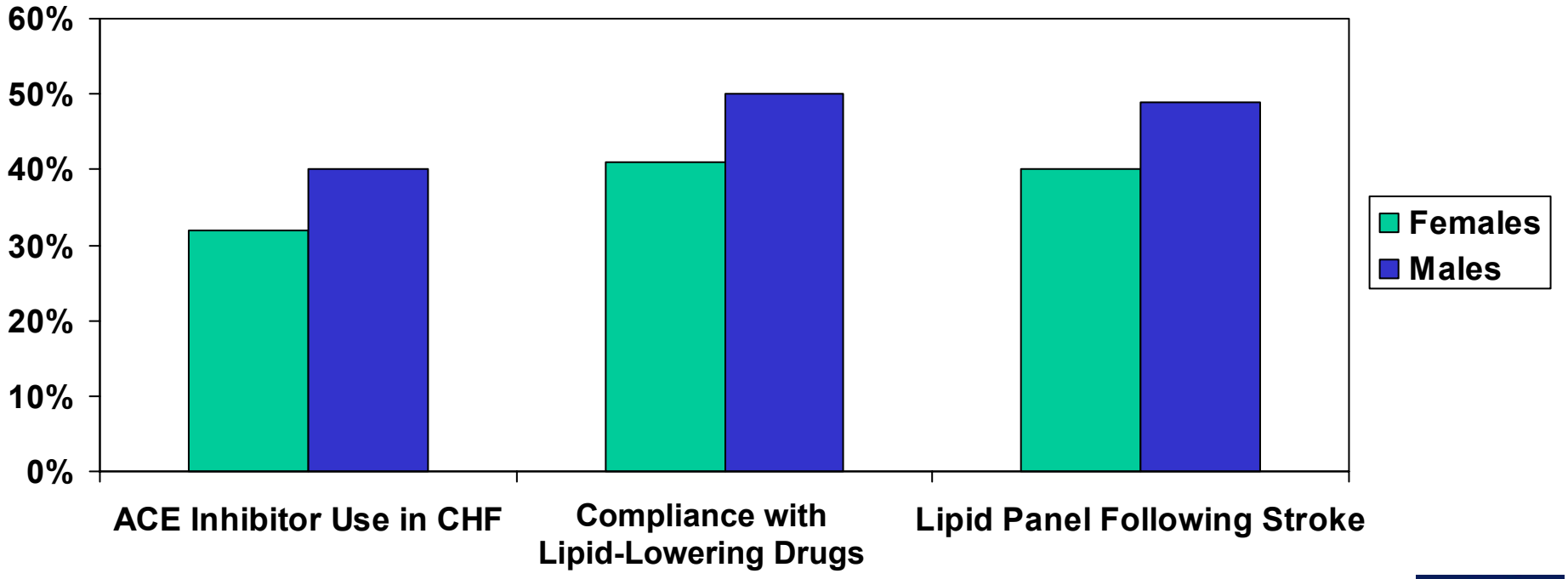


PPO Clinical Trends 2004



Teaming with Physicians to Improve Disparities

Practice Rates by Gender – PQIP Cardiac Based Indicators



Differences for these indicators were statistically significant to the 0.05 level

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Interim Summary

- Builds on BCC experience with quality reports and incentives in HMO market
- Combines unique web-based report card with feedback and educational material
- State-wide data provides view of variation in adherence to good practice guidelines
- Differences found by region, specialty, gender and age
- Drill down allows for development of targeted interventions to improve guideline adherence

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Evaluation Components

- RAND performing external evaluation of PQIP
- Process evaluation to document development and implementation of *PQIP*
- Assessments of physician and plan performance
  - Baseline performance
  - Changes over time in performance scores with and without financial reward
- Analysis of dollars paid out for financial reward
  - Characterize “winners” and “losers”
- Focus groups with physicians to assess their perspective of PQIP

Program Focus on Individual Physicians

- Measurement
  - Low eligibility for most measures
  - To attribute care, submitted claims must include physician license number
    - License number not required for payment
- Communication and Outreach
  - Large target audience – over 12,000 physicians
- Who makes improvement happen?
    - physician, office staff, group structure/management?

Web Based Platform

- PQIP Scorecard located on new ProviderAccess® site
  - The good - one on-line site to communicate with physicians
  - The bad – slow transition to new Web site; limited capacity to promote PQIP use
- The need to log on
  - Internet use in office, by physicians, is unknown
  - Mailing hard copy reports stirred more response

Measurement Issues

- Provider attribution (who provides care?)
- Services outside plan system
- Plan members not 100% of physician practice
- Lack control over patient compliance
- TIN is contracting entity, physician is measured
- Physician data contains all / multiple specialties
- Physician demographic information out-of-date

Physician Active Participation

Logged Inquiries	2003	2004	2005	%
Unique Inquiries	59	282	14	3%
*				
Check Re-Issues / Questions	0	204	0	49%
General Info on Program or Methodology	15	53	5	17%
Administrative Measures	21	39	0	14%
Accessing Web	32	2	5	9%
Scorecard/Data/Measures/Specialists	7	31	1	9%
Contract Amendments	0	0	3	1%
Total	75	329	14	100%
Phone Calls		212		75%
E-Mails		62		22%
Letters and Faxes		8		3%

* Note: 120, or 7%, of 1,700 checks were thrown away

Physician and Group Feedback

AWARENESS

- Low web utilization
- Busy schedules
- Aware of P4P but still contentious and in early stages

ACCEPTANCE

- May not trust health plan
- May believe financial incentive is money already owed to them
- Seemingly distrustful of measures
- Feel performance is sometimes out of their control

ADOPTION

- Seemingly resistant to change
- Intrinsically concerned with "doing the right thing" and extremely competitive by nature
- May be motivated by financial incentives but what is sufficient to change behavior?

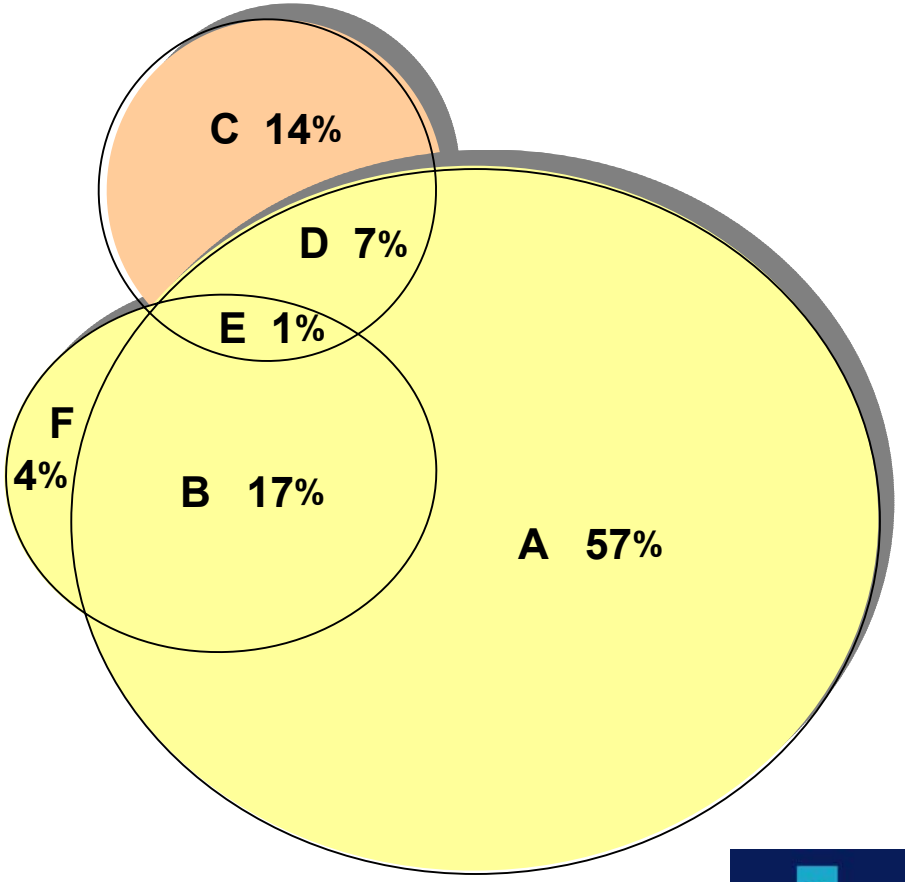
Note: Of those offered fee schedule increases less than 50% accepted

Going Forward with PQIP PQIP ver 2.0

- Modify Scorecard
  - Focus on Clinical Quality and Generic
  - Revise Administrative Measures
  - Change Financial Reward Structure
- Revise Pilot Program
  - Confirm Timeline
  - Develop PQIP fee schedule(s)
  - Re-contract physicians on standard fee schedule in Pilot area
- Communicate

The Communication Challenge

A. Single Group Only – 57%
B. Multi-Groups – 17%
C. Solo Only – 14%
D. Solo and Group – 7%
E. Solo and Multi-Groups – 1%



Communication Next Steps

communications

- **Increase the frequency and quality of physician communications, hone in on key motivational messages and improve quality of printed materials to increase response rates and improve usability**

program design

- **Augment web-based scorecard efforts with other communications (mail, fax, calls) in the short term to increase physician adoption; seek to legitimize scorecard and measurements; and provide tools to aid physicians in their goal to improve patient care**

PQIP Measures

PQIP ver 2.0

- Clinical Measures
  - Preventive Composite (Primary Care Specialty)
  - Care Management Composite (Primary Care Specialty)
  - Specialty Composite (Endocrinology, Cardiology, OB/GYN, Psychiatry)
- Pharmacy Measures
  - % Generic (Generic Select Composite)
- Administrative Measures
  - EDI
  - Provider Access Usage
  - Open for New Patients

Program Modifications Scoring

- Composites rather than percentile ranking on individual indicators
- Score reflects 2 years of data
- Physician performance classified as Above Peer Mean, At Peer Mean, or Below Peer Mean
  - Mitigates problem of low patient sample
- Increased weight of clinical measures
- Eliminated some administrative/structural measures
  - Board certification
  - Tenure with PPO product
  - Contracts with other products
- Payment approach
  - Variable fee schedule rather than lump sum
- Updated Web site

Changes to PQIP

PQIP ver 2.0

- Larger Bonus to Fewer Physicians
  - Fewer Specialty Physicians are included
  - PCPs preferentially rewarded
  - Award only the physicians whose better performance can be assessed statistically.
  - Estimated Bonus Difference
    - From $1,551 (3.9% of annual reimbursement to $2,091 (5.3%), An increase of 33%
    - 7% of physicians receive $3000 or more in 2004
    - 26% of physicians receive $3000 or more in 2005

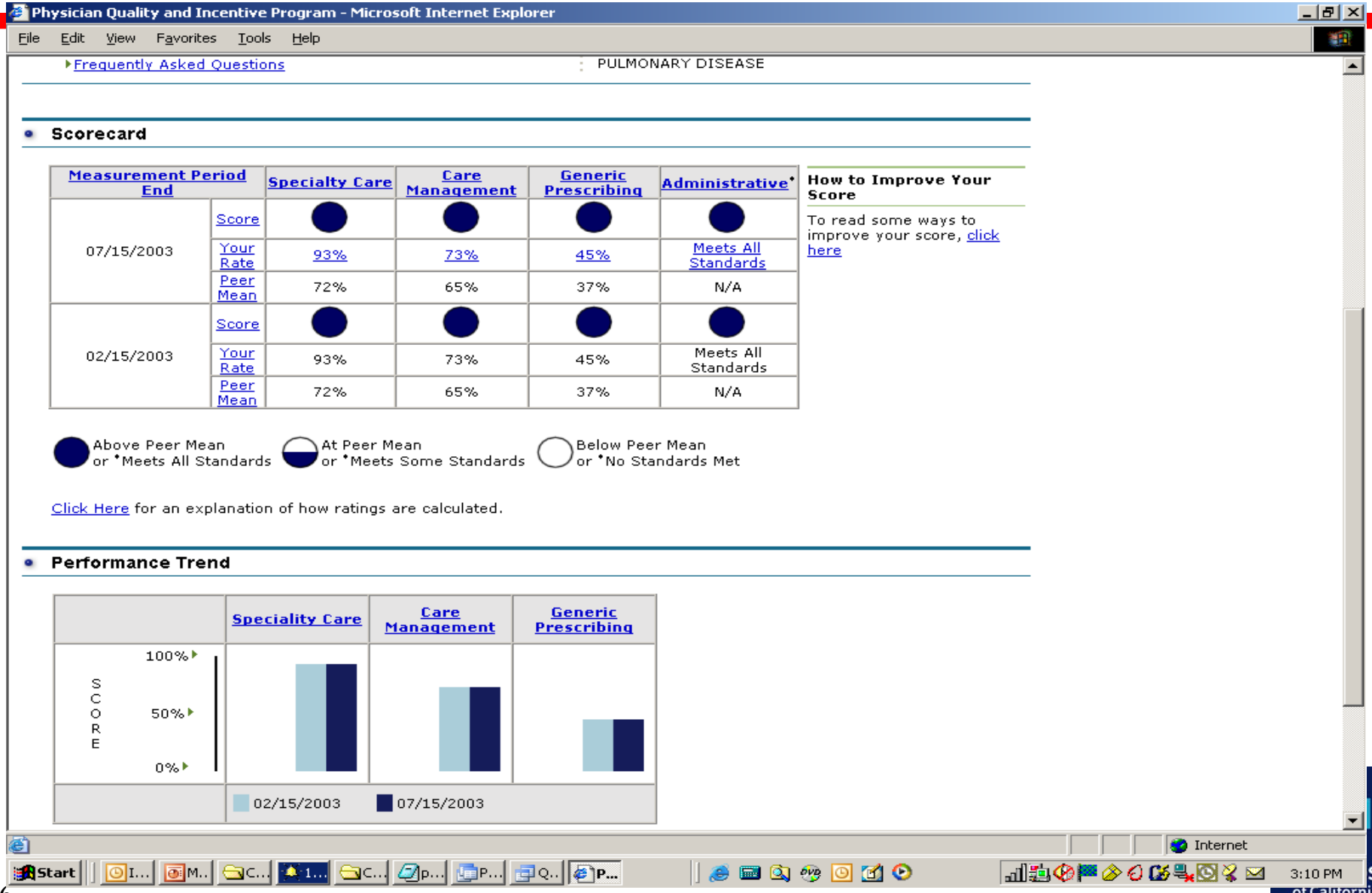
Who Qualified for new PQIP?

Criteria		# of MDs
Contract with BCC PPO		45,000
Targeted specialties – CA		21,369
Targeted specialties – Pilot		2,550
Score in clinical composite – CA	Scorecard	11,655
Score in clinical composite – Pilot		1,349

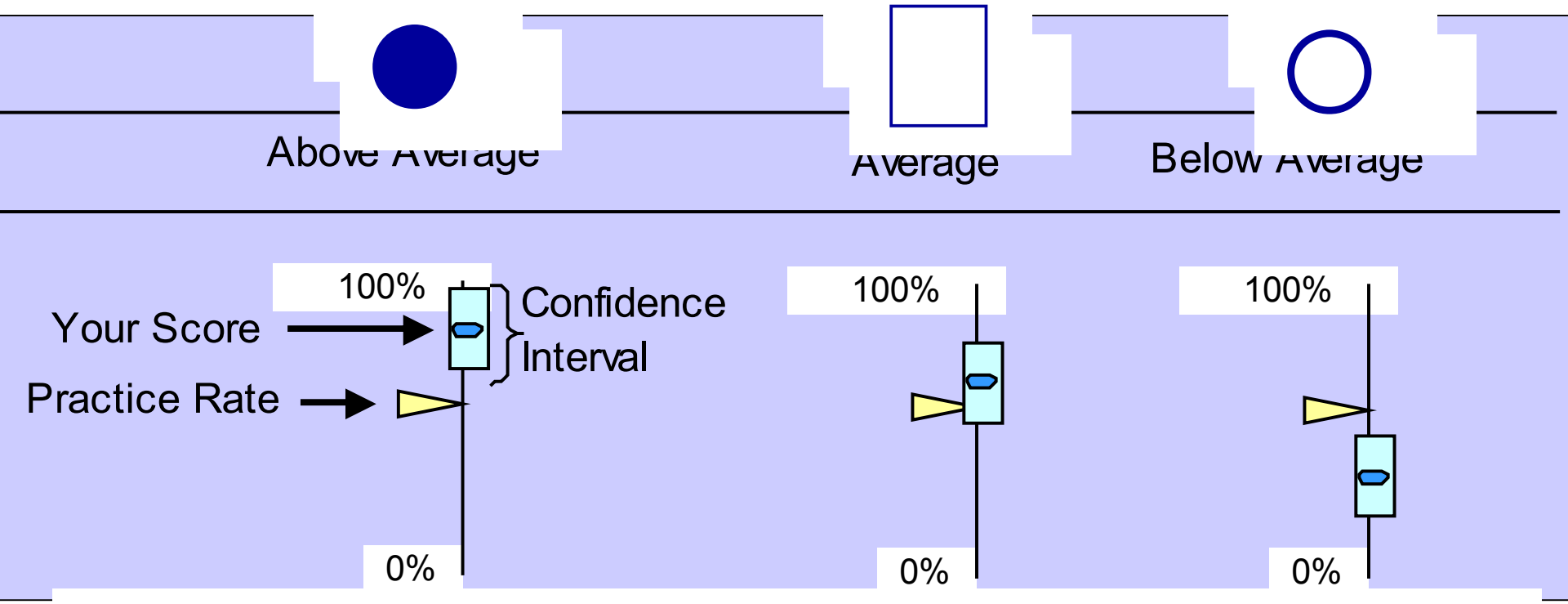
* For measurement through 2004

BlueCross of California

PQIP 2.0 “Scorecard”



New Composite Ratings
Clinical and Rx



Confidence Interval – based on the number of observed cases for the physician, the range within which one can be 95% confident of the actual performance. Statistically, takes into account that observed cases are considered a sub-set of a larger population of performance events for a physician. The more observed cases, the narrower the confidence interval i.e., increased certainty that the observed performance rate is the actual performance rate.

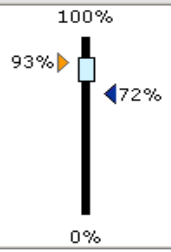
PQIP 2.0 Clinical Composites

Physician Quality and Incentive Program - Microsoft Internet Explorer

File Edit View Favorites Tools Help

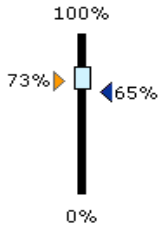
Specialty Care — Above Peer Mean

Clinical Indicator	Observed Care	Eligible Cases	Your Rate (Confidence Interval)	Peer Mean	Composite Summary
Long Term Control Drugs for Asthma	39	42	93%	84%	
Composite Total (Confidence Interval)	39	42	93% (85% - 101%)	72%	



Care Management — Above Peer Mean

Clinical Indicator	Observed Care	Eligible Cases	Your Rate (Confidence Interval)	Peer Mean	Composite Summary
Breast Cancer Screening	49	58	84%	82%	
Cervical Cancer Screening	68	84	81%	78%	
Colorectal Cancer Screening	26	45	58%	59%	
Compliance with Lipid Lowering Drugs	11	22	50%	43%	
Diabetes: Diabetic Retinal Exam	5	11	45%	32%	
Diabetes: Glycosylated Hemoglobin for Diabetics	10	11	91%	71%	
Composite Total (Confidence Interval)	169	231	73% (67% - 79%)	65%	

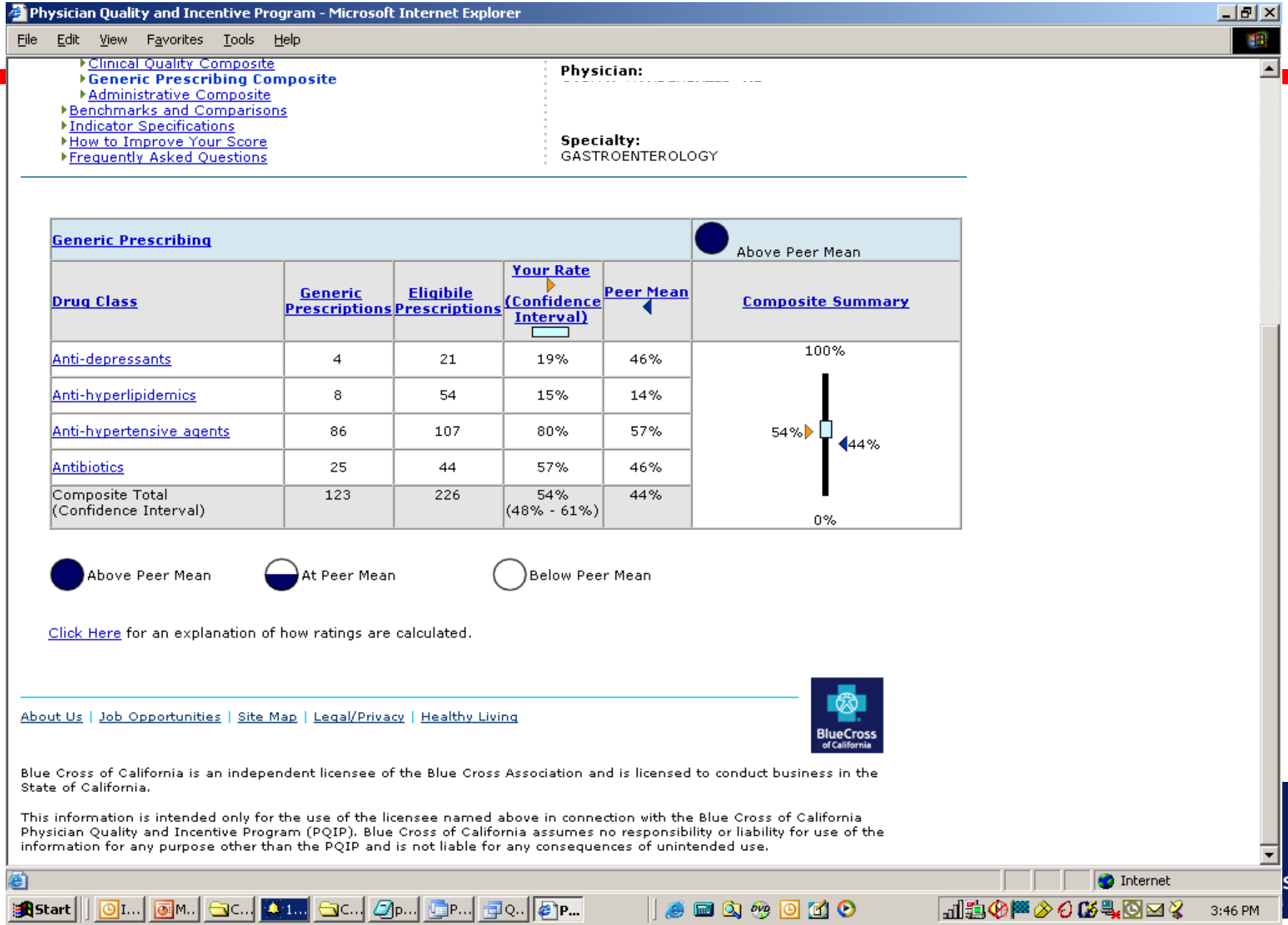


Above Peer Mean At Peer Mean Below Peer Mean

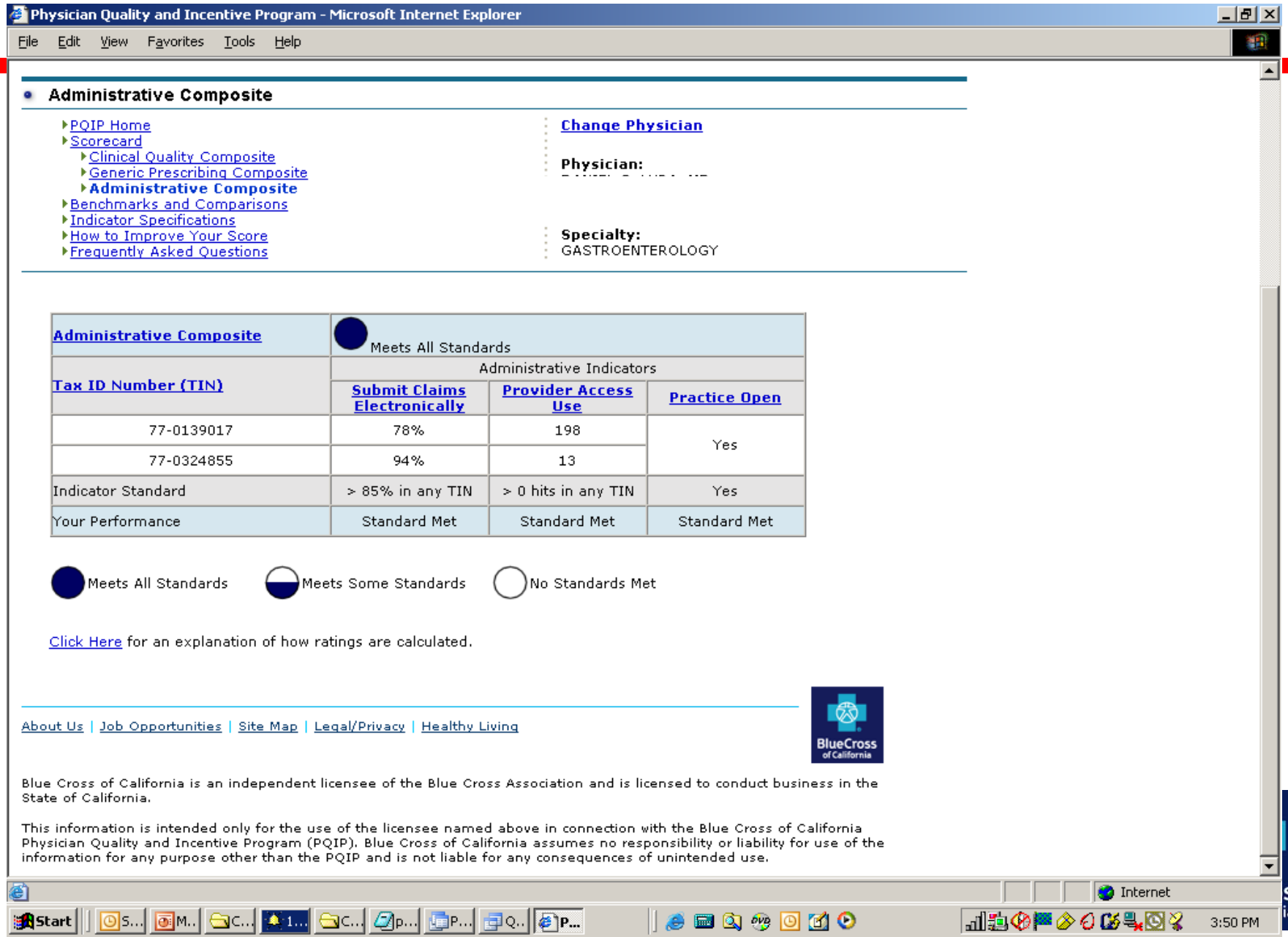
Done Internet

Start 3:11 PM

PQIP 2.0 Generic Composite



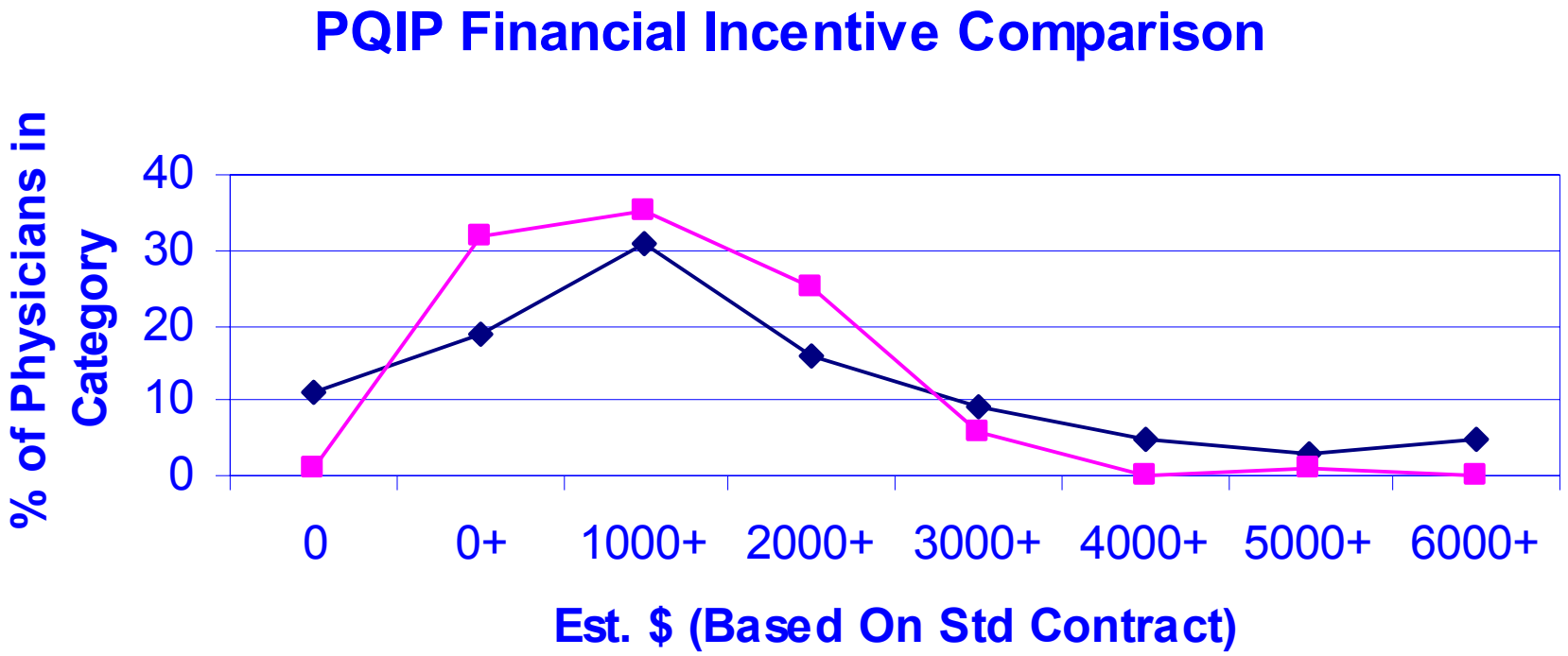
PQIP 2.0 Administrative Composite



Fee Schedule Methodology

Composite Ratings		Associated Fee Schedule Adjustment[4]	Maximum Possible Fee Schedule Adjustment
Clinical Composites "Above Peer Mean" in each composite scored[5]		8%	
One "Above Peer Mean" and One "At Peer Mean"Clinical Composite		6%	8%
"At Peer Mean" in each composite scored		4%	
Generic Prescribing Composite "Above Peer Mean"		2%	2%
Administrative Composite "All Standards Met"		2%	2%
TOTAL PQIP INCENTIVE POSSIBLE	Prudent Buyer +		12%

Payout Comparison 1.0 vs 2.0



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Performance Measurement Challenges

- How big should an incentive be and how much of a practice should it impact
- Right mix of quality measures – danger that unmeasured areas will be neglected
- Resistance from participants-physicians who do not receive incentives at risk of lower payment
- Risk adjustment of process measures- non-compliant patients or lower SES
- Threat to sense of professionalism amongst physicians

Future Enhancements

- **Web-based patient registries and performance profiles**
  - **Provide real time information to physicians**
  - **Provide specific patient information to physicians**
- **Add measures to enhance scoring and add more specialties**
- **Find methods to reward improvement as well as performance**
- **Find affordable methods to measure customer satisfaction**
- **Report physician performance to our members**
- **Develop network designs based on physician performance**

Today's Big Picture

- In our experience incentives and rewards work in organized health care systems
- The return on investment must be proven
- Efficiency measures will become an important part of our reward programs
- Incentives for quality must be financed through existing health care dollars – there is no "new money"
- Further work is needed in PPO systems to prove their value
- Pay for performance must be linked with other strategies to improve performance
- We must understand and manage the influence of disparities due to race and culture on physician performance measures

Looking forward

- Improve resources for performance improvement
  - Incorporate patient registries
- Deeper internal analysis of data to target interventions
- Expanding program beyond pilot area
  - Roll out to a High Performance Network

Why the Interest in Healthcare Quality?

- Healthcare dollars are not limitless and must be spent wisely
- Members depend on us to structure the best arrangements
- There are major opportunities for improvement
- Our global competitiveness depends on a healthy, productive, satisfied workforce
- Collaboration amongst purchasers, payors, providers is essential for success

Summary

- P4P is needed to reduce the clash between "medicine, money and morals"
- P4P is no panacea… offers the potential to balance the autonomy critical to the practice of medicine

Millenson M. Quality and Safety in Health Care; 2005

Conclusion

- Builds on BCC experience with quality reports and incentives
- Combines unique web-based report card with feedback and educational material
- Grant funding enables detailed and comprehensive evaluation of program
- High potential to provide critical information on which future incentive programs can be designed