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

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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
# 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

- “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)
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
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.

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

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

Save Lives

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

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

Eliminate Ethnic Disparities

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

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


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**

- Practice Pattern Variation
- Diagnostic Studies
- Redundancy of Tests
- Error Reduction

**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)

<table>
<thead>
<tr>
<th>PCP Programs</th>
<th>Specialist Programs</th>
<th>Hospital Programs</th>
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<tbody>
<tr>
<td>Focused on primary care physicians. Typical major components:</td>
<td>Focused on specialty care physicians. Early initiatives in: Ob/Gyn, Cardiology, Orthopedics. Measures similar to PCP programs:</td>
<td>Focused on acute care hospital, typically full service cardiac facilities. Hospital programs typically have the following components:</td>
</tr>
<tr>
<td>✓ Clinical Outcomes</td>
<td>✓ Clinical Outcomes</td>
<td>✓ Patient Safety</td>
</tr>
<tr>
<td>✓ Evidence-based medical procedures</td>
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<td>✓ Clinical Outcomes</td>
</tr>
<tr>
<td>✓ Generic Prescribing Rates</td>
<td>✓ Generic Prescribing Rates</td>
<td>✓ Patient Satisfaction</td>
</tr>
<tr>
<td>✓ Technology &amp; streamlined administrative processes</td>
<td>✓ Technology &amp; streamlined administrative processes</td>
<td></td>
</tr>
<tr>
<td>✓ Patient Satisfaction</td>
<td>✓ Patient Satisfaction</td>
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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
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
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

<table>
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<tr>
<th>Year</th>
<th>Proportion of rate increase based on clinical quality</th>
<th>Base increase in hospital contract rate</th>
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<tbody>
<tr>
<td>2002</td>
<td></td>
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<td>2003</td>
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<td>2004</td>
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<tr>
<td>2005</td>
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</table>
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

Program Results

- **Patient Satisfaction**
  - Pre-Program: 4.20%
  - Post-Program: 13.20%
  - Post-Program: 98%

- **Mammography**
  - Pre-Program: 4.20%
  - Post-Program: 13.20%
  - Post-Program: 86%

- **Cervical Cancer Screening**
  - Pre-Program: 4.20%
  - Post-Program: 13.20%
  - Post-Program: 100%

- **Postpartum Care**
  - Pre-Program: 4.20%
  - Post-Program: 13.20%
  - Post-Program: 73.30%

- **Hysterectomy**
  - Pre-Program: 4.20%
  - Post-Program: 13.20%
  - Post-Program: 90%

- **Pharmacy Cost Trend**
  - Pre-Program: 4.20%
  - Post-Program: 13.20%

Legend:
- **Pre-Program**
- **Post-Program**
Physician Quality Scorecard: Blue Cross of California

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

- **Consumer-Centric Product**
  - Product and Plan Design
  - Cost-share Funding Mechanisms
  - Consumer Decision Support Tools
  - Technology Platform
  - Flexible Provider Network
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
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.
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

% of WellPoint Members

69%
Well Members

24%
Low Risk Members

7%
Moderate Risk Members

High Risk, Single or Multiple Diseases

Complexly Ill

% of Health Care Costs

13%
13%

24%
24%

63%
63%

Data Mining, Predictive Modeling

Integrated Care Models/Care Counselors

Disease Management

Hospital and Physician Quality Programs/Pay For Performance

New Technologies and Therapeutics Processes

Specialty Pharmacy Programs
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?
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
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
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