The Promise of Pay For Performance:
Better Value

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GE imagination at work

The ABC of a better health care system

Accountability

Better payment model

Consumer activation

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Accountability is for everyone: employers, plans, providers, consumers

Employers should hold themselves accountable for where their dollars flow in the system, which includes holding Plans accountable for the performance of their networks

Providers should be held accountable for the cost and quality of the services they deliver

Consumers should be held accountable for their modifiable health-related behaviors

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Today, less than 25% of our employees or their dependents go to top performing providers

$$Y = \frac{\text{\# of members seeking care at top providers}}{\text{total number of members}}$$

X_1 = Increasing transparency of provider performance

X_2 = Increasing # of top docs/hospitals through rewards & other market activities

X_3 = Increasing consumer awareness of top performers and activation to seek care there

Provider accountability leads to performance improvement

Percentage of hospitals with quality improvement activities in reducing hemorrhage following poor results in OB performance

Reference: Hibbard et al. Health Affairs 2003;22(4):84

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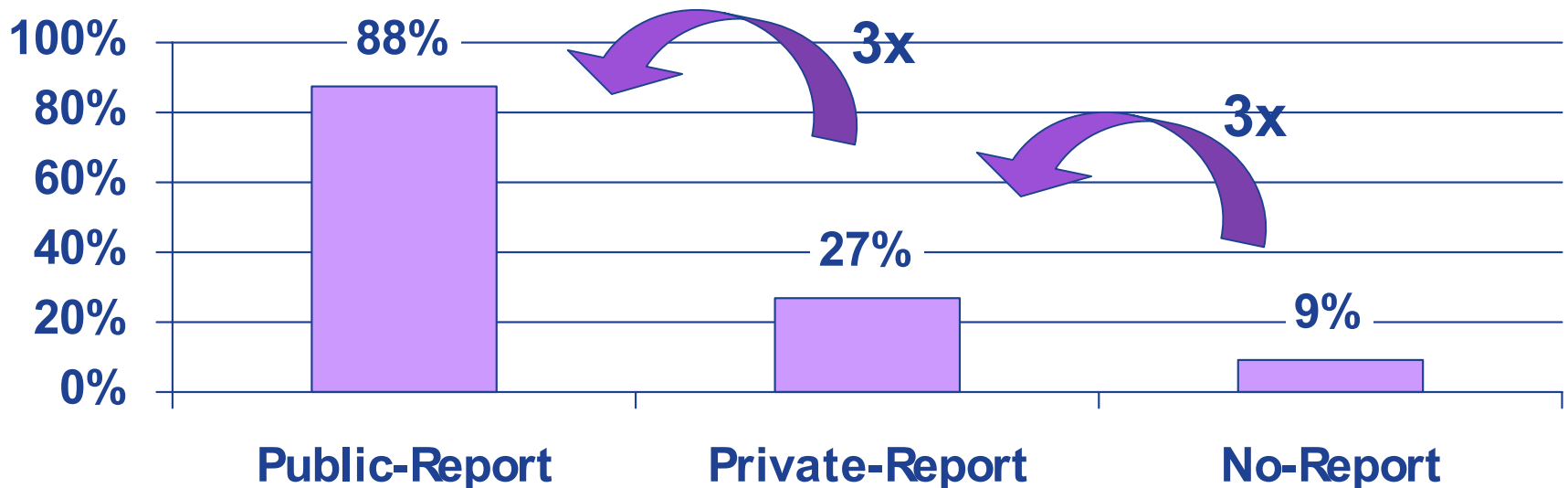
Over time, adoption of HIT coupled with HIEs promises access to a true wealth of clinical performance

Health Information Exchange

- NCQA
- ABIM
- Other

- BTE
- Plans

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In the meantime, we'll continue collaborating with others to measure physician performance

1. NCQA's PPC v2 – just released

2. ABIM-BTE Joint effort – develop performance assessment program for physicians board-certified in internal medicine.

   • Currently recruiting plans & regions to participate in the beta testing.

   • **All AQA measures included**

3. NCQA Spine Care Recognition Program – on track for release in Q3 2006

4. NCQA Cancer Care Recognition Program – under development and expected in Q2 2007

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Having a better payment model does not stop at P4P

Fee-for-service encourages overuse and misuse, and broad-based capitation encourages underuse

Adding bonuses or tying future fee increases to performance mitigates some of these effects and does lead to better outcomes

We're working on an alternative model -- PROMETHEUS

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BTE's experience demonstrates P4P needs a few ingredients to succeed

Meaningful incentives – 5% to 10% of physician revenue ~ $10K to $15K per physician…cash is especially important for PCPs

Independent review of performance (i.e. NCQA), and panel-wide sampling

Standard and recognized measures that are attainable

Consumer engagement when holding physicians accountable for outcomes

Predictable costs & benefits, and timely rewards

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The size of the bonus impacts participation, especially for IT adoption

| Market & Program	t-value	p-level (.01 = sign.)	Non-Recognized Physician Mean Patient Count	Recognized Physician Mean Patient Count
Cincinnati DCL	4.33	<.0001	5.2	10.0
Louisville DCL	3.35	.0021	5.2	17.9
Boston DCL	2.47	.0166*	2.2	4.1
Boston POL	13.10	<.0001	10.7	31.9
NY Cap. Reg. POL	8.68	<.0001	18.9	82.8

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BTE's programs have led to better clinical and financial outcomes

Diabetes Care Link
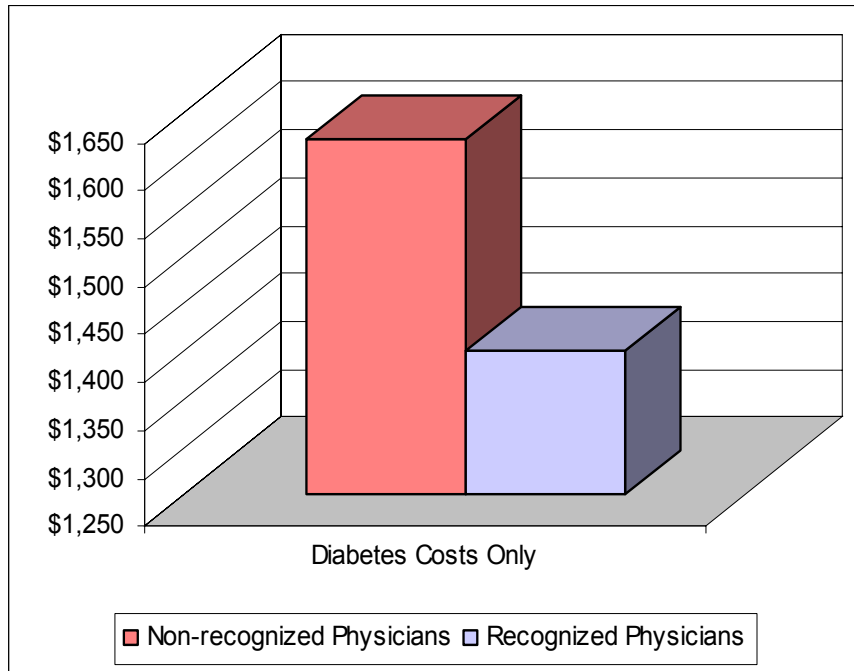
Physician Office Link
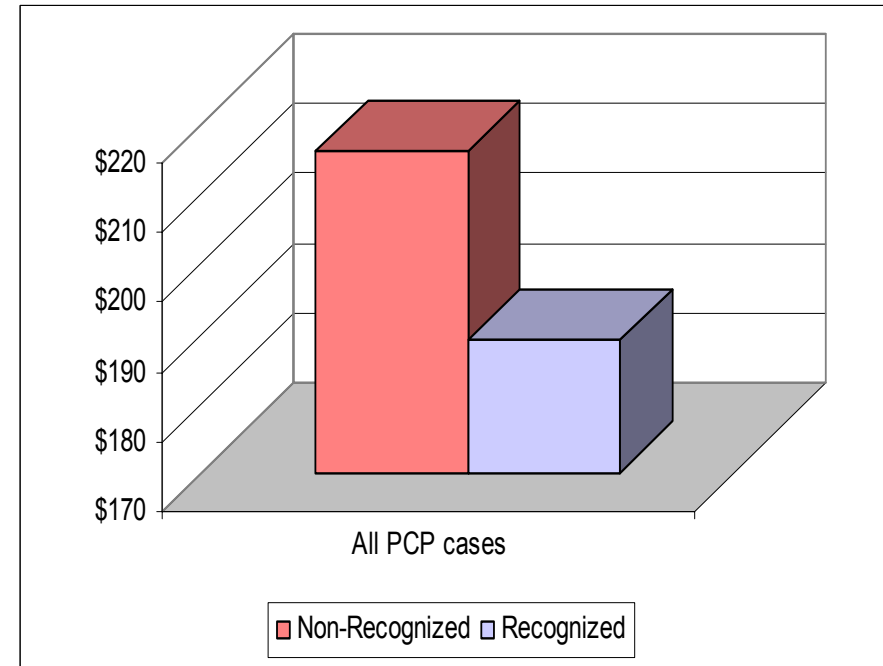
Average episode costs of care for recognized and non-recognized physicians

Towers Perrin has validated actuarial savings for DCL and CCL

We estimate the following annual savings per patient for each clinical measure

Clinical Measure		Annual savings per diabetic patient	Max
HbA1c Control	Poor Control	$177	$279
	Good Control	$96	
Blood pressure control	< 140/90 mm Hg	$166	$494
	< 130/80 mm Hg	$230	
LDL control	< 130 mg/dl	$149	$369
	< 100 mg/dl	$251	
Nephropathy Assessment		$77	
Eye Examination		$1	
Notation of smoking status and cessation advice or treatment		$1	
Completion of Lipid Profile		$0	
Foot Examination		$0	

> Savings vary significantly for individual measures

Overall Savings Estimates

Measure	Savings per Patient
Blood pressure control < 140/90 mm Hg	$547
Completion of Lipid Profile	$0
LDL control < 100 mg/dl	$91
Use of aspirin or other antithrombotic	$168
Notation of smoking status and cessation advice or treatment	$12

> Savings vary significantly for the 5 measures and are *not* additive
> Estimated Savings per patient = $547 with Blood pressure measure vs. $271 without Blood pressure measure

Towers Perrin

- Maximum savings estimate is $1,059 per patient, which occurs when all measures are met
  - Savings are greatest if Blood Pressure, HbA1c and LDL control measures are met
- In contrast, when recognition is achieved with the least cost-saving measures, the savings estimate is $421
- Aside from 'Nephropathy Assessment,' little or no savings are derived from process measures

PROMETHEUS is a payment model with P4P built-in

Starts with Evidence-based Case Rates (ECRs) that are adjusted to reflect patient severity

10% to 20% of the payment is deposited in a performance contingency fund and tied to provider performance on process and outcomes of care, patient experience of care, and cost-efficiency

Providers are encouraged to be clinically integrated, even virtually, with 30% of their score dependent on the performance of providers they refer to

Can be deployed in any market and does not require new claims systems

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Consumers need to be activated at many levels

Health risk-related behaviors should be discouraged. Many companies are starting to take a strong stand on having employees pay more for smoking

We need to systematically introduce sensitivity to the cost and quality of providers, encouraging plan members to seek out better performers

There are already some prototypes that link physician and hospital performance with co-pays

These physicians, with your requested specialty, are in the area you selected.

Printer Friendly

Gen/Fam Practice						
Physician's Name	Excellence In:				Hospital Affiliation	You Pay
	Systems of Care	Diabetes	Heart/Stroke	Patients' Experiences		
Walter J Alt MD	◕	★	★ Super Star	★	●	$0
S. Mark Bean MD	◕	★	★ Super Star	★		$0
Barrie Paster MD	◕	--	N/A	Data Not Yet Available		$15
Joseph Py	--	--	N/A	Data Not Yet Available	○	$30

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