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

Ian Morrison

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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

\[
\text{Value} = \frac{(\text{Access} + \text{Quality} + \text{Security})}{\text{Cost}}
\]
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
Fee-for-service payment rewards:
- Volume
- Fragmentation
- High margin services
- Growth

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

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*

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUS</td>
<td>72</td>
</tr>
<tr>
<td>CAN</td>
<td>8</td>
</tr>
<tr>
<td>GER</td>
<td>32</td>
</tr>
<tr>
<td>NETH</td>
<td>59</td>
</tr>
<tr>
<td>NZ</td>
<td>87</td>
</tr>
<tr>
<td>UK</td>
<td>83</td>
</tr>
<tr>
<td>US</td>
<td>19</td>
</tr>
</tbody>
</table>

* 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

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
### Availability of Data on Clinical Outcomes or Performance

<table>
<thead>
<tr>
<th>Percent reporting yes:</th>
<th>AUS</th>
<th>CAN</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>UK</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ clinical outcomes</td>
<td>36</td>
<td>24</td>
<td>71</td>
<td>37</td>
<td>54</td>
<td>78</td>
<td>43</td>
</tr>
<tr>
<td>Surveys of patient satisfaction and experiences</td>
<td>29</td>
<td>11</td>
<td>27</td>
<td>16</td>
<td>33</td>
<td>89</td>
<td>48</td>
</tr>
</tbody>
</table>

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

Overall healthcare quality in U.S. (Rand Study 2003)

Defects per million

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

1

11

21

31

41

51

Annual Medicare spending per beneficiary (dollars)

3,000  4,000  5,000  6,000  7,000  8,000


Note: For quality ranking, smaller values equal higher quality.
Coronary Artery Bypass Graft Surgery
Age-sex-race adjusted rate per 1000 enrollees in 2003
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

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

* 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*

<table>
<thead>
<tr>
<th>Country</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
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<tr>
<td>NETH</td>
<td>58</td>
</tr>
<tr>
<td>NZ</td>
<td>79</td>
</tr>
<tr>
<td>UK</td>
<td>95</td>
</tr>
<tr>
<td>US</td>
<td>30</td>
</tr>
</tbody>
</table>

* 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.
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

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

* 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

2004 Commonwealth Fund International Health Policy Survey
## Cost-Related Access Problems

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

2004 Commonwealth Fund International Health Policy Survey
All Adults   Adults with Below Average Incomes

AUS CAN NZ UK US

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…

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

* 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**

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

* 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

- 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)
- Catastrophic coverage (premium sharing based on income)
- First Dollar coverage of preventive benefits for all including chronic care medications

Co-Insurance Zone based on Income

- Catastrophic Coverage with a $10,000 Deductible

Preventive Care

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

Education & Decision-Support Tools

Source: Ian Morrison 2007©
Consumer Use of Quality Ratings Remains Low

<table>
<thead>
<tr>
<th></th>
<th>Seen information that rates...</th>
<th>Considered a change based on these ratings</th>
<th>Actually made a change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>22%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>2006</td>
<td>21%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Health plans</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>18%</td>
<td>4%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>2006</td>
<td>23%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Physicians</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>13%</td>
<td>2%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>2006</td>
<td>15%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

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

Comparison between 2007 and 2017:
- **2007**
  - Pay for Nothing to do
  - Pay for Procedures
  - DRG
  - Pay per Episode
  - Prometheus
  - Capitation
  - Daughter of Capitation

- **2017**
  - Pay for Nothing to do
  - Pay for Procedures
  - DRG
  - Pay per Episode
  - Prometheus
  - Capitation
  - Daughter of Capitation

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
“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.”

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*

<table>
<thead>
<tr>
<th></th>
<th>England</th>
<th></th>
<th>United States</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>Total</td>
</tr>
<tr>
<td>Years of Schooling, Percent Distribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>7.7</td>
<td>6.2</td>
<td>7.4</td>
<td>7.2</td>
</tr>
<tr>
<td>Hypertension</td>
<td>37.6</td>
<td>32.9</td>
<td>32.5</td>
<td>35.1</td>
</tr>
<tr>
<td>All heart disease</td>
<td>12.2</td>
<td>8.3</td>
<td>7.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>4.8</td>
<td>4.0</td>
<td>3.3</td>
<td>4.2</td>
</tr>
<tr>
<td>Stroke</td>
<td>2.7</td>
<td>2.3</td>
<td>1.8</td>
<td>2.3</td>
</tr>
<tr>
<td>Lung disease</td>
<td>7.7</td>
<td>5.4</td>
<td>4.3</td>
<td>6.2</td>
</tr>
<tr>
<td>Cancer</td>
<td>4.9</td>
<td>5.3</td>
<td>6.5</td>
<td>5.4</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income, Percent Distribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>8.1</td>
<td>7.7</td>
<td>6.0</td>
<td>7.2</td>
</tr>
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<td>Hypertension</td>
<td>37.9</td>
<td>35.8</td>
<td>31.6</td>
<td>35.1</td>
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<td>3.3</td>
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<td>6.2</td>
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<tr>
<td>Cancer</td>
<td>5.7</td>
<td>5.1</td>
<td>5.5</td>
<td>5.4</td>
</tr>
</tbody>
</table>

*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.
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