Pay for Performance Strategies: Improving Quality Performance and Return on Investment

National Pay for Performance Summit
Los Angeles

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WELLPOINT

Agenda

- The State of U.S. Health Care: Quality Gaps Persist
- Timing is Right for P4P
- The Power of Pay for Performance
- P4P Programs at WellPoint
- The Perfect Storm: High Performance Networks
- Information Transparency and Consumer Empowerment
- Issues and Observations
- Competition vs. Collaboration
- Conclusion

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The Quest for Affordable, High Quality Health Care

Many strategies have attempted to improve health care quality and affordability. None has systematically applied evidence-based medicine and quality outcomes.

1980s

- HMOs
- Contracting in the setting of excess capacity
- Aggressive medical management

1990s

- Capitation
- Physician management companies
- Vertically integrated health care delivery (and financing) systems

2000s

- "Boutique" delivery models, such as specialty hospitals
- Consumer-driven health care and health savings accounts
- High performance networks with cost and quality information
- Disease and care management programs
- Rewarding quality performance (pay for performance)

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Hospital Quality Improves, but Quality of Care Remains Inconsistent Nationwide

- **Performance of more than 3,000 accredited hospitals on 18 standardized indicators for acute myocardial infarction (AMI), congestive heart failure (CHF) and pneumonia over two-year period (2002-2004):**
  - Significant improvement ($p<0.01$) on 15 of 18 measures
  - No measure showed significant deterioration
  - Magnitude of improvement ranged from 3 to 33 percent

Williams, Schmaltz, Morton, Koss, Loeb, NEJM 2005;353:255-64

- **Hospital Quality Alliance data set on 10 quality indicators for AMI, CHF and pneumonia; > 3,500 hospitals reported data on at least one stable measure:**
  - Half the hospitals scored above 90 percent for 5 of the 10 measures (primarily AMI); level of performance for other 5 measures was much lower
  - High quality of care for AMI predicted high quality of care for CHF but not for pneumonia
  - Substantial variability in quality of care provided by hospitals in different metropolitan areas
  - No consistent association between performance and size of hospital

Jha, Li, Orav, Epstein, NEJM 2005;353:265-74

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To Err is Human:
Health Care Still Not Safe Five Years Later

- **Impact of IOM landmark study:**
  - Progress slow but report changed conversation about medical errors
  - Mobilized broad array of stakeholders – including AHRQ, National Patient Safety Foundation, Institute for Healthcare Improvement, regional coalitions, payers, purchasers, health care professionals
  - Catalyst for changing practices
- **Advances expected in next 5 years:**
  - Implementation of electronic health records
  - Diffusion of proven, evidence-based practices
  - Team training
  - Full disclosure to patients

Source: Leape, Berwick, JAMA 2005;293:2384-2390

Need New Financial Incentives for Quality

- **Dominant methods of payment today don't achieve goal of clinical quality.**
  - **Fee-for-service payments encourage overuse**
  - **Capitated payments encourage underuse**
  - **Neither systematically rewards excellence in quality**
- **Strategy is undercut by difficulties in measuring quality and adjusting for risk in way that is meaningful to consumers/patients.**
- **Some early experiments in rewarding quality with more favorable payments, but limited.**

P4P Analysis Contributes to National Dialogue

- **Study evaluated prototype pay-for-performance program with physician group vs. control group.**
- **Authors concluded that P4P is more likely to reward high performers to maintain status quo than generate noticeable quality gains.**
- **Findings contribute to national discourse – illuminate potential pitfalls in developing quality incentive programs:**
  - **Financial incentives must be substantive enough to effect significant improvement**
  - **Must establish appropriate thresholds and allow sufficient time for lower-performing groups to improve appreciably.**

Source: Rosenthal, Frank, Li, Epstein, JAMA 2005;294:1788-1793

Timing Is Right for Pay for Performance

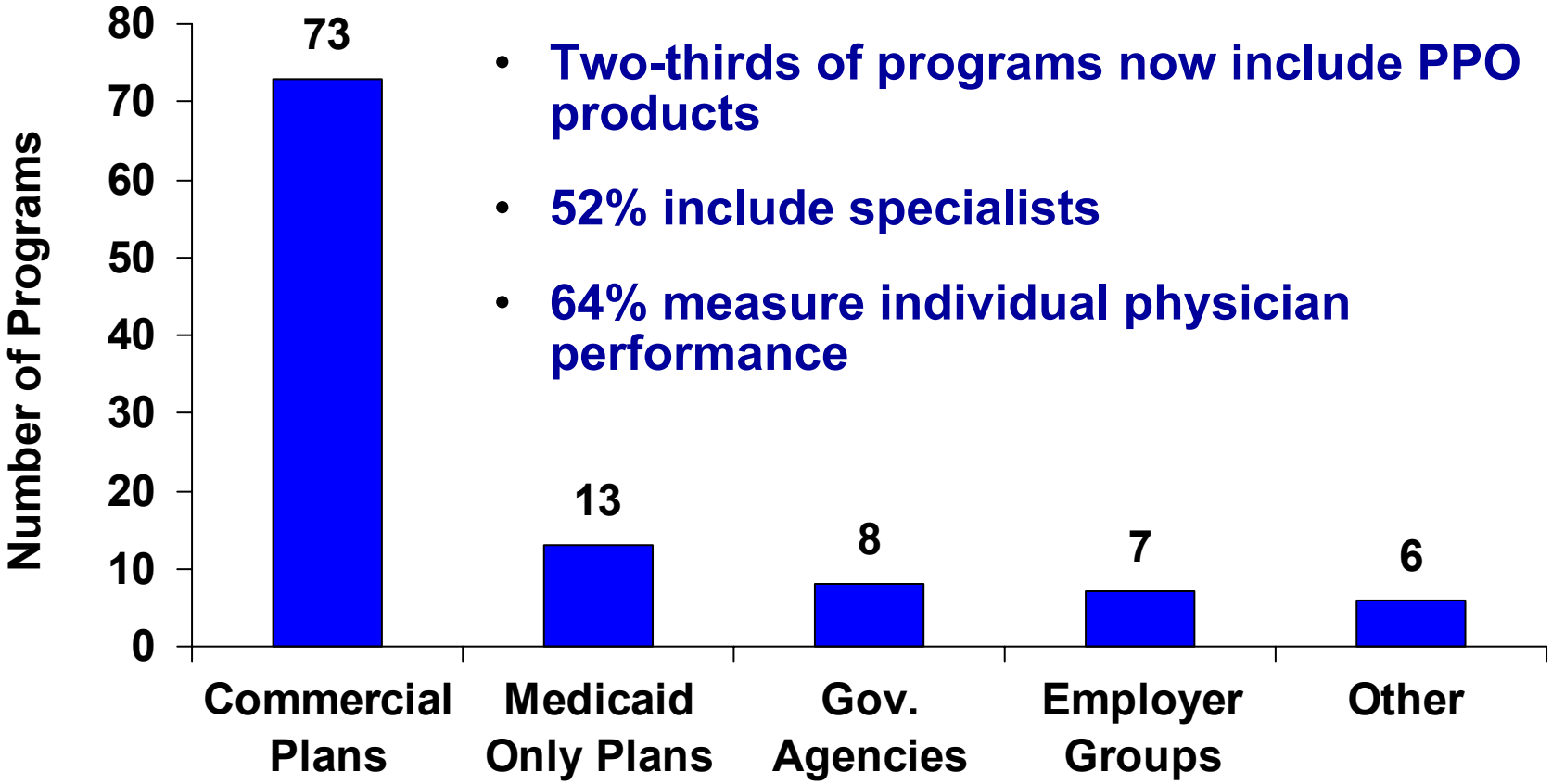
- **Increasing purchaser interest in quality as a factor in buying decisions**
- **IOM reports and Medicare reform boost quality measurement; Medicare launched P4P physician program in April 2005**
- **President's EMR goal to improve quality**
- **AMA, JCAHO and MedPAC focused on P4P**
  - Senate and House "Value-Based Purchasing" bills incorporate MedPAC P4P recommendations
- **Regional coalitions forming to improve market adoption of P4P (Leapfrog, IHA, Bridges to Excellence)**
- **Growing public interest: media coverage on pay for performance increased nearly 150 percent (2004-2005)**

Institute of Medicine: Pathways to Quality Health Care

- **Reports designed to accelerate diffusion and pace of quality improvement**
- **First report outlines several recommendations:**
  - Establish National Quality Coordination Board with structural independence, contract and standards-setting authority, financial strength and representation from public and private sectors
  - Local innovation encouraged; performance measurement and reporting should be aligned with national goals and standardized measures
  - Promulgate measure sets that build on work of key public and private organizations
  - Pursue research agenda to support national system for performance measurement and reporting

P4P Is Moving Forward

- 107 provider P4P sponsors nationwide – 25% increase from previous year
- Two-thirds of programs now include PPO products
- 52% include specialists
- 64% measure individual physician performance



Source: 2005 P4P National Study, Med-Vantage, Inc.

Why Pay for Performance?

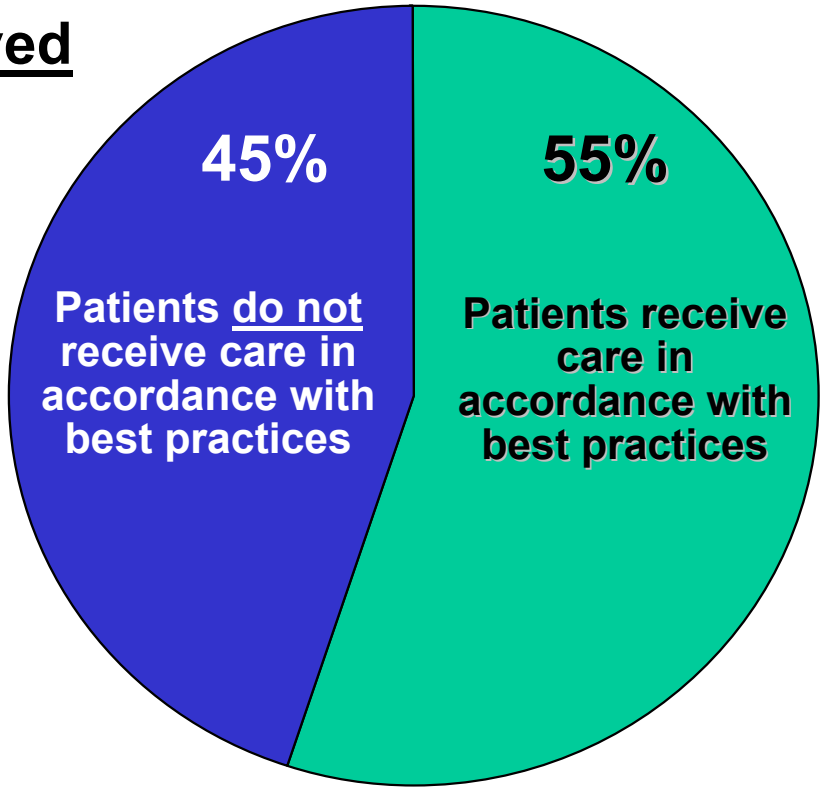
- Improve Care and Outcomes
- Save Lives
- Eliminate Ethnic Disparities
- Reduce Costs
- Incent Health IT Adoption

Improve Care and Outcomes

Nearly one-half of physician care not based on best practices

% of Recommended Care Received

64.7%	Hypertension
63.9%	Congestive Heart Failure
53.9%	Colorectal Cancer
53.5%	Asthma
45.4%	Diabetes
39.0%	Pneumonia
22.8%	Hip Fracture



Source: Elizabeth McGlynn et al, RAND, 2003

Improve Care and Outcomes

More care, higher spending do not result in better outcomes

- **Using Medicare claims data, researchers found:**
  - Where people live, who treats them and in what hospital-- not their illness-- determines how much care is given and how much money is spent
  - Hospitals providing more care for one condition have similar patterns for other conditions
  - Level of care intensity likely to apply to commercially insured patients

Source: John Wennberg, et al and Elliott Fisher, et al, Health Affairs web exclusives, October 7, 2004.

Save Lives

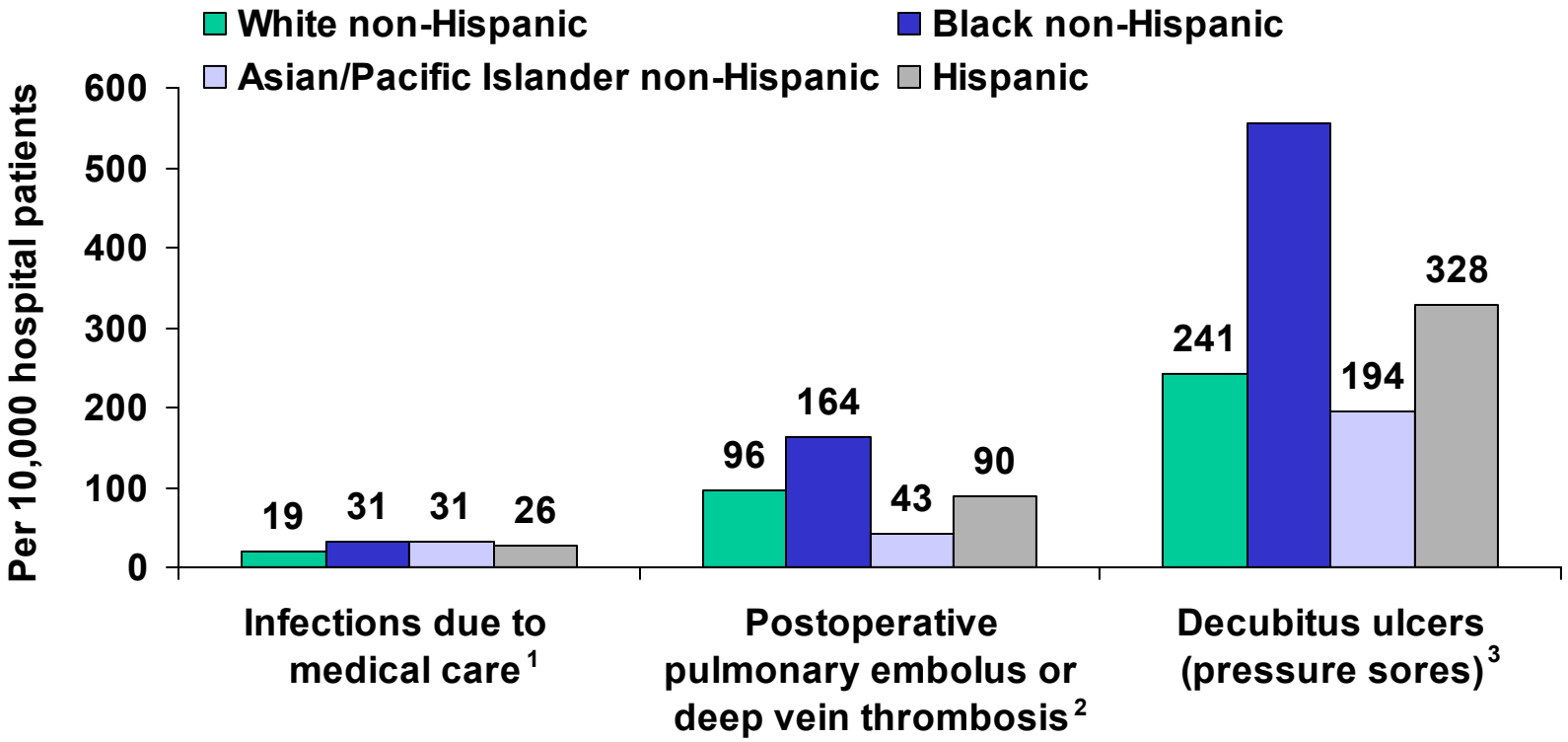
Patients receive recommended care only half of the time. These consequences are avoidable.

Condition	Shortfall in Care	Avoidable Toll
Diabetes	**Average blood sugar not measured for 24%**	**2,600 blind; 29,000 kidney failure**
Hypertension	**<65% received indicated care**	**68,000 deaths**
Heart Attack	**39% to 55% didn't receive needed medications**	**37,000 deaths**
Pneumonia	**36% of elderly didn't receive vaccine**	**10,000 deaths**
Colorectal Cancer	**62% not screened**	**9,600 deaths**

Source: Woolf, SH, JAMA, Vol. 282, 1999

Eliminate Ethnic Disparities

Risk-adjusted rates of potentially preventable adverse events and complications of care among elderly patients

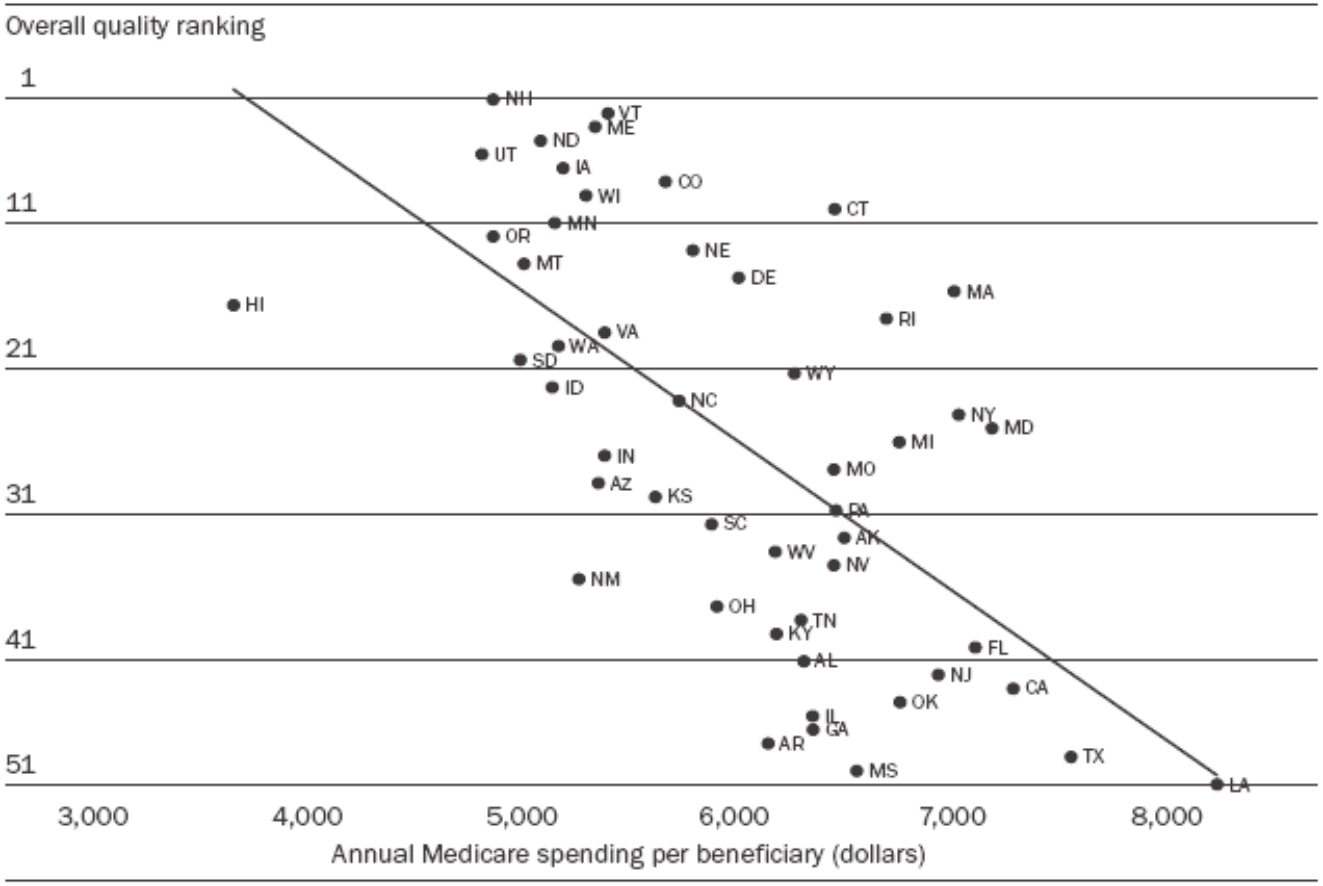


Source: "Quality of Health Care for Medicare Beneficiaries: A Chartbook, 2005" The Commonwealth Fund.

1. *Infections primarily related to intravenous lines and catheters.*
2. *Among surgical patients.*
3. *Among patients with hospital stays of five days or longer.*

Reduce Health Care Costs

A negative relationship: As costs go up, quality goes down



Sources: Medicare claims data: and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001." JAMA 289, no. 3 (2003); 305-312.

Note: For quality ranking, smaller values equal higher quality

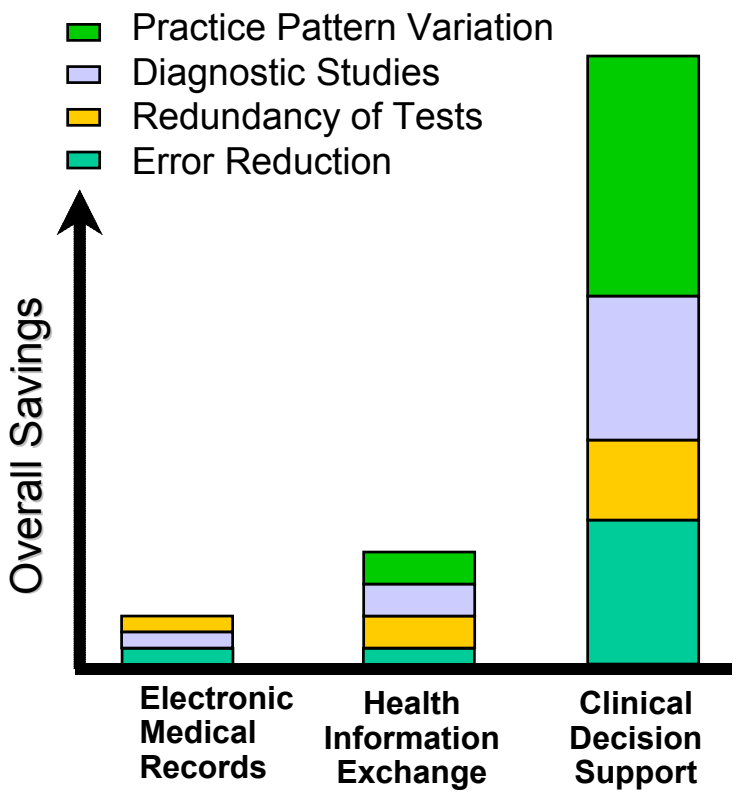
Incent Health IT Adoption

- **Tracking, reporting and rewarding clinical quality requires better data and information**
- **P4P will help fund investment in Health IT**
  - PBGH found CA medical groups installed new IT systems after $100 million awarded in bonus payments
- **Investments in Health IT will improve quality, reduce costs and increase efficiency**
  - Computerized clinical decision support
  - Patient reminder systems
  - CPOE and e-Prescribing

HIT Reduces Variation, Speeds Adoption of Evidence-Based Medicine

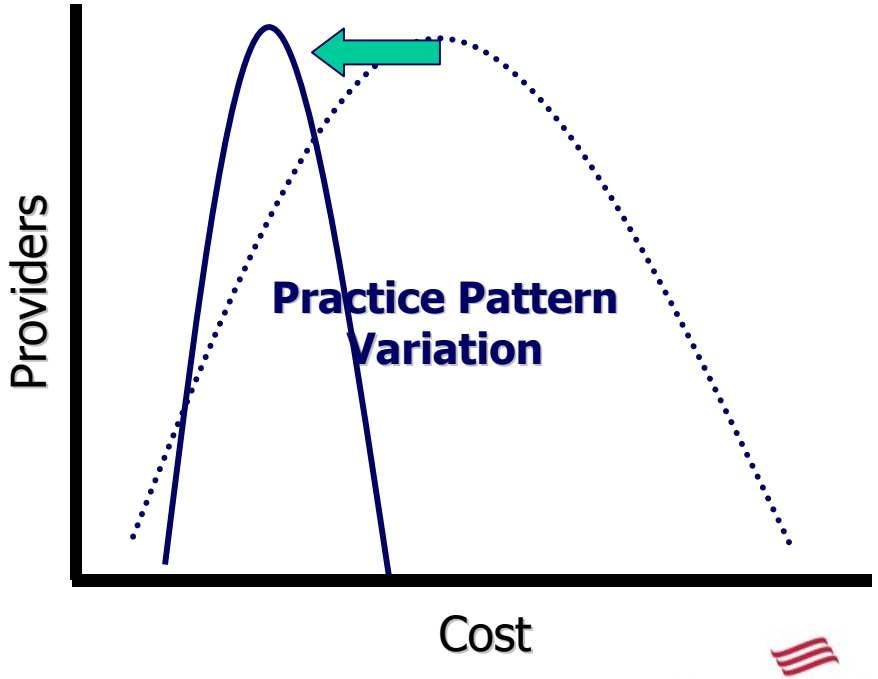
Timely health information that is linked to decision support reduces practice pattern variation and increases adherence to evidence-based medicine.

Benefit Drivers



Benefit Accrual

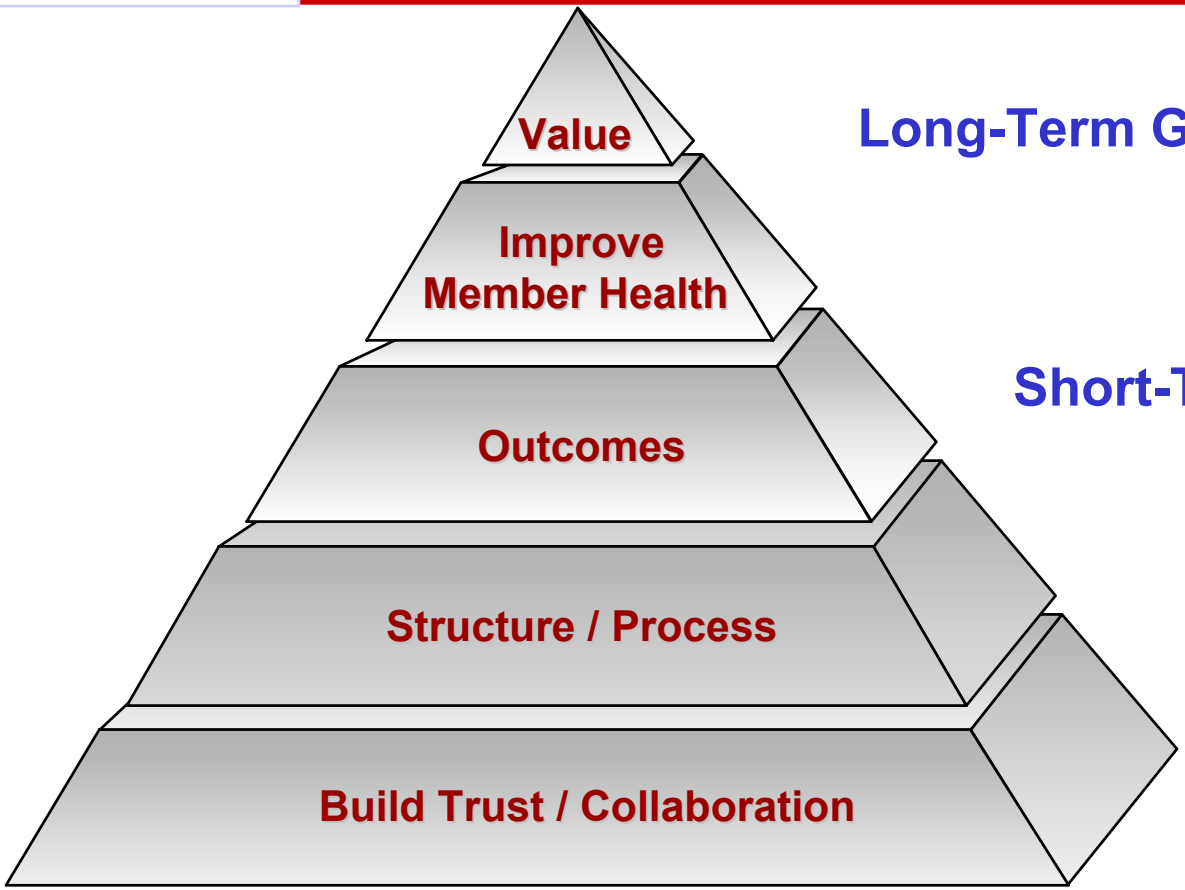
As more physicians practice evidence-based medicine, health-care costs per episode of care are reduced.



Multiple Collaborations to Improve Quality of Care, Reduce Medical Errors

- Integrated Healthcare Association
- National Quality Forum
- National Committee for Quality Assurance
- Centers for Medicare and Medicaid Services
- Bridges to Excellence
- The Leapfrog Group
- Care Focused Purchasing
- Hospital Quality Alliance (consortium of health care organizations, including AHIP, CMS, JCAHO, AHA, AARP)
- Blue Cross Blue Shield Association (BCBSA)

Quality Vision for P4P Programs



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

P4P Programs at WellPoint

Partnerships with physicians and hospitals on quality incentive programs (include PPO and HMO products, and Medicaid)

PCP Programs

Focused on primary care physicians. Typical major components:

- ✓ Clinical Outcomes
- ✓ Evidence-based medical procedures
- ✓ Generic Prescribing Rates
- ✓ Technology & streamlined administrative processes
- ✓ Patient Satisfaction

Specialist Programs

Focused on specialty care physicians. Early initiatives in: Ob/Gyn, Cardiology, Orthopedics. Measures similar to PCP programs:

- ✓ Clinical Outcomes
- ✓ Evidence-based medical procedures
- ✓ Generic Prescribing Rates
- ✓ Technology & streamlined administrative processes
- ✓ Patient Satisfaction

Hospital Programs

Focused on acute care hospital, typically full service cardiac facilities. Hospital programs typically have the following components:

- ✓ Patient Safety
- ✓ Clinical Outcomes
- ✓ Patient Satisfaction

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WellPoint Hospital Quality Programs: Goals and Guiding Principles

- Continuously improve quality of care delivered in network hospitals
- Develop program using comprehensive evidence-based metrics
- Minimize administrative burden to participate
- Promote partnerships with key hospitals
- Drive change in overall health care delivery arena
- Designed to improve care delivered to all patients, not just WellPoint members; reporting for all hospital patients
- Support health care delivery goals and public reporting of outcomes data
- Financial incentives for clinical performance, quality care, error reduction

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WellPoint Coronary Services: Extensive Quality Outcomes Metrics

- **Coronary Artery Bypass Grafts (CABG)**
  - number of procedures
  - mortality
  - return to OR
  - saphenous vein use
  - infections
- **Percutaneous Transluminal Coronary Arteriography (PTCA)**
  - number of procedures
  - repeat PTCA
  - failed PTCAs which go onto CABG within 24 hours
  - primary PTCA for acute myocardial infarction
- **Myocardial Infarction (MI)**
  - number of patients with MI
  - time to PTCA
  - time to thrombolytic therapy from ER (door to drug)
  - aspirin use in 24 hours
  - mortality
  - ß-blocker use
  - critical pathway use
  - number with LVEF < 40% prescribed ACE inhibitors

Quality Insights Hospital Incentive Program

Patient Safety - 25%

- Meet 6 JCAHO patient safety goals:
  - Improve the accuracy of patient identification
  - Improve the safety of using high-alert medications
  - Eliminate wrong-site, wrong-patient and wrong-procedure surgery
  - Improve the safety of using infusion pumps
  - Improve the effectiveness of clinical alarm systems
  - Improve the effectiveness of communication among caregivers
- Implement 3 patient safety initiatives
  - Computerized Physician Order Entry (collected via Leapfrog survey)
  - ICU staffing standards (collected via Leapfrog survey)
  - Automated pharmaceutical dispensing devices
- Report 2 patient safety indicators
  - Anesthesia complications, post-operative bleeding, etc.

Note: Text in red reflects NQF measure

Quality Insights Hospital Incentive Program

Patient Outcomes - 60%

- Improve indicators of care for patients with heart disease
  - Participation in American College of Cardiology cardiovascular data registry
  - Cardiac catheterization and angioplasty intervention indicators
  - Acute MI or heart failure indicators (collected via JCAHO)
    - Administer aspirin, beta blockers at ER arrival, discharge
    - Smoking cessation
  - Coronary artery bypass graft indicators
- Pregnancy-related or community acquired pneumonia indicators

Patient Satisfaction - 15%

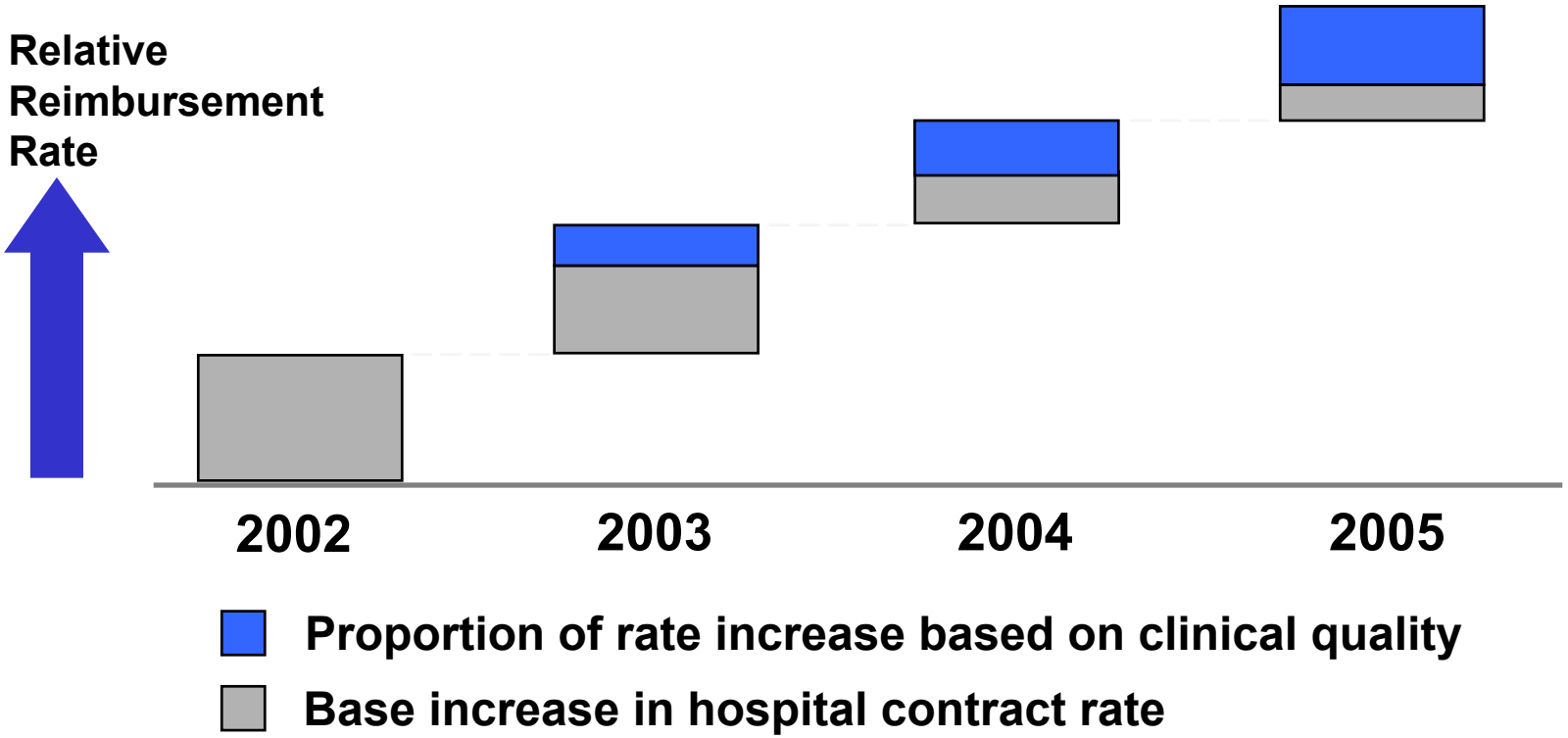
- Survey of members
- Link between improvement in care processes and outcomes, and patient satisfaction

Note: Text in red reflects NQF measure

Hospital Quality Programs

Rewarding high scores creates tangible incentive for quality improvement

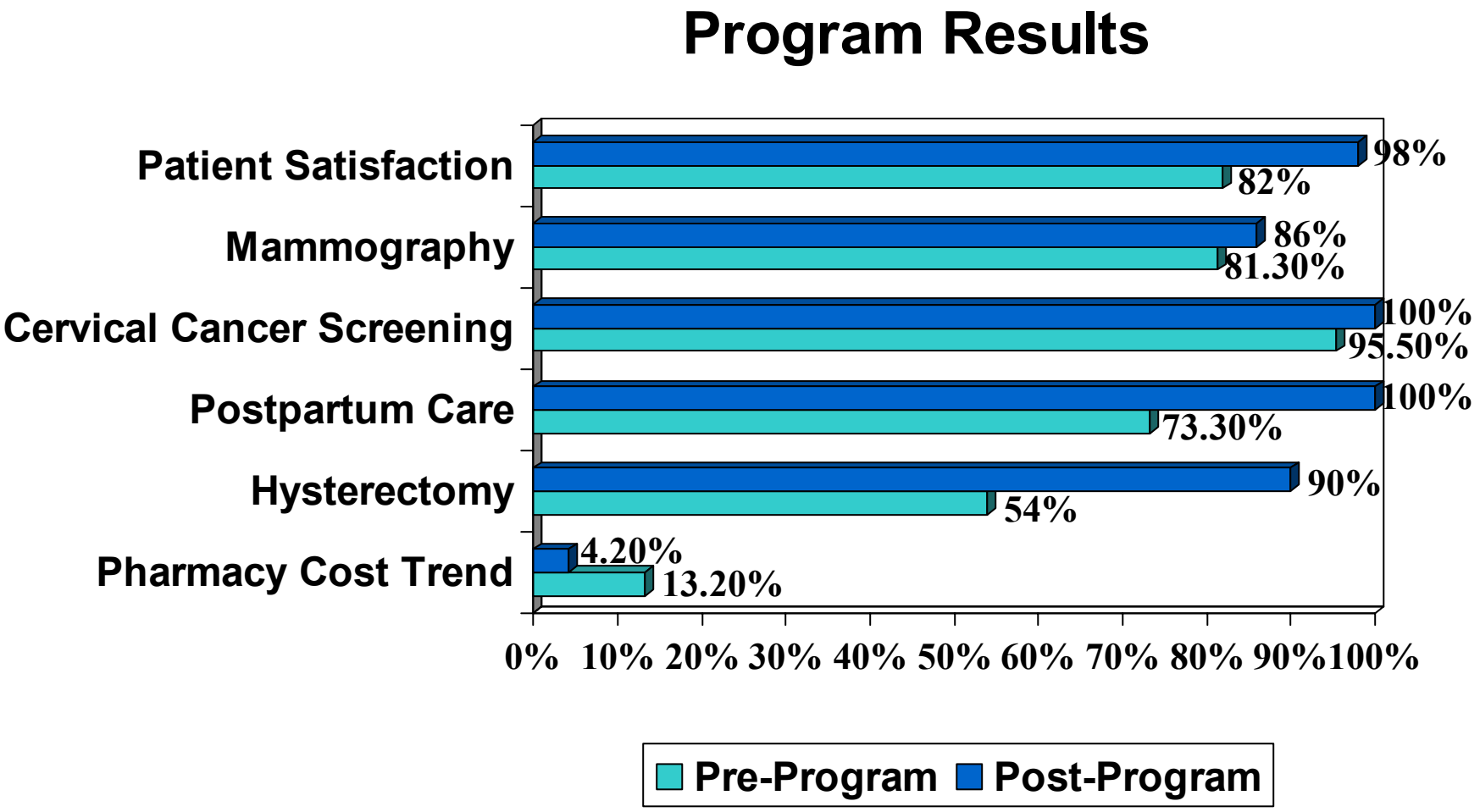
Reimbursement Increase Schedule



Payment for Clinical Performance and Quality:
Obstetrics and Gynecology Program with MaternOhio Physicians

- **Approach:**
  - Preventive care: mammography, pap smear
  - Patient satisfaction
  - American College of Obstetrics and Gynecology's guidelines for hysterectomy
  - Generic index for pharmaceuticals
- **Recognition and reward:**
  - No precertification or concurrent review requirements
  - Positive adjustment in reimbursement

Payment for Clinical Performance and Quality:
Obstetrics and Gynecology Program with MaternOhio Physicians



Physician Quality Scorecard: Blue Cross of California

- A decade of quality: scorecards (1994) and bonus payments (1997-1998)
- Scorecard combines: clinical quality measurements, generic prescription performance, administrative service, member satisfaction
- Third year of expanded incentive program
- Added efficiency measure for 2005 based on medical group-specific UM targets
- Total of $66 million in quality and generic pharmacy payments
- 176 of 190 PMG/IPAs on new program
- Alignment with IHA clinical and member satisfaction measures

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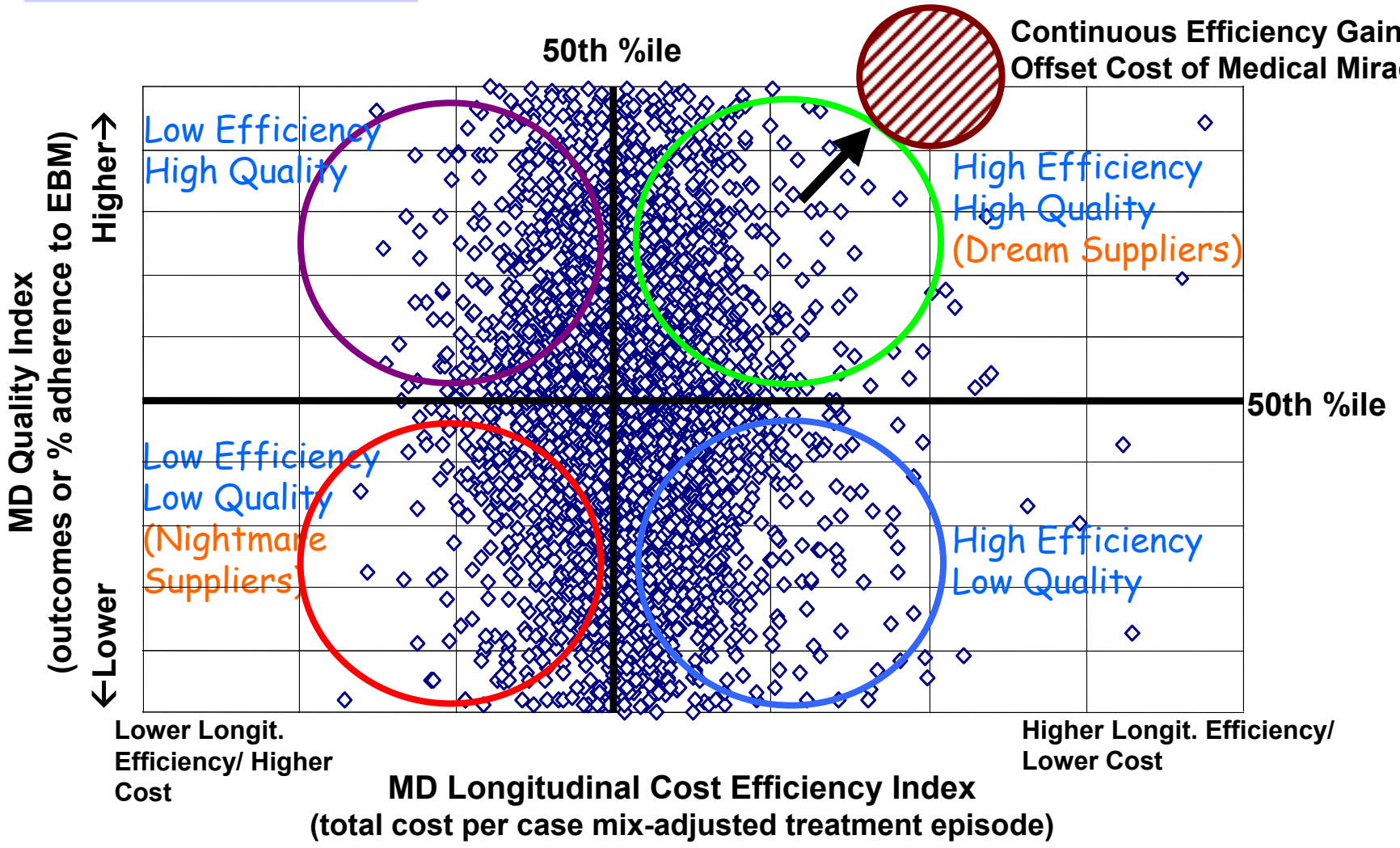
The Perfect Storm for High Performance Network Development

- **Health care quality and safety gaps are significant**
  - RAND: only 55% of care delivered is high quality, error free, scientifically based and includes the recommended treatment
  - Emergence of employer-driven programs to improve quality (e.g. Leapfrog, Bridges to Excellence) and recognize high-quality physicians
- **Efficiency and safety of care varies significantly**
- **High Performance Networks offer a potential solution for high cost**

High Performance Network Opportunities



Source: Arnie Milstein, Mercer

Adapted from Regence BlueShield

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High Performance Networks: Finding the Right Balance

Issues to Consider

- Can HPNs combine quality and efficiency criteria, particularly for high-cost, high-impact specialties?
- Will purchasers embrace long-term value of addressing quality as well as cost?
- What is the best approach where there is insufficient data to determine quality or efficiency?

The Way Forward

- Measurable, meaningful quality criteria must be developed for primary care and specialty physicians
- Develop methodology that reflects optimal care
- Programs should be designed to enhance physician relationships
- Involve key physicians, hospitals and national specialty societies
- Programs should be developed around “raising the bar” – supporting initiatives to make all physicians/hospitals higher quality and more efficient

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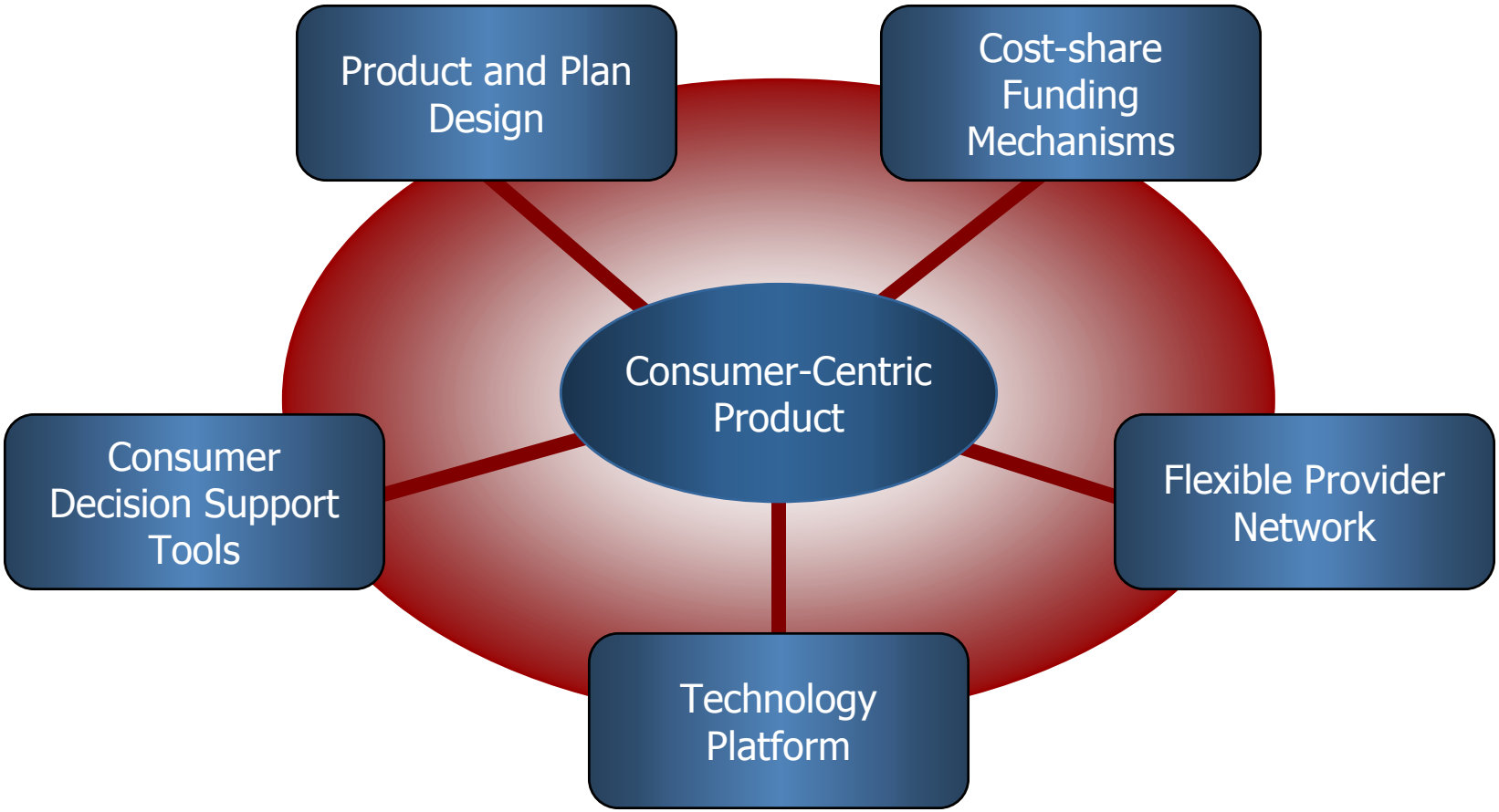
New Market-Driven Model Centers on Consumer-Driven Health Care Products



Preliminary Evidence for Consumer-Driven Health Plans is Promising

- **McKinsey & Company conducted a primary research study of more than 2,500 adult Americans with varying types of commercial health coverage.**
- **The study included more than 1,000 consumers with employer-based, full-replacement CDHPs, as well as a control group that carried traditional insurance.**
- **Among the self-reported findings, CDHP consumers were:**
  - > 50 percent more likely to ask about cost
  - Three times more likely to have selected a less extensive, less expensive treatment during the past 12 months (including those with chronic conditions)
  - 25 percent more likely to engage in healthy behaviors
  - > 30 percent more likely to get an annual check-up
  - > 20 percent more likely to follow treatment regimens for chronic conditions very carefully
  - Twice as likely to inquire about drug costs

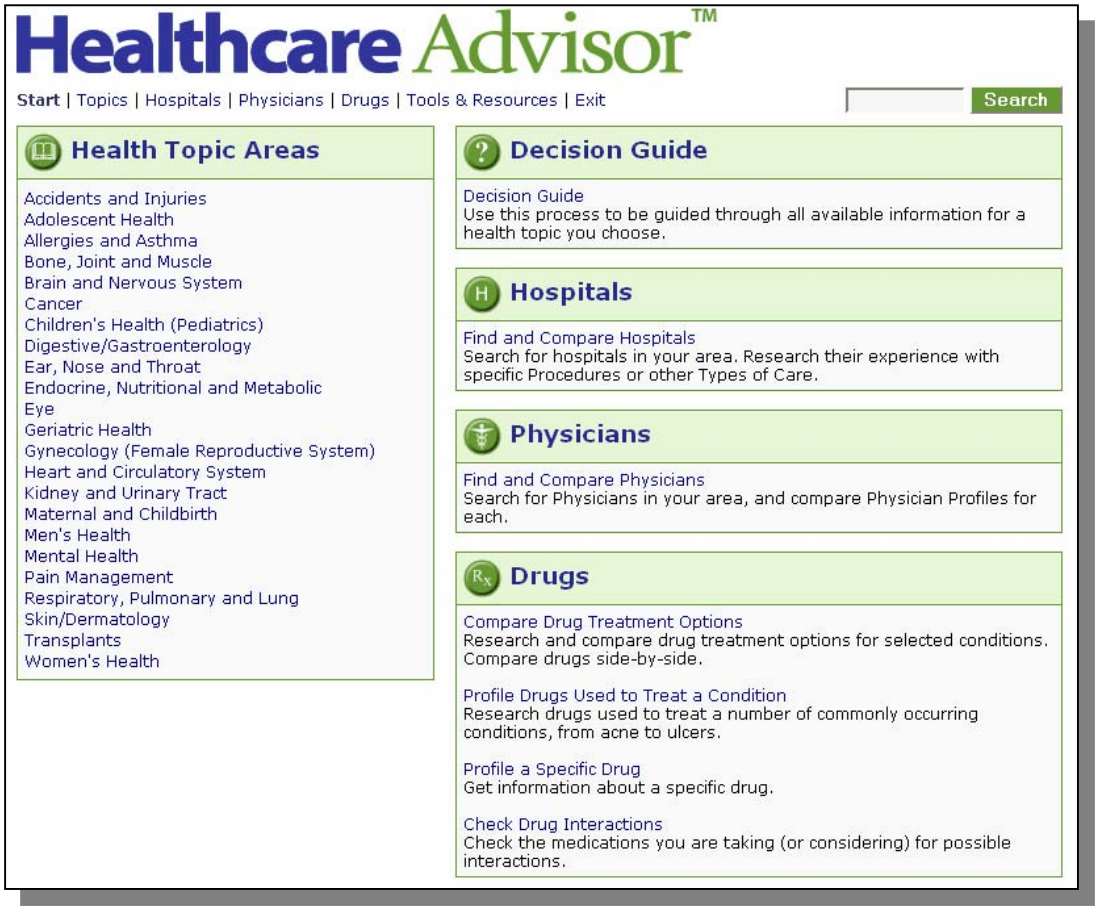
Is CDHP Having an Impact?

- **Reduction in pharmacy costs – 15%**
- **Increased generic substitution rate – 92%**
- **Increase in preventive care spend**
  - 5% of total medical expenses represent preventive care expenditures compared with 2 to 3% market average
- **Reduction in outpatient visits – 18%**
- **Lower cost trend – 30 to 40% reduction in year-over-year cost trend**
- **Customers report health- and cost-related behavior changes since joining Lumenos***
  - 44% report increased knowledge about managing their health care
  - 27% report they are more involved in health-related behaviors. Among those respondents:
    - 77% report improved diet/nutrition
    - 71% report increased exercise

** Source: Lumenos Customer Satisfaction Survey, 2004*

Transparency and Consumer Empowerment: Decision Tools Enable Quality Comparisons

- **User-friendly data and information**
- **Research more than 150 different medical conditions and procedures**
- **Compare hospital quality**



Side-by-Side Comparisons with Healthcare Advisor

- Clinical outcomes
- Patient safety
- Hospital reputation
- Market-specific studies
- Hospital comments

Healthcare Advisor™

Start | Topics | Hospitals | Physicians | Drugs | Tools & Resources | Exit

Search

Topic: Coronary Artery Bypass Graft Surgery (Heart Bypass)

Topic Home
What You Should Know
Find and Compare Hospitals:
> Choose Comparison Topic
> Select Factors Important to You
> Input Search Radius
> View Search Results
> **Profile and Compare: Summary Report**
> Profile and Compare: Detailed Report
Find and Compare Physicians
Questions to Ask Your Doctor
Questions to Ask Your Insurance Company
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...Resources
...cyclopedia
...pics:
...lerosis (Hardening ...teries)
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...Catheterization ...iocardiography ...sty (PTCA) and
...ost-Surgical ... (at home)

Find and Compare Hospitals: Profile and Compare: Summary Report

Comparison Topic: Coronary Artery Bypass Graft Surgery (Heart Bypass)

Here is a summary report of information for the hospitals you selected. Click on factor names for more detailed explanations of the factors and why they might be important to consider.

How Well Hospital Matches Your Selected Factors

	UCLA MEDICAL CENTER	CEDARS-SINAI MEDICAL CENTER	SANTA MONICA UCLA MEDICAL CENTER
Match Score	100	98	95
Distance from ZIP 90210	3 mile(s)	2 mile(s)	6 mile(s)

Your Selected Factors

Coronary Artery Bypass Graft Surgery (Heart Bypass): Inpatient

Treated more patients (High Importance)	160	428	56
Had fewer patients with complications (High Importance)	‡	As Expected	As Expected
Had fewer patients with infections (High Importance)	As Expected ‡	Worse than Expected	As Expected

Other Hospital Factors:

Is an accredited (certified) facility (High Importance)	Yes	Yes	Yes
Is a teaching hospital (Medium Importance)	Major Teaching Hospital	Teaching Hospital	No
Has many high technology services	Above Average	Above Average	Above Average

Hospital Clinical Experience and Outcomes for Selected Procedure
Coronary Artery Bypass Graft Surgery (Heart Bypass): Inpatient

	UCLA MEDICAL CENTER	CEDARS-SINAI MEDICAL CENTER	SANTA MONICA UCLA MEDICAL CENTER
Patients Treated in One Year	160	428	56
Severely Ill Patients Treated in One Year	129	352	42
Complication Rate	‡	As Expected	As Expected
Post-Operative Infection Rate	As Expected ‡	Worse than Expected	As Expected
Mortality Rate	As Expected ‡	As Expected	As Expected
Patient Safety Standard for Procedure Experience	Good Early Stage Effort	Good Progress Toward Standard	Good Early Stage Effort
California Bypass Surgery Reporting Program	As Expected	As Expected	As Expected

P4P: Issues and Observations

- **Claims data gives limited picture of quality**
  - Improved Health IT required
- **Incentives can prompt behavior change and capital investment**
  - Are same doctors rewarded each year?
  - How to influence doctors not improving care?
- **What magnitude of incentive will result in:**
  - Individual behavior change
  - Investment in health IT and workflow
- **Some feel "quality" investments benefit insurers**

Lessons Learned: A Health Plan Perspective

- **Measuring quality improvement helps ensure performance levels are acceptable, guides performance improvement, and allows comparisons across hospitals, medical groups and physicians.**
- **WellPoint experience shows that pay for performance can serve as a powerful incentive for quality performance improvement.**
- **Performance measures should be robust (especially for specialty care), evidence-based, reflect national standards and be meaningful for consumers.**
- **Financial incentives must be structured appropriately to effect behavior change (for example, 10% differential for physicians versus 2% to 4% for hospitals).**
- **Effective pay-for-performance programs must be based on collaboration and have sufficient flexibility to evolve over time.**

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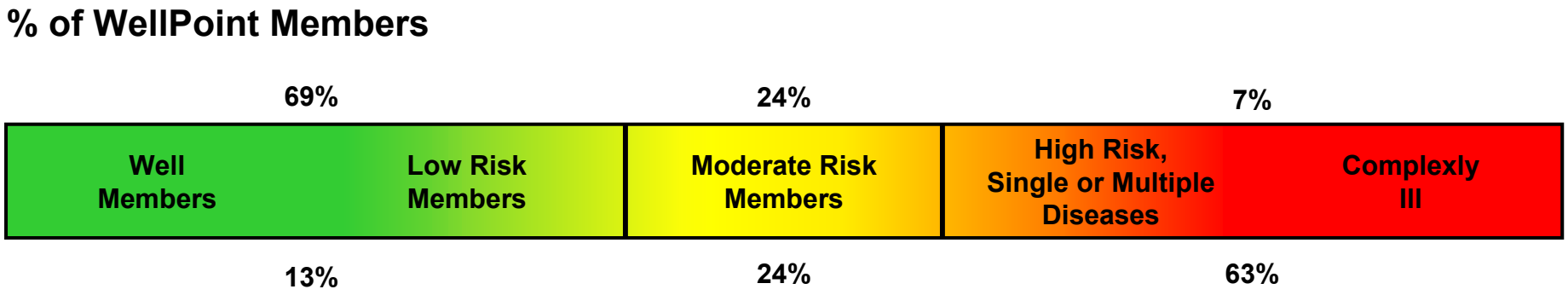
Next Generation of WellPoint Programs

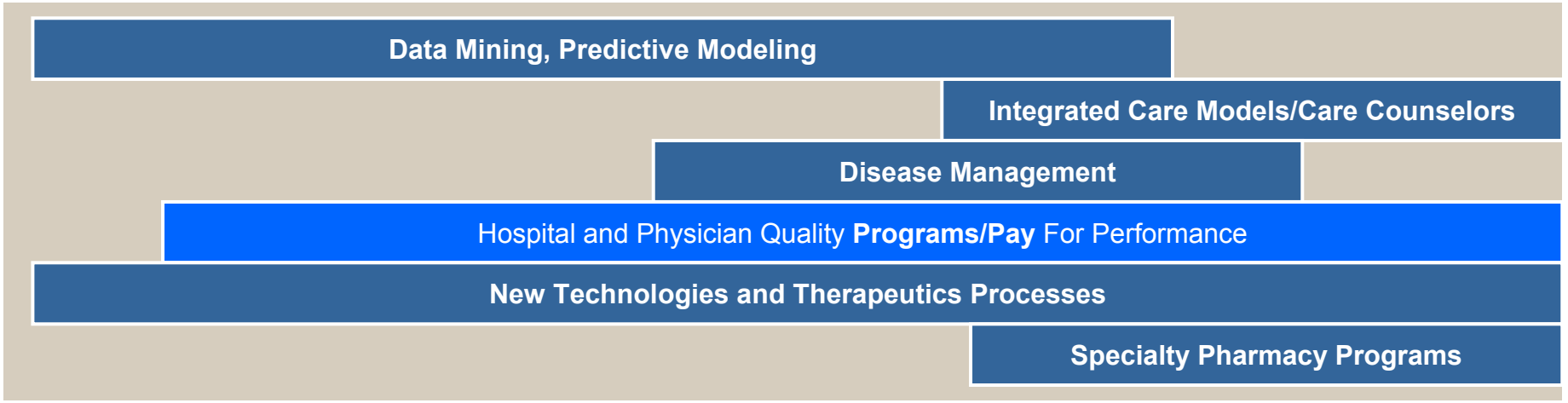
- **Web-based performance profiles**
  - Provide “real-time” information to physicians
  - Provide patient-specific information to physicians
- **Reward quality improvement, not just high quality providers**
- **Expand programs to more hospitals and physicians**
- **Greater focus on efficiency measures**
- **Give members performance information**
- **Encourage members to use “high performers”**

Return On Investment (ROI)

- **ROI must be proven, but will take time**
- **ROI depends on:**
  - Widespread change in behavior and practice
  - Developing networks based on provider performance
  - IT investment in infrastructure
  - Patient and physician satisfaction
  - Longer-term assessment of reduction in medical illness burden
- **ROI for P4P linked to other care management strategies**

P4P: Integrated with Medical Management





Moving Forward: Industry Challenges

- HMO versus PPO product designs
- Role of specialists when performance measures are not as well developed
- Different programs (CMS, health plans) and common metrics (NQF, specialty societies, employer coalitions)
- Administrative data versus chart abstraction
- Will information be used wisely (i.e., tiered hospital contracting versus centers of excellence)?
- Should data be reported at the physician or group level?
- Public reporting, transparency and risk adjustment – easily understood by consumer?

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Moving Forward: Industry Trends

- Expand P4P to PPO and self-insured (ASO) products
- Reward specialist physicians as well as primary care physicians
- Supplement quality metrics with measures that result in positive savings (generic drug substitution, IT adoption)
- Tiered fee schedules instead of annual bonus payments
- Demonstrate Return on Investment (ROI)
- Balanced scorecards combined with increased transparency
- Rising role of CMS as P4P market driver

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Competition vs. Collaboration

- **Competition, market leadership facilitate speed to market**
  - Collaboration can slow implementation
  - Effectiveness of solutions may be diminished

- **Balance required to ensure consistent quality improvement across nation while also facilitating market competition and competitive distinction (i.e., collaborate on framework and measures, but differentiate on reward structures)**

- **Must be mindful of unintended consequences: too much transparency can lead to inequitable contract discussions and ultimately drive up the cost of health care**

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Prerequisites for Healthy Competition

- **Accurate, accessible information about cost and quality**
- **Uniform, transparent quality information available**
- **Stronger connection between provider payments and quality of care delivered**
- **Widespread use of evidence-based clinical practices**
- **Credible methodology for demonstrating return on investment**

Conclusion

- Purchasers want value for their premium dollar
- We must close the quality chasm and reduce variation in health care
- Quality measurement is imperfect; we need consistent standards
- Quality improvement requires multiple strategies beyond P4P, including new reimbursement models
- Leading health plans, coalitions, CMS will continue efforts to align reimbursement with quality