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Implementing the IOM's Rewarding Provider Performance Report

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Rewarding Provider Performance: Aligning Incentives in Medicare – IOM, September, 2006

Key Messages:

- Current payment system is broken and must be fixed
- PFP must be a key factor, but not a “magic bullet”
- Evidence base for PFP is not robust
- PFP should reward quality, efficiency and “patient-centeredness”
- Transparency requirement
- Promote electronic data collection & systems and standardized measures
- PFP should be phased in by provider via reporting, improvement, and achievement
- Paid w/ existing funds
- PFP should be introduced within a learning system

4 Cornerstones of Value-driven Health Care

- Issued by DHHS Secretary Leavitt
- Responding to President's Executive Order, 8/06

Transparency on Health Care Quality	Transparency on Price
Incentives for Providers/Consumers	HIT Standards

Standardized Measures

- Evidence-based, consensus-driven
- CMS
- AHRQ / NQF
- AQA – 26 starter measures, 8 areas→93 measures
- HQA – 21 measures, 4 areas
- Leapfrog – 30 safe practices
- BTE/NCQA – 25 measures, 3 areas
- ABIM MOC
- MDs, MG/IPAs, Hospitals

Improve Performance & Reduce Variation

- Quality Measures
  - Virtually all measures only address under-use
- Efficiency Measures
  - Required to address over-use and mis-use
  - Required to help mitigate HCC inflation
  - Urgency emphasized by CMS, employers, consumers

Implications for Health Plans

- Velocity
- Standardized Measures
  - Transparency measures
  - Incentive measures
- Quality and Efficiency
- Multiple units of analyses
- Incentives / disincentives
- High-performance networks

Overview of PFP Impact Estimates*

- Rigorous studies of pay-for-performance in health care are few (17 since 1980)
- Overall findings are mixed: many null results even for large dollar amounts
- But in many cases negative findings may be due to short-term nature of analysis, small incentives
- Evidence suggests pay-for-performance can work but also can fail

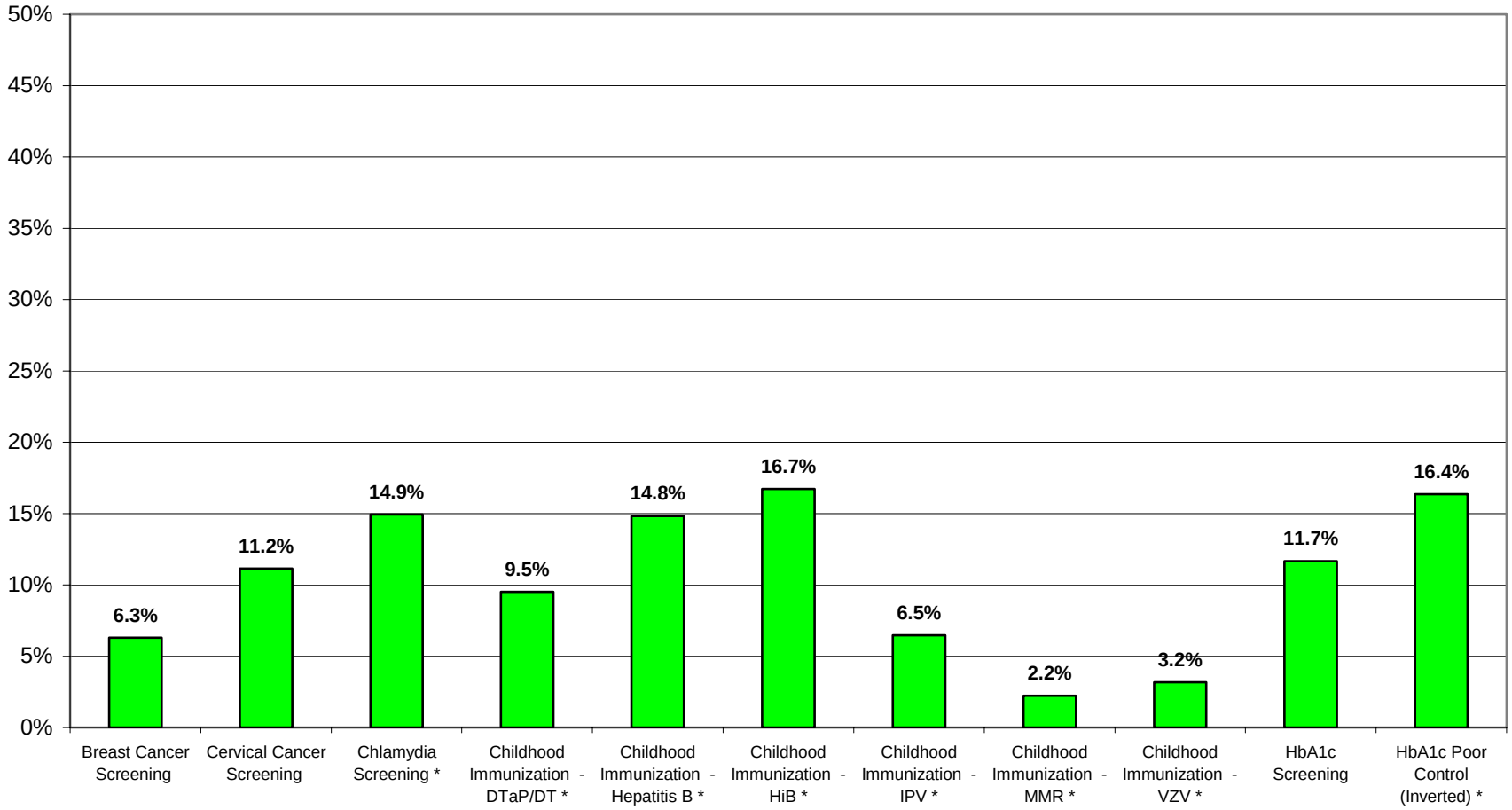
* Research reviewed by M. Rosenthal, PhD, Harvard School of Public Health

California IHA Program Results

- Amongst providers, +10% in IHA clinical measures and +2.7% in PAS since 2003
- Yet 75% of health plan measures < national 50%ile HEDIS
- Incentive payments total over $140 million from 2004-2006
- Single public report card through state agency in 2004/2005 and self-published in 2006
- Successful collaboration amongst purchasers, plans and providers

IHA P4P Clinical Quality Performance

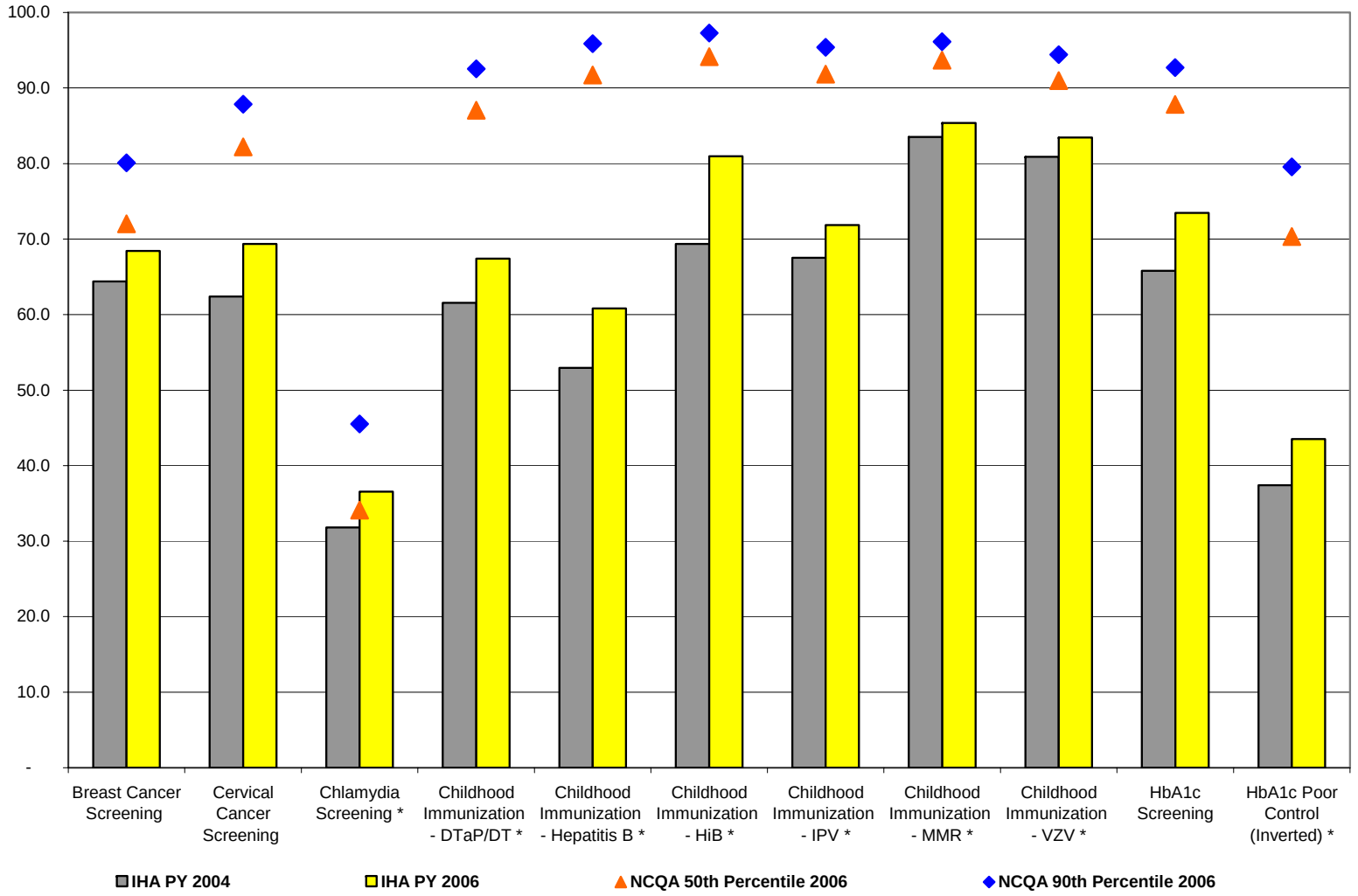
Percent Change from PY 2004 to PY 2006



For Childhood Immunization, Chlamydia Screening and HbA1c Poor Control, the IHA P4P baseline data is from PY2005

IHA P4P Clinical Quality Performance

Trend Analysis Payment Year 2004-2006:
Compared to NCQA 50th and 90th Percentile 2006



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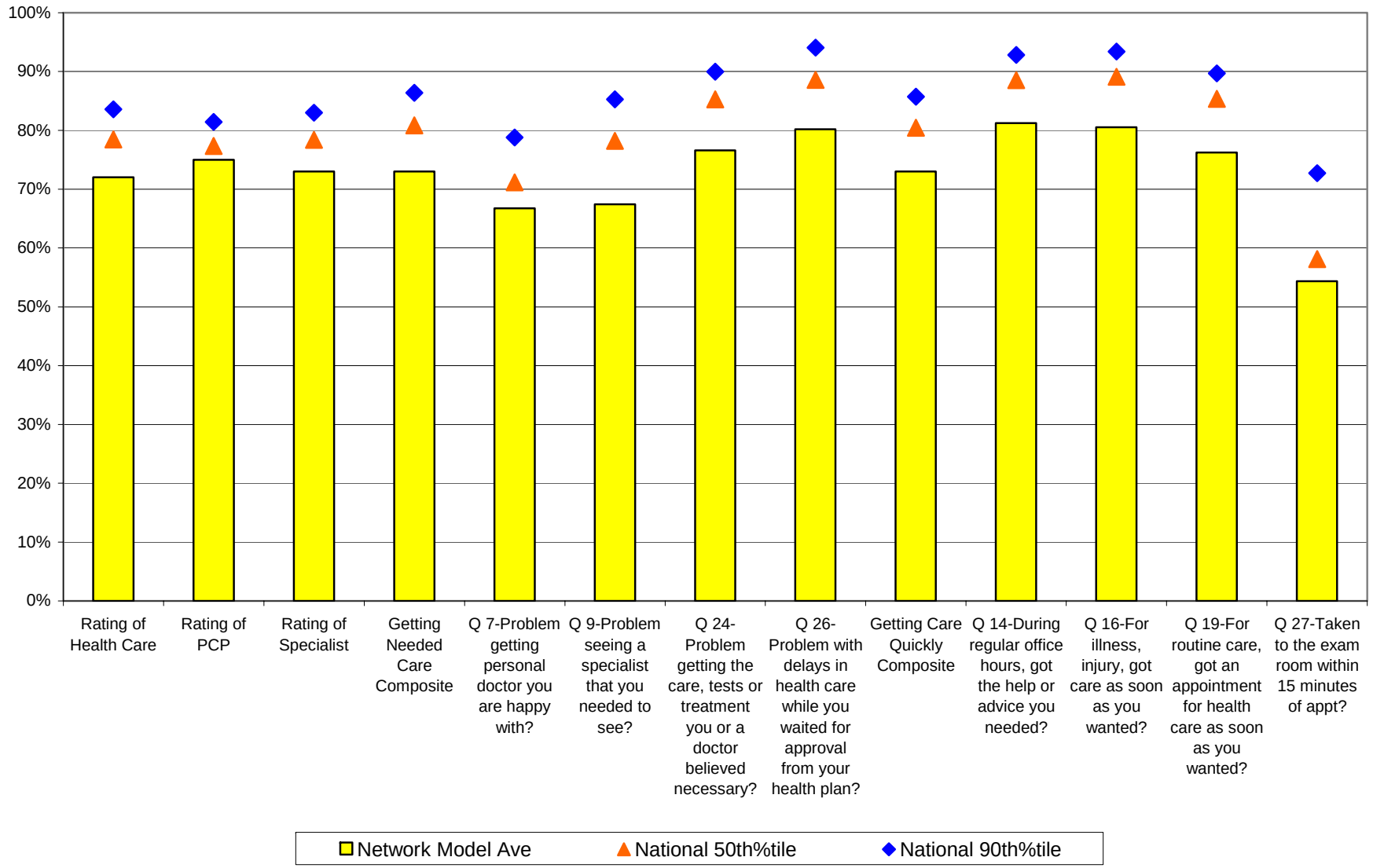
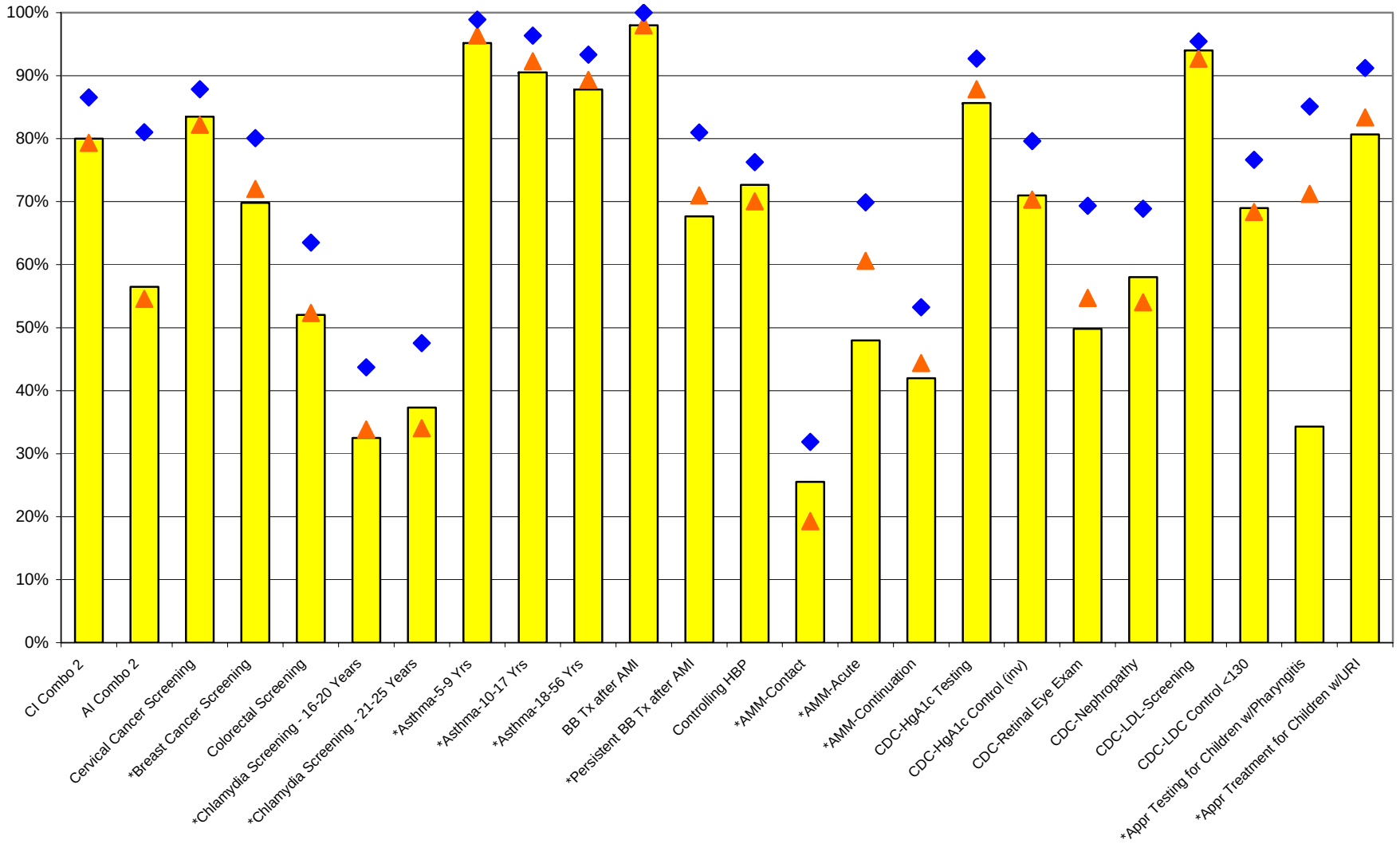
CAHPS 2006

CA Network Model Average versus National Benchmarks



HEDIS 2006

CA Network Model Average versus National Benchmarks

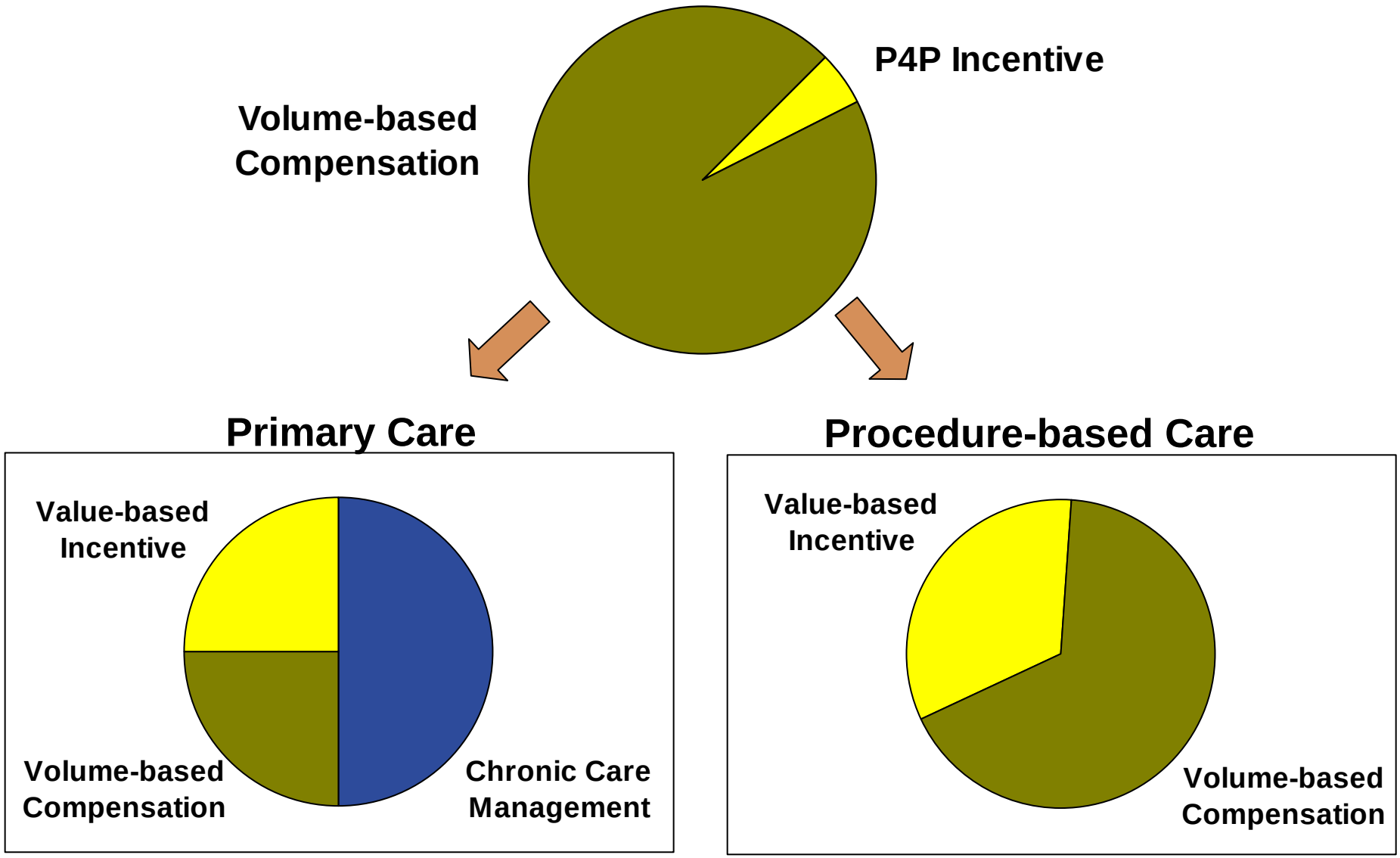


*Based on administrator data only; all others based on hybrid data.

So….Future Incentives / Disincentives for Providers

- Direct incentives
  - IOM health care aims include Quality & Efficiency
  - Rational value demands Quality & Efficiency
  - P4P →→ Value-based contracting w/ incentives and disincentives
  - Increase market share
- Indirect incentives
  - Administrative simplicity
  - Network status

Fundamental Challenges to P4P



Integrating Provider and Consumer Incentives

- Share accountability with consumers, customers, and providers
- Evolve quality incentive programs for providers to value-based compensation
- Consumer report cards to track behavior, choices, and results
- Value-based benefits for consumers
  - Rewards for healthier behaviors, provider choices, and better health outcomes—e.g., preferred Rx, value-priced networks
  - Greater responsibility for their choices and results
- Mirror and expand on auto or property/casualty insurance model

Discussion