Closing Thoughts: The Role of Pay for Performance in the Future of American Healthcare

Ian Morrison

www.ianmorrison.com

Outline

- The Context for P4P
  - Incentives to perform
  - Value in Healthcare
  - The Transformation Agenda
- The 8 P4Ps
- Conclusions

Compensation Philosophy

We pay our CEO, like most CEOs, at the 75th percentile of the market, that way, his income goes up a lot every year. We believe this is in the interests of shareholders because he is very tall and has an impressive head of hair.

At the other extreme, we pay our lowest level employees at the 25th percentile, we never give them a raise, and we cut their health benefits every year. This ensures we make lots of profit to pay for our CEO, and it also sends a powerful signal to the low-level employees that they should have paid more attention in high school.

The Holy Trinity

- Cost
- Quality
- Access
- (Security of Benefits)

Defining Value of Health Services

$$\text{Value} = \frac{(\text{Access}+\text{Quality}+\text{Security})}{\text{Cost}}$$

Strategic
Health
Perspectives

The Five Big Positives

- The Quest for Value: Payers are waking up
- Transparency of Cost and Quality: We have turned the corner and are headed for the sunshine
- HIT: Everybody loves it, but who pays?
- Intelligent Consumer Engagement: Dumb Cost Shifting is not enough
- Pay For Performance: Follow the Money

The Progressive Transformation Story

- Cost and Quality are correlated inversely
- Utilization is not based on need and doesn't create outcomes
- Measurement matters
- Transparency on cost and quality will:
  - Embarrass providers to improve
  - Motivate payers to differentially pay
  - Motivate consumers to change providers
  - Steer business to the high performance providers
  - Do all of the above given enough time
- Re-engineering of delivery system will ensue
- Value gains will make healthcare more affordable and of much higher reliability and quality

The 8 P4Ps

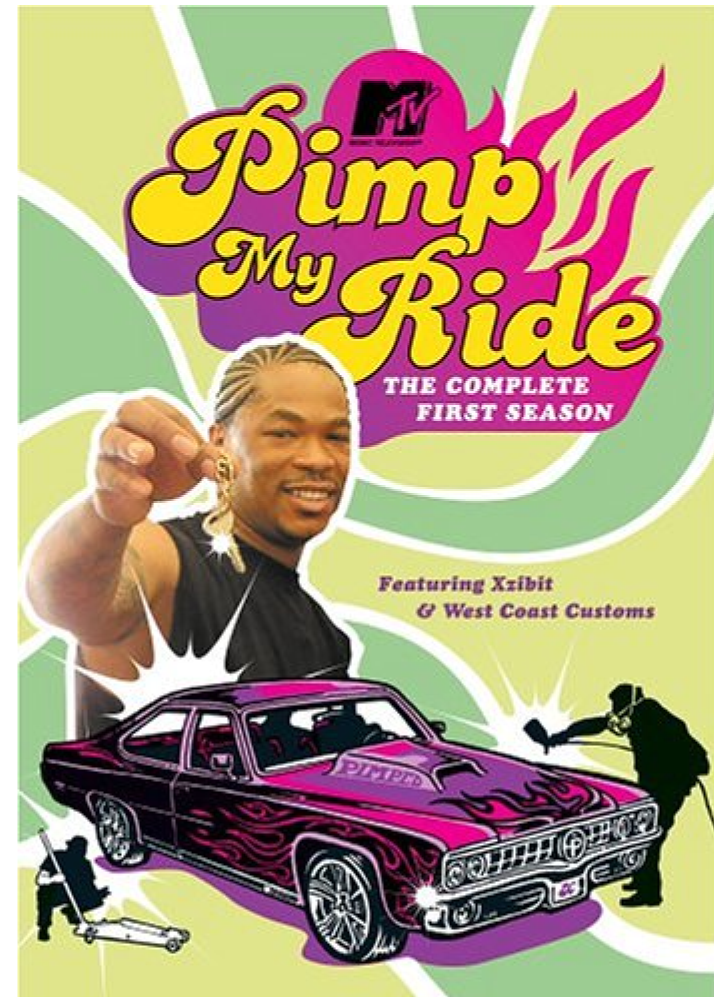
- Pay for Procedures AKA Pimp My Ride Healthcare

The Battle for Quality: IOM versus "Pimp My Ride"

The IOM Vision of Quality:

Charles Schwab meets Nordstrom meets the Mayo Clinic

The Prevailing Vision of Quality in American Healthcare: "Pimp My Ride"



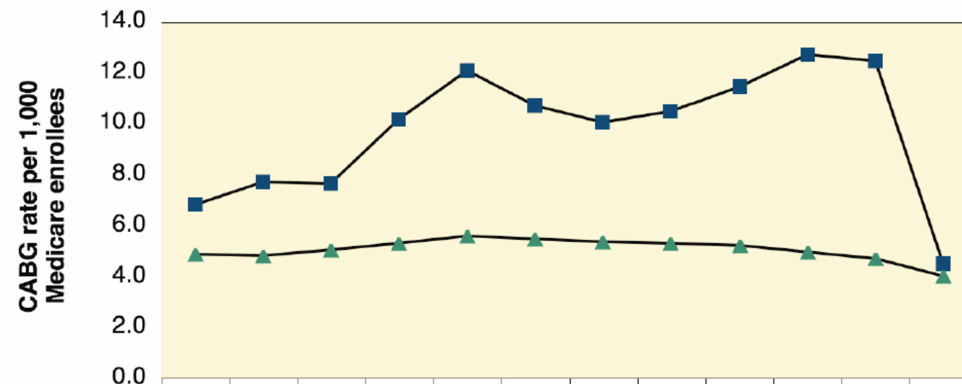
The Battle for Quality: IOM versus “Pimp My Ride”

- Really Bad Chassis
- Unbelievable amounts of high technology on a frame that is tired, old and ineffective
- Huge expense on buildings, machines, drugs, devices, and people at West Coast Custom Healthcare
- People who own the rides are very grateful because they don’t have to pay for it in a high deductible catastrophic coverage world
- It all looks great, has a fantastic sound system, and nice seats but it will break down if you try and drive it anywhere

Strategic
Health
Perspectives

Pimp My Ride in Redding

- Fee-for-service payment rewards:
  - Volume
  - Fragmentation
  - High margin services
  - Growth



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Redding HRR	6.8	7.7	7.7	10.2	12.1	10.7	10.1	10.5	11.5	12.8	12.5	4.5
California average	4.9	4.8	5.1	5.3	5.6	5.5	5.4	5.3	5.2	5.0	4.7	4.0
Number of procedures in excess of CA average	81	123	111	209	278	223	200	227	277	349	352	22
U.S rank in year	27	5	10	1	1	2	2	2	2	1	1	227

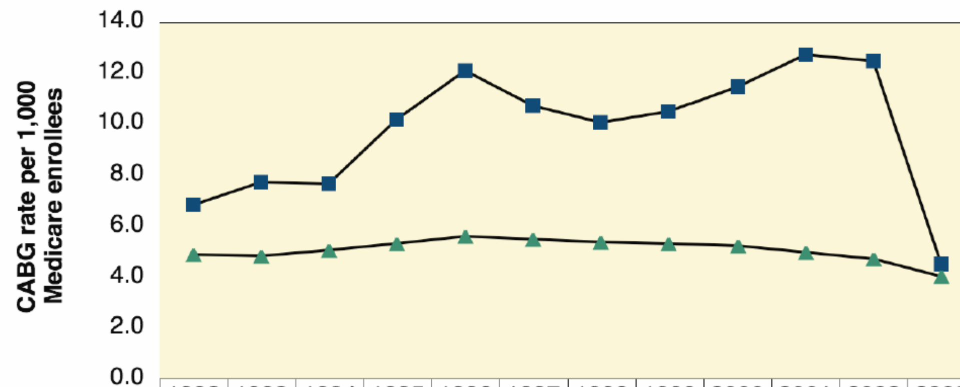
Source: Dartmouthatlas.org courtesy Elliot Fisher MD

Pimp My Ride in Redding

- Fee-for-service payment rewards:
  - Volume
  - Fragmentation
  - High margin services
  - Growth

Clinical Intervention

The FBI Arrived



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Redding HRR	6.8	7.7	7.7	10.2	12.1	10.7	10.1	10.5	11.5	12.8	12.5	4.5
California average	4.9	4.8	5.1	5.3	5.6	5.5	5.4	5.3	5.2	5.0	4.7	4.0
Number of procedures in excess of CA average	81	123	111	209	278	223	200	227	277	349	352	22
U.S rank in year	27	5	10	1	1	2	2	2	2	1	1	227

Source: Dartmouthatlas.org courtesy Elliot Fisher MD

The 8 P4Ps

- Pay for Procedures AKA Pimp My Ride Healthcare
- Pay for Participating

Primary Care Practices with Advanced Information Capacity

Percent reporting seven or more out of 14 functions*

Country	Percent
AUS	72
CAN	8
GER	32
NETH	59
NZ	87
UK	83
US	19

* Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Capacity to Generate List of Patients by Diagnosis

Percent reporting very difficult or cannot generate

Country	Percent
AUS	14
CAN	43
GER	10
NETH	7
NZ	6
UK	1
US	33

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Availability of Data on Clinical Outcomes or Performance

Percent reporting yes:	AUS	CAN	GER	NETH	NZ	UK	US
Patients' clinical outcomes	36	24	71	37	54	78	43
Surveys of patient satisfaction and experiences	29	11	27	16	33	89	48

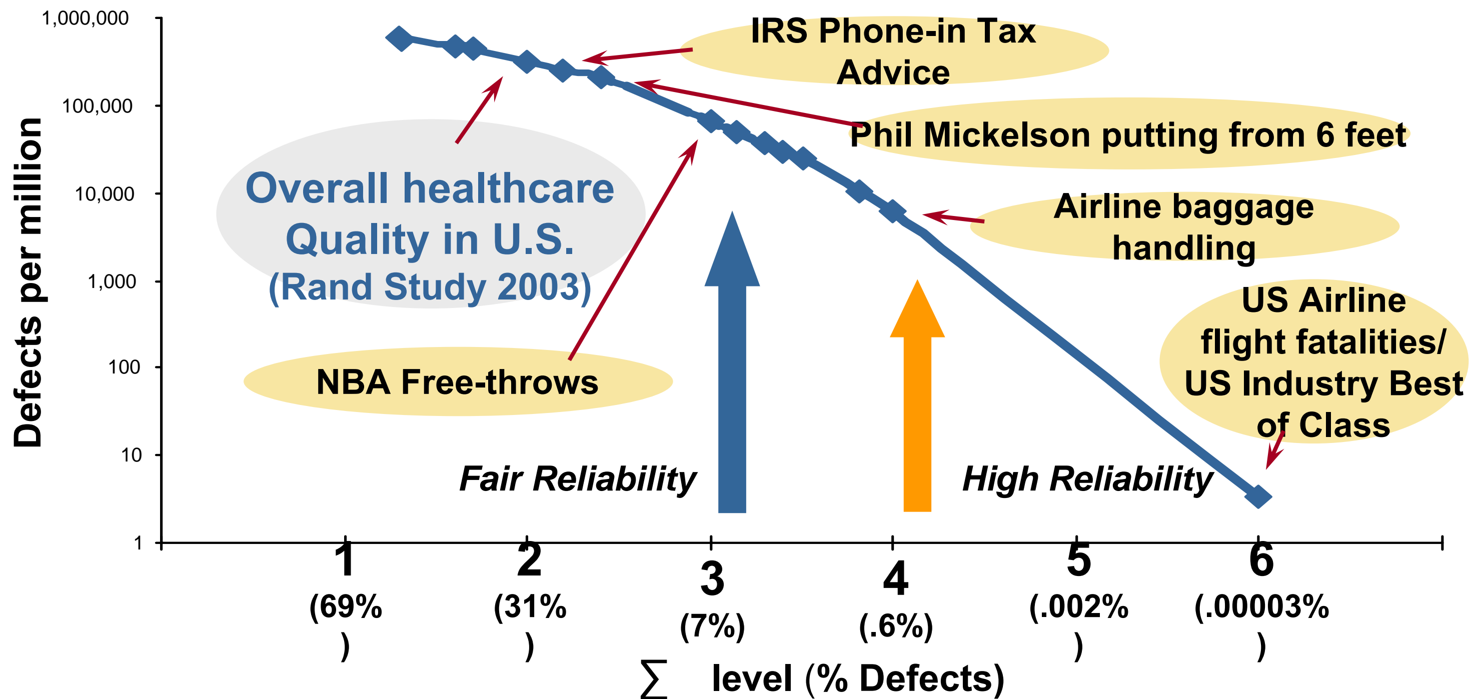
Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Strategic Health Perspectives

The 8 P4Ps

- Pay for Procedures AKA Pimp My Ride Healthcare
- Pay for Participating
- Pay for Perfection

Quality of Care Today: We are Worse than Shaq from the Line

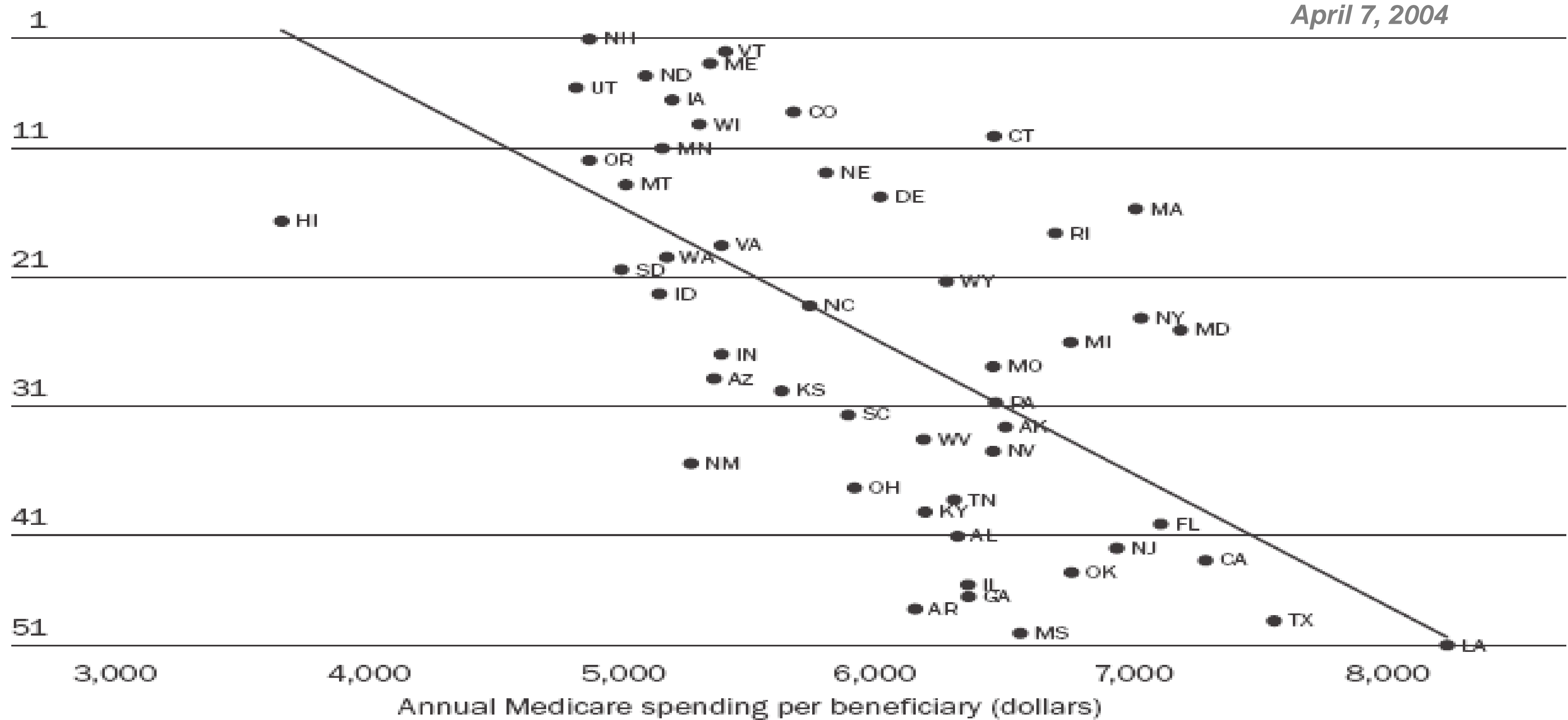


Sources: Courtesy A. Milstein modified from C. Buck, GE; Dr. Sam Nussbaum, Wellpoint; & Mark Sollek, Premera

Quality and Efficiency Vary Widely By State

EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001

Overall quality ranking

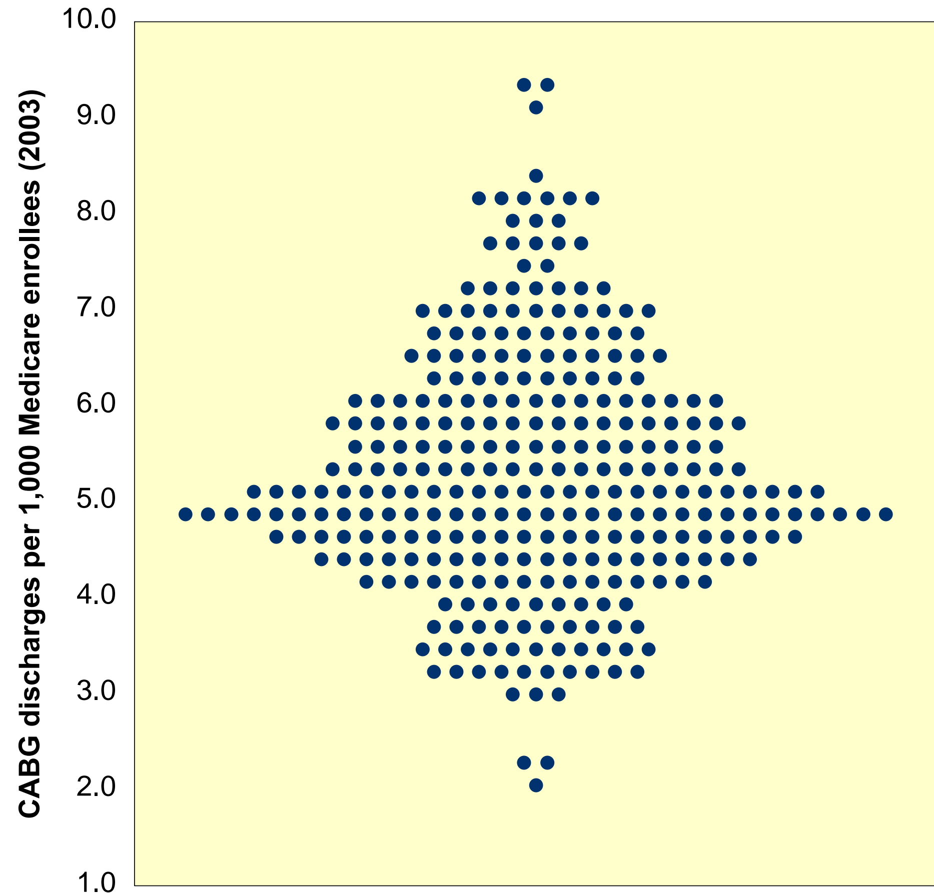


SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.
NOTE: For quality ranking, smaller values equal higher quality.

Enormous Variations in Practice and Spending

Coronary Artery Bypass Graft Surgery

Age-sex-race adjusted rate per 1000 enrollees in 2003

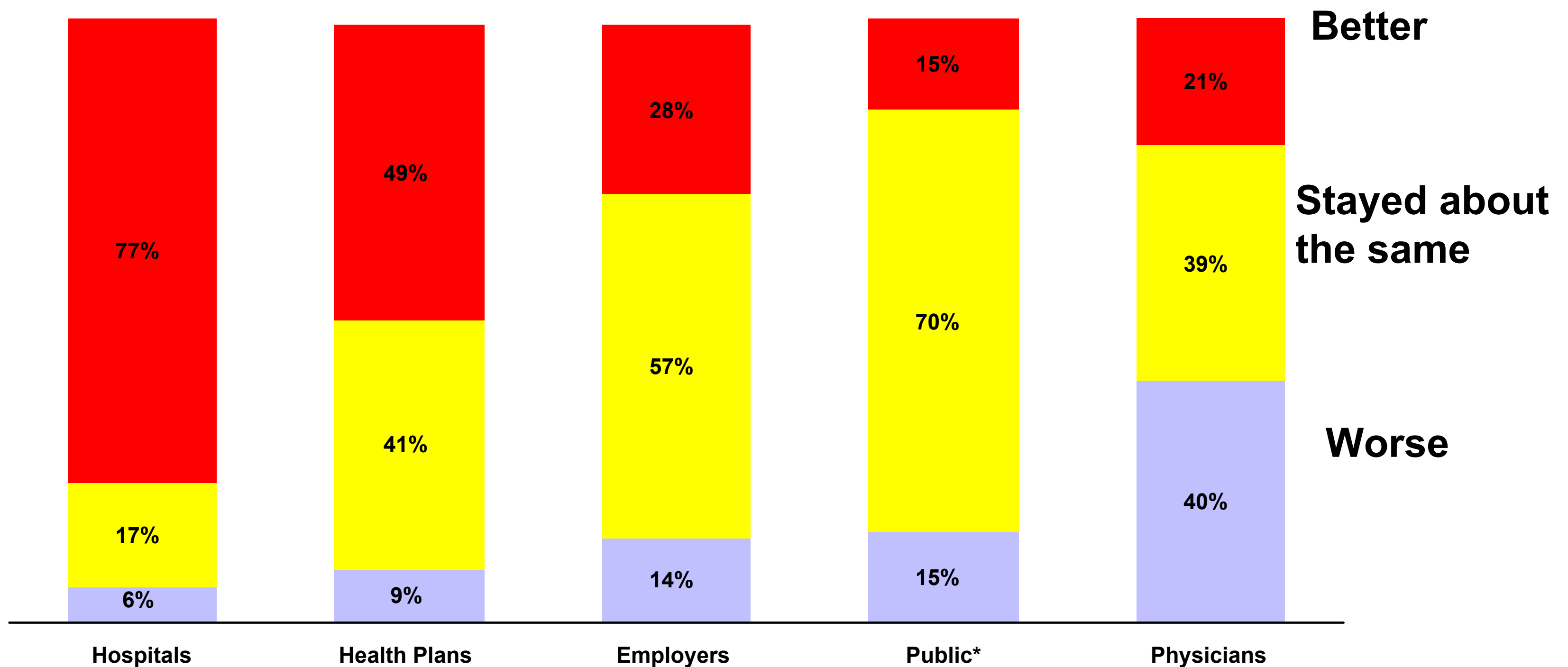


Source: Dartmouthatlas.org courtesy Elliot Fisher MD

Strategic Health Perspectives

If Quality has Improved, Doctors and Patients Have Not Noticed

Has quality of care gotten better or worse in the past 5 years, or has it stayed about the same?



Source: Harris Interactive, Strategic Health Perspectives 2005, 2006
Note: Percentages do not add to 100 because "not sure" answers are not included.

* Has the quality of medical care that you and your family receive gotten better or worse in the last 5 years, or has it stayed about the same?

The 8 P4Ps

- Pay for Procedures AKA Pimp My Ride Healthcare
- Pay for Participating
- Pay for Perfection
- Pay for Progress

Primary Care Doctors' Reports of Financial Incentives Targeted on Quality of Care

Percent receive financial incentive:*	AUS	CAN	GER	NETH	NZ	UK	US
Achieving certain clinical care targets	33	10	9	6	43	92	23
High ratings for patient satisfaction	5	—	5	1	2	52	20
Managing patients with chronic disease/ complex needs	62	37	24	47	68	79	8
Enhanced preventive care activities	53	13	28	18	42	72	12
Participating in quality improvement activities	35	7	21	28	47	82	19

* Receive or have the potential to receive.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Primary Care Doctors' Reports of Any Financial Incentives Targeted on Quality of Care

Percent reporting any financial incentive*

Country	Percent
AUS	72
CAN	41
GER	43
NETH	58
NZ	79
UK	95
US	30

* Receive of have potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or QI activities.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Strategic
Health
Perspectives

The 8 P4Ps

- Pay for Procedures aka Pimp My Ride Healthcare
- Pay for Participating
- Pay for Perfection
- Pay for Progress
- Pay for Persistence

Consumer Responsibility: Arguments For and Against

For

- Consumers insulated from the cost of care
- If they had to pay they would use it less
- If they had to pay they would take more responsibility
- Consumers should have the right to choose
- When consumers choose and pay the market is working

Against

- The 5/55 Problem
- One day in an American hospital and consumers exceed maximum deductible, so
- Catastrophic coverage is a green light for esoterica
- Does it save money overall?
- Poor people with chronic illnesses will be disproportionately affected

Across the board, HDHP consumers have more compliance problems

Treatment compliance problems

	All Privately Insured* %	All HDHP** %
Had a specific medical problem but did not visit a doctor	17	33
Took a medication less often than I should have	14	29
Did not fill a prescription	15	28
Did not receive a medical treatment or follow up recommended by a doctor	17	28
Did not get a physical or annual check-up	19	25
Took a lower dose of a prescription than my doctor recommended	15	19

* Currently insured in employer-sponsored or self-purchased plan
** Currently enrolled in high deductible health plan

Out-of-Pocket Medical Costs in the Past Year

Percent

	AUS	CAN	NZ	UK	US
No out-of-pocket cost	10	22	7	57	11
More than US $1,000	14	12	5	4	26

2004 Commonwealth Fund International Health Policy Survey

Cost-Related Access Problems

Percent in the past year who due to cost:	AUS	CAN	NZ	UK	US
Did not fill prescription or skipped doses	12	9	11	4	22
Had a medical problem but did not visit doctor	17	6	28	4	29
Skipped test, treatment or follow-up	18	8	20	2	27
Percent who said yes to at least one of the above	29	17	34	9	40

2004 Commonwealth Fund International Health Policy Survey

Strategic Health Perspectives

Going without Needed Care Due to Costs, Total and Low Income

Percent went without care due to cost

	AUS	CAN	NZ	UK	US
All Adults	29	17	34	9	40
Adults with Below Average Incomes	35	26	44	12	57

2004 Commonwealth Fund International Health Policy Survey

The Good, the Bad and the Ugly of Non-Compliance

- The Good: Unnecessary care is foregone
- The Bad: You don’t take the Lipitor and it hurts in the long run
- The Ugly: You don’t take the asthma medication you go to the ER

HDHP Consumers, Including Those with HSAs and HRAs, are More Non-compliant Because of Cost

In the past 12 months, was there a time when, because of cost, you…

	Other Privately insured* %	HDHP** %	HDHP with accounts %
Did not fill a prescription	13	28	27
Had a specific medical problem but did not visit a doctor	15	37	37
Did not receive a medical test, treatment or f/u that was recommended by a doctor	13	29	28
Took a medication less often than your doctor recommended	12	23	17
Took a lower dose of a prescription medication than what your doctor recommended	8	14	12

* Currently insured in employer-sponsored or self-purchased plan (not high deductible)
** Currently enrolled in high deductible health plan

Source: Harris Interactive, Strategic Health Perspectives 2005

Rx Non-compliance Rates Among HDHP Consumers with Chronic Medical Conditions are Troubling

Did not fill a prescription medication because of cost for the following conditions	Other Privately Insured* %	HDHP** %
All	13	28
Diabetes (n=31, 71)	15	24
Depression (n=69, 96)	9	30
Arthritis (n=85, 229)	9	16
Chronic Pain (n=60, 156)	9	23
Heart Disease/Hypertension (n=129, 295)	8	18
Allergies (n=140, 374)	7	23
Asthma (n=51, 135)	9	23
High cholesterol (n=131, 274)	2	16
Other chronic condition (n=96, 234)	17	25

* Currently insured in employer-sponsored or self-purchased plan (not high deductible)
** Currently enrolled in high deductible health plan

Source: Harris Interactive, Strategic Health Perspectives 2005

Morrison's Modest Proposal for True Consumer Directed Healthcare

Catastrophic coverage (premium sharing based on income)

Catastrophic Coverage with a $10,000 Deductible

Sliding scale of co-insurance from 0% at zero income to 100% at $250,000 of income and above (all paid with after tax dollars)

Co-Insurance Zone based on Income

First Dollar coverage of preventive benefits for all including chronic care medications

PREVENTIVE CARE

- Consumer education
- Chronic disease management
- Health promotion
- Online tools
- Telephonic support

EDUCATION & DECISION-SUPPORT TOOLS

Source: Ian Morrison 2007©

Strategic Health Perspectives

Consumer Use of Quality Ratings Remains Low

Seen information that rates...				Considered a change based on these ratings		Actually made a change
Hospitals	**2001**	**22%**	➡	**4%**	➡	**2%**
	2006	**21%**	➡	**3%**	➡	**1%**
Health plans	**2001**	**18%**	➡	**4%**	➡	**<1%**
	2006	**23%**	➡	**4%**	➡	**1%**
Physicians	**2001**	**13%**	➡	**2%**	➡	**<1%**
	2006	**15%**	➡	**1%**	➡	**1%**

Source: Harris Interactive, Strategic Health Perspectives 2001-2006

The 8 P4Ps

- Pay for Procedures aka Pimp My Ride Healthcare
- Pay for Participating
- Pay for Perfection
- Pay for Progress
- Pay for Persistence
- Pay for Prometheus

Transformation in Reimbursement is the Goal

2007	2017
Pay for Procedures	Pay for Procedures
FFS	FFS
DRG	DRG
Pay per Episode	Pay per Episode
Prometheus	Prometheus
Capitation	Capitation
Daughter of Capitation	Daughter of Capitation
Pay for Nothing to do	Pay for Nothing to do

Source: Ian Morrison,2007©

The 8 P4Ps

- Pay for Procedures aka Pimp My Ride Healthcare
- Pay for Participating
- Pay for Perfection
- Pay for Progress
- Pay for Persistence
- Pay for Prometheus
- Pay for Prevention

We are not as Healthy as the English

"The US population in late middle age is less healthy than the equivalent British population for diabetes, hypertension, heart disease, myocardial infarction, stroke, lung disease, and cancer. Within each country, there exists a pronounced negative socioeconomic status (SES) gradient with self-reported disease so that health disparities are largest at the bottom of the education or income variants of the SES hierarchy. This conclusion is generally robust to control for a standard set of behavioral risk factors, including smoking, overweight, obesity, and alcohol drinking, which explain very little of these health differences. These differences between countries or across SES groups within each country are not due to biases in self-reported disease because biological markers of disease exhibit exactly the same patterns. To illustrate, among those aged 55 to 64 years, diabetes prevalence is twice as high in the United States and only one fifth of this difference can be explained by a common set of risk factors. Similarly, among middle-aged adults, mean levels of C-reactive protein are 20% higher in the United States compared with England and mean high-density lipoprotein cholesterol levels are 14% lower. These differences are not solely driven by the bottom of the SES distribution. In many diseases, the top of the SES distribution is less healthy in the United States as well."

Banks, J. et al. JAMA 2006;295:2037-2045.

Self-reported Health by Education and Income in England and the United States, Ages 55-64 Years*

Table 3. Self-reported Health by Education and Income in England and the United States, Ages 55-64 Years*

	England				United States			
	Low	Medium	High	Total	Low	Medium	High	Total
Years of Schooling, Percent Distribution								
Diabetes	7.7	6.2	7.4	7.2	13.9†	11.9†	10.6‡	12.5†
Hypertension	37.6	32.9	32.5	35.1	46.0†	40.2†	38.0‡	42.4†
All heart disease	12.2	8.3	7.9	10.1	17.1†	14.9†	11.9	15.1†
Myocardial infarction	4.8	4.0	3.3	4.2	6.7‡	4.2	4.3	5.4‡
Stroke	2.7	2.3	1.8	2.3	4.7†	4.1‡	2.0	3.8†
Lung disease	7.7	5.4	4.3	6.2	10.4†	7.9‡	4.4	8.1†
Cancer	4.9	5.3	6.5	5.4	8.8†	9.7†	10.5†	9.5†
Income, Percent Distribution								
Diabetes	8.1	7.7	6.0	7.2	16.8†	11.4†	9.2†	12.5†
Hypertension	37.9	35.8	31.6	35.1	46.1†	42.8†	38.2†	42.4†
All heart disease	14.3	9.1	6.9	10.1	20.2†	13.1†	12.1†	15.1†
Myocardial infarction	6.7	3.3	2.5	4.2	8.6	4.3	3.3	5.4‡
Stroke	3.5	1.9	1.6	2.3	5.8‡	3.7†	1.8	3.8†
Lung disease	7.6	6.3	4.8	6.2	12.3†	7.0	5.1	8.1†
Cancer	5.7	5.1	5.5	5.4	9.3†	9.8†	9.5†	9.5†

*Adjusted for risk factors so that everyone has same as average US risk factors but coefficients are country specific. Source: English data are from first wave of English Longitudinal Survey of Aging, and US data are from the 2002 wave of the Health and Retirement Survey. See Table 1 for sample sizes and definitions of income and education groups. All data are weighted

†$P<.01$ vs data from England.

‡$P=.05$ vs data from England.

Banks, J. et al. JAMA 2006;295:2037-2045.

Copyright restrictions may apply.

JAMA

The 8 P4Ps

- Pay for Procedures aka Pimp My Ride Healthcare
- Pay for Participating
- Pay for Perfection
- Pay for Progress
- Pay for Persistence
- Pay for Prometheus
- Pay for Prevention
- Pay for Partnership

Conclusions

- P4P is powerful because it affects provider incentives
- P4P can build on the broader positive trends
- P4P is being widely embraced (including CMS)
- P4P now enters the big time with all the scrutiny that entails
- But…..
  - We must make the incentives big enough to matter
  - We must build the infrastructure to measure, manage, and referee the system
  - We must be vigilant that P4P does not amplify disparities
  - We must engage high-tech, procedure oriented specialists
  - We must reward high-performance systems (virtual or actual)
  - We need to implement and sustain the trend not just wander off in pursuit of the next big fad
- P4P has to deliver
- P4P has to evolve