Impact of P4P:

Are There Improvements in Cost and Care?

The National Pay for Performance Summit
The Beverly Hilton Hotel
February 15, 2007
Kathleen Curtin
Agenda

- Introduction – The Importance of Improvements
- Examples of Progress in P4P
- P4P Program Assessments Reported to Date
- Challenges Ahead
- Recommendations for the Future
What is P4P?

- Performance Measurement for Providers
- Transparency for Consumers
- Tools for Provider and Patient Improvement
- Electronic Health Records for Providers
- Personal Health Records for Consumers
- Value – based Payment for Providers
- Cost Containment for Consumers
- Aggregate Information and Business Case for Shared Savings for the Healthcare System
P4P is a Driver of Innovation
The Importance of Improvements

- **Do No Harm**
  - Burning Platforms in Care and Cost
    
    Escalating cost, uninsured, quality/safety gaps, public health
  
  - **Add NO cost without improvement**

- **Opportunity for Systematic Innovation**
  - Ineffective payment system
  - Multiple information sources, repositories
  - Limited interoperable digital information
  - Users without useful data at point of care
Progress: Recent Events

- Presidential Executive Order on Quality and Efficiency
- NCQA and AMA are developing specialty measures
- NCQA has proposed efficiency measures
- NQF and AQA are standardizing measures
- CMS P4P Projects: Premier Hospital, Physician Group Practice Demo, AQA Pilot in 5 States
- Laurels
  - Public reporting in California, Mass, Maine, Minn, etc
  - IOM Report calls for Pay for Performance, again
  - Employers require/or deliver performance information
Progress: Program Elements

- Measures – Primary Care and Specialty
- Reporting Measures and Registry by Paper and Web
- Scoring Methods and Incentive Programs
- Physician Engagement
- Commitment to Tools for Improvement
- Alignment with Developing Standards
  - NQF/AQA Quality Measures
  - NCQA Efficiency Measures
- Recognition of the Need to Aggregate Across Payers
Progress: Measurement Principles

• Balance Scorecards
  - Care: Evidenced – based or specialty supported measures
  - Cost: ETG – based measures
  - Patient Experience
  - IT Adoption

• Replicable, Reliable, and Valid
  - Standardization of the measures and reporting rules
  - Analysis of frequency and variation
  - Risk adjust clinical outcome and cost measure

• Feasible
  - Administrative data – Claims, LOINC, Pharmacy, Rad
  - Integration of EMR data

• Actionable
  - Patient detail to practitioners and consumers
## Progress: Statewide Reporting

### MAINE

<table>
<thead>
<tr>
<th>Primary Care Practice</th>
<th>1. Uses SYSTEMS to Manage Patient Information</th>
<th>2. Follows Clinical GUIDELINES</th>
<th>3. MEASURES Results of Patient Care</th>
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Healthcare Value Management 2007

Reporting: Health Plans

Clinical Quality - Baseline Lipid Profile in Those Over 35 With High Risk CVD

Report Period: June 2003 - July 2005
# of Patients Met Goal: 293
Patient Goals: < 130

Patient Profile

Patient Demographic & Benefit Information

- First Name: Kim
- Middle Name: 
- Last Name: Jones
- Sex: F
- Member ID: 4640526
- Primary Tel: (913) 412-4332
- Address 1: 1456 Maple Street
- Address 2: 
- City: Rochester
- State: NY
- Zip: 14617
- Email: Jones@sys.com
- Eligibility: Active
- Eligibility Dates: 2/1/2003

Clinical Measures for this Patient

- Measure Description: 
- Patient_met Goal: 
- Last Encounter: 
- Claim Detail: 

Diagnoses

- Claim #: 
- Description: 
- Date: 
- Condition: 
- Date First: 
- Date Last: 
- Pres: 

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Reporting: Patient Health Records
Assessments Reported to Date

• Large Scale Studies
  - Premier/CMS Hospital Demo
  - Rand Assessment of P4P for Medicare
  - “Rewarding Results” Report to CMS

• Detail from One Case Study
  - Published Improvements in Cost and Care
Premier/CMS Hospital Quality Incentive Demo

- 206 Premier Hospitals, initiated Oct 2003
- Composite quality measures for AMI, CHF, CABG, CAP, Hip/Knee (Total 33)
- Collaborative knowledge transfer
- $8.85 million in incentives with public recognition
- Bonus program
  - 2% - top 10% and 1% - top 10 to 20%
Premier/CMS Hospital Quality Incentive Demo

- Year One Report – Fall 2003 to Fall 2004
- Data final 11/05. Reported 4/06
  - Estimated lives saved – 235 AMIs
  - Significant improvement in all categories (6.6% with 10% in CHF and CAP)
  - Five hospitals in top 20% (NJ, SC, Minn, Okla, Texas)
  - Incentive payments made to 123 hospitals
Rand Assessment of P4P for CMS

- Thorough and comprehensive study reported April 2006
- Reports on:
  - Existing empirical evidence
  - Interviews with 20 programs and 10 groups in CMS PGP P4P demo
  - Survey findings (Med-Vantage, Rosenthal, Leapfrog) on characteristics of current programs
  - Assessment of features critical to Medicare
Rand Findings

- Published evidence is equivocal
  - 15 Studies, 7 with randomized controlled trials with mixed results or no effect

- Interview themes:
  - Foundations - Health care is local and physician engagement is necessary
  - Infrastructure, capital investment is substantial
  - Flexibility is required - Testing, ongoing development, audit and appeal processes
Rand Findings

• Survey themes:
  - 157 programs covering, at least, 50 million lives
  - HMO, POS, PPO, Self insured, Medicare and Medicaid
  - Quality, cost, other measures
  - Variation in Program Characteristics:
    Responsible entity, attribution, risk adjustment, reporting and feedback methods, decision support, payment determination and financing
“Rewarding Results” Invited to CMS

- RWJ grantees reported lessons learned 12/06
- Established P4P Programs
  - Blue Cross of California
  - Blue Cross Blue Shield of Michigan
  - Bridges to Excellence
  - Integrated Healthcare Associates
  - Local Initiative for Rewarding Results
  - Massachusetts Health Quality Partners
  - Excellus Health Plan and Rochester IPA
Highlights of Report to CMS

- BCBS of Michigan Hospitals
  - Improvements in quality measures
    1. AMI measures increased 2-15% points
    2. CHF measures increased 9 to 17% points
    3. CAP measures increased 0 to 5% points
  - Impact on Cash Flow
    1. Reduced hospitalizations lowered hospital net income
    2. Incentive program increased hospital cost
    3. Payer experienced cost savings
Highlights of Report to CMS

- IHA of California
  - Program Status - BIG
    1. YE 2006 is forth year for 7 health plans, 6 million members, 35,000 physicians
    2. Incentive payments of $145 million for 2003 to 2005
    3. Measures of quality, patient experience, HIT adoption
  - Improvements
    1. Clinical improvement ranges from 1 to 10 %, with an average of 5.3%
    2. Increase in HIT adoption ranges from 54% to 200%
    3. Correlation between clinical performance and HIT adoption
       Full HIT credit = Increase in clinical measures of 9% on average
Highlights of Report to CMS

- Massachusetts Health Quality Partners
  - Program Status
    1. 18 health plan/group contracts with incentives ranging from $200 to $2500 per MD and $10K to $2.7 million per group
    2. Clinical measures derived from HEDIS
  - Improvements
    1. All measure improved, with or without P4P
    2. P4P compared to control varied
      Same as control for 21 contracts, 5 less, 4 more
Therefore ..........
Case Study: Rochester, New York

- Partnership between BCBS health plan and IPA
- Health plan enrollment 80% of insured community and IPA 100% of physicians
- P4P Program:
  - Implementation of quality and cost measures
  - Reports with registry to individual primary care and specialty physicians
  - Improvement tools for patients and MD offices
  - Incentive payment averaging 10% of income
Improvements in Acute Care

Overall Exceptions per 1000 Episodes

Episode start month and year


Healthcare Value Management 2007
Improvements in Chronic Care

Healthcare Value Management 2007
Improvements in Chronic Care

• “Control” 1: Same community, competing HMO
  - Identical physician network
  - Other HMO delivers chronic care measurement reports without P4P, registries, reports to patients, POS to MD offices
  - RIPA-Excellus improved more rapidly

• “Control” 2: Excellus HMO in a neighboring city
  - Sister HMO without measurement reports and P4P
  - RIPA-Excellus improved more rapidly

Business Case for P4P

- Actuarial Rolling Trend Analysis
- HMO population in BCBS penetrated community
- Diabetes only, Repeated for CAD
- First published ROI for Physician P4P

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<tr>
<th>Rolling Trend Analysis</th>
<th>2003</th>
<th>2004</th>
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<tr>
<td>Annual Trend Savings</td>
<td>$1,900,000</td>
<td>$2,900,000</td>
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<td>Annual Cost</td>
<td>$1,150,000</td>
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<td>ROI</td>
<td>1.6 : 1</td>
<td>2.5 : 1</td>
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2.5 : 1 ROI
$1,150,000 Annual Cost
$1,900,000 Annual Trend Savings
Physician Engagement

**Reason for Measures is Quality**
- Strongly Agree: 18.1%
- Agree: 44.6%
- Neutral: 12.2%
- Disagree: 19.5%
- Strongly Disagree: 5.6%

**Measures Help MDs Improve**
- Strongly Agree: 19.2%
- Agree: 62.7%
- Neutral: 9.8%
- Disagree: 5.9%

**Comparison to Peers Informative**
- Strongly Agree: 8.3%
- Agree: 66.7%
- Neutral: 15.3%
- Disagree: 8.3%

**Financial Incentives are Effective**
- Strongly Agree: 11.2%
- Agree: 45.6%
- Neutral: 19.5%
- Disagree: 16.7%
- Strongly Disagree: 7.0%

Percent of Respondents (N = 290, Fall 2004)

Source: RWJ Rewarding Results National Evaluation Team, Boston University School of Public Health, Jim Burgess, 7/2005
Physician Engagement

- Stages of Physician Engagement
  - This is worthless
  - This is interesting
  - This may be true but it isn’t important
  - That is exactly my point
Challenges Ahead

- **Measure standardization**
  - NQF offers 49 quality measures
  - Cost measure standardization beginning

- **Integration of multiple payer platforms**

- **Aggregating data to reflect physician office practice and to ensure valid reporting**

- **Accessible, actionable information for both physicians and the community**

- **Shared savings models to finance incentives in a budget neutral environment**
Recommendations for the Future

• Community – wide, all payer data bases
• Interoperable systems, aggregating multi – source data
  - Administrative data: health plan claims, pharmacy, lab/radiology results
  - Physician office EMR, hospital data
  - Survey data: HIT adoption, risk assessment, patient experience
• Business case model for all stakeholders with shared savings for incentives
References


Questions?

Kathleen Curtin
Healthcare Value Management
716 880-0681
kathleenmary.curtin@gmail.com