P4P: PART OF A LARGER HEALTH REFORM AGENDA

MARGARET E. O'KANE
PRESIDENT, NCQA

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ABOUT TODAY'S DISCUSSION

- **About NCQA**
  - **Physician Recognition Programs**
- **Trends in Pay for Performance**
- **P4P: Part of a Larger Strategy**

NCQA: A BRIEF INTRODUCTION

- **Private, independent non-profit health care quality oversight organization founded in 1990**
- **Mission: To improve the quality of health care**
- **Committed to measurement, transparency and accountability**
- **Unites diverse groups around common goal: improving health care quality**

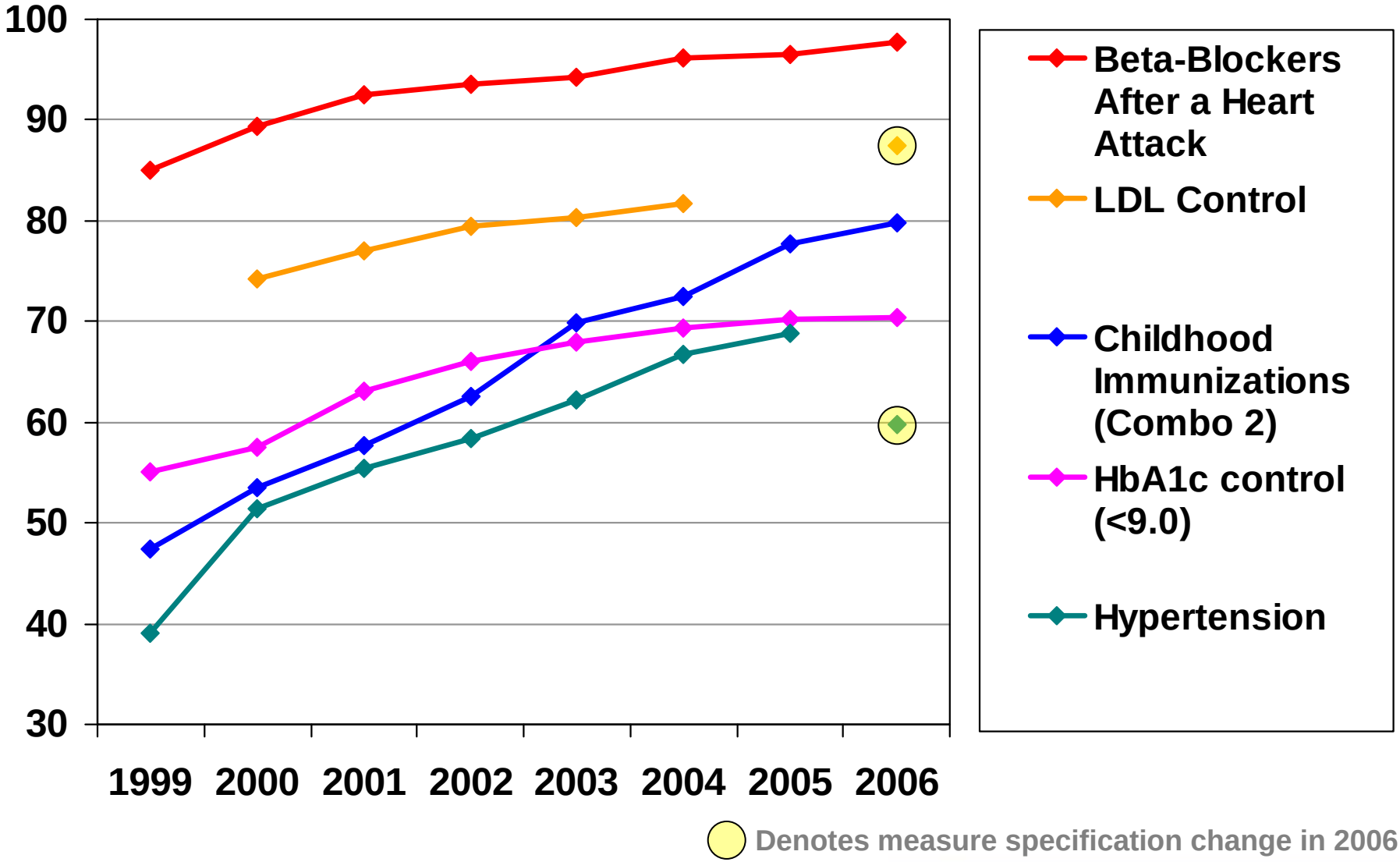
WHAT DOES NCQA MEASURE?

- **HEDIS®**
  - **Cancer screening, diabetes, cardiac care**
  - **Measures of effective, appropriate care**
  - **HEDIS measure criteria: valid, relevant, feasible**
  - **Specifications vetted by committee of health care stakeholders, thought leaders**
  - **Results are rigorously audited**
- **CAHPS®**
  - **Access, timeliness, satisfaction**
  - **Independently collected**

WHAT DOES NCQA MEASURE?

- **Health Plans**
  - **HEDIS and CAHPS quality measurement**
  - **2/3 of HMOs in U.S. are NCQA Accredited**
    - **Covering 75% of HMO lives**
  - **Only Accreditation program that scores programs on quality of care**
  - **2008: NCQA extends many MCO Accreditation requirements to PPOs**
- **Physicians/physician groups**
  - **HEDIS for Physician Measurement**
  - **NCQA Physician Recognition programs**

MEASUREMENT LEADS TO IMPROVEMENT



PHYSICIAN RECOGNITION PROGRAMS

- **Identify providers who deliver superior care**
- **Measure against evidence-based standards**

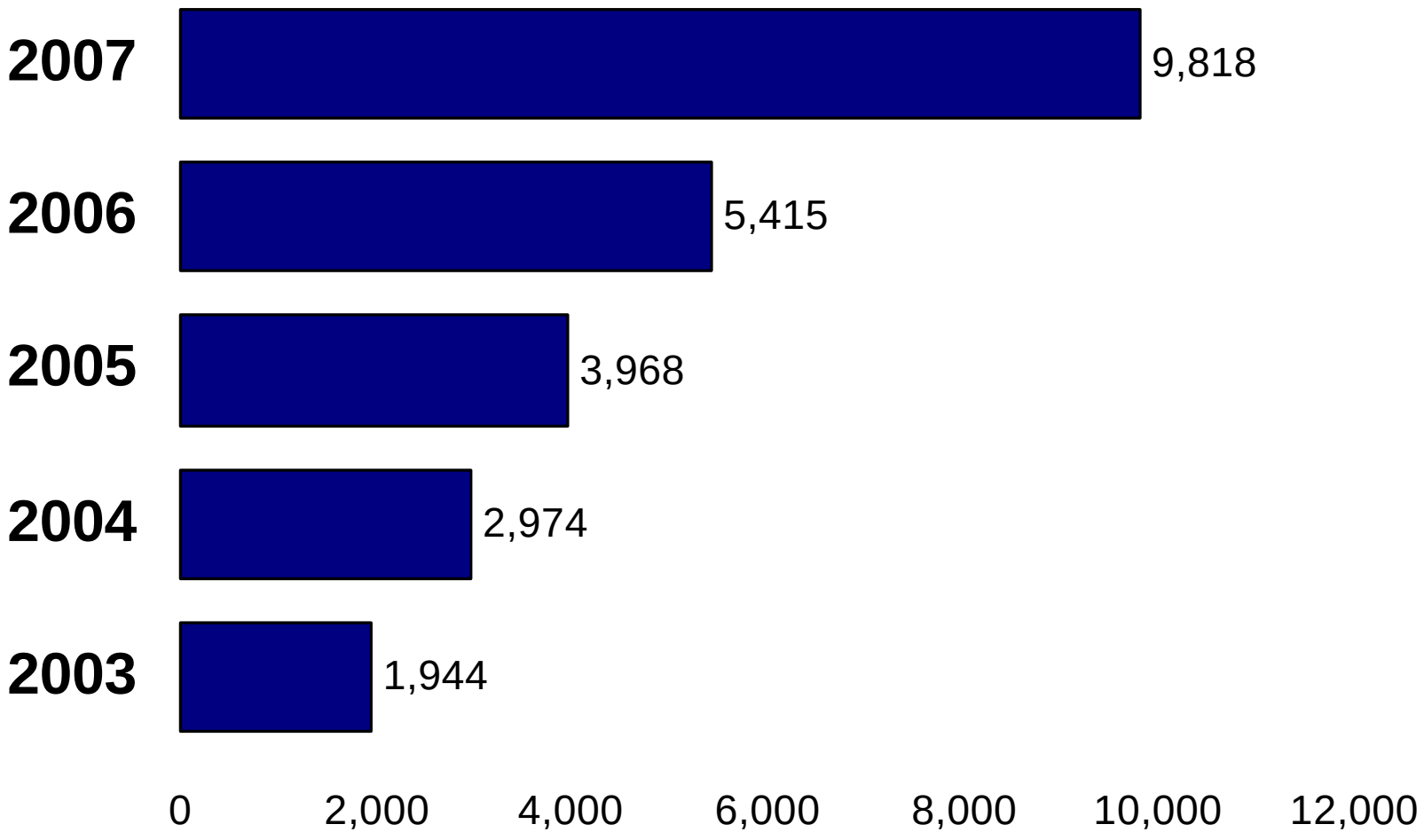
- **Assess care for diabetes, heart/stroke, back pain, care delivery systems**
- **New PPC-PCMH program serves to identify practices as “medical homes”**

IDENTIFYING PATIENT-CENTERED MEDICAL HOMES

Assessing whether practices provide:

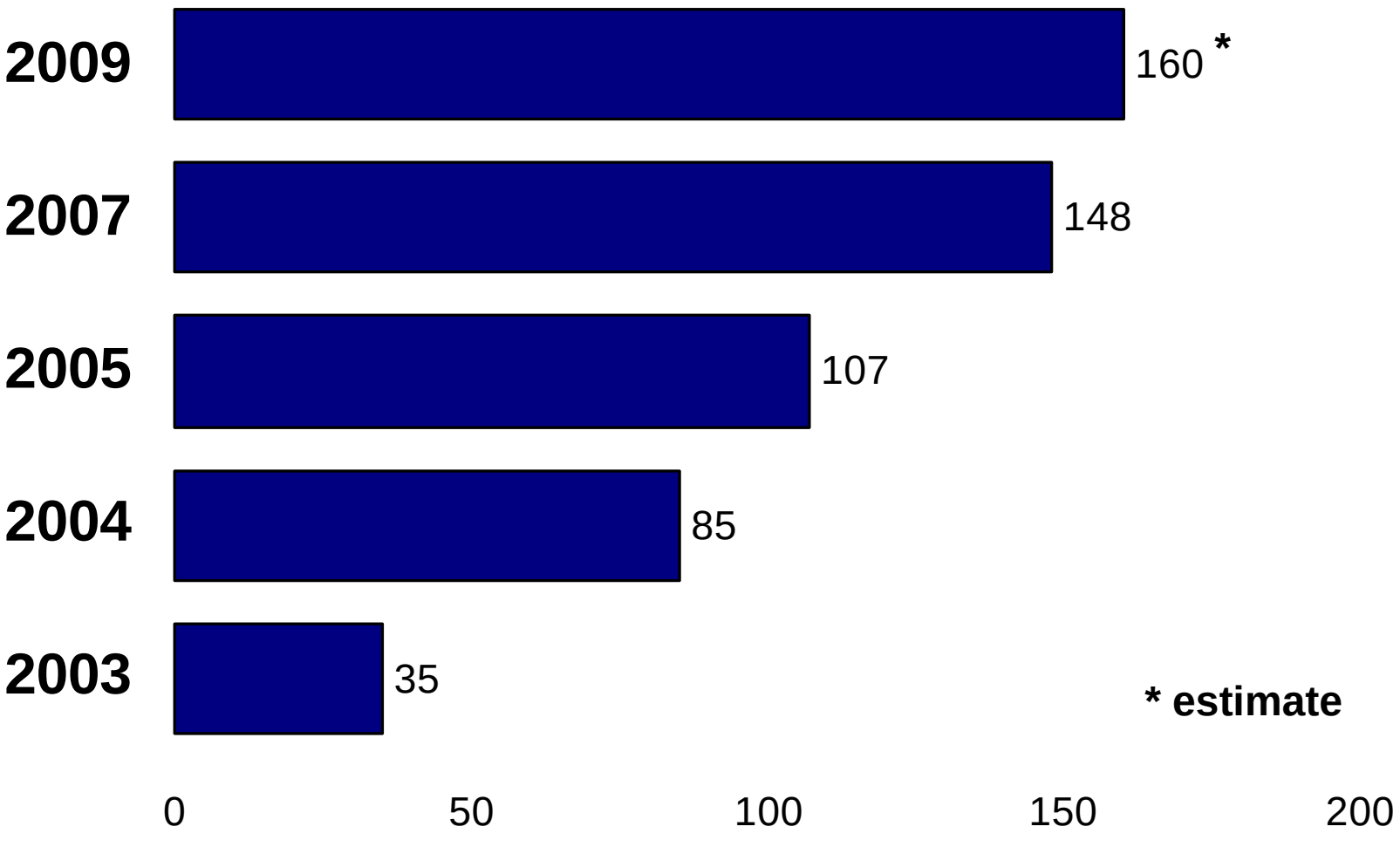
- **Access and communication**
- **Patient tracking and registry functions**
- **Care management**
- **Patient self-management support**
- **Electronic prescribing**
- **Test tracking**
- **Referral tracking**
- **Performance reporting and improvement**
- **Advanced electronic communications**

RECOGNIZED PHYSICIANS, 2003-2007



Active Recognitions as of December 31 of each year.

P4P PROGRAMS GAIN TRACTION



Source: MedVantage

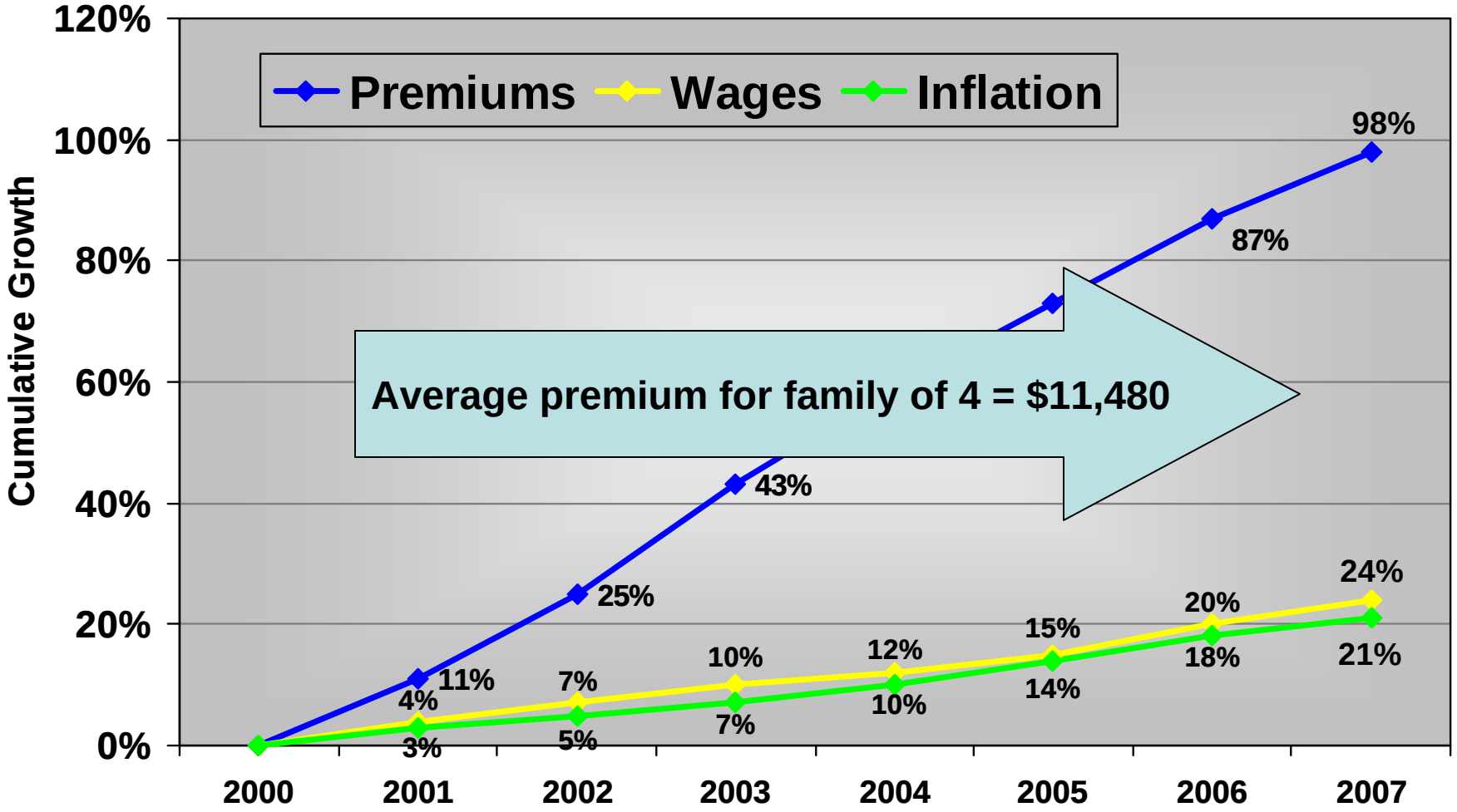
...BUT THEIR IMPACT ON THE SYSTEM ISN'T YET REALIZED

- **Penetration is still limited**
- **Often target primary care**
- **Incentives are not strong compared to underlying payment system**
- **Not a silver bullet!**

A CROSSROADS FOR QUALITY

WE MUST ADDRESS THE COST JUGGERNAUT

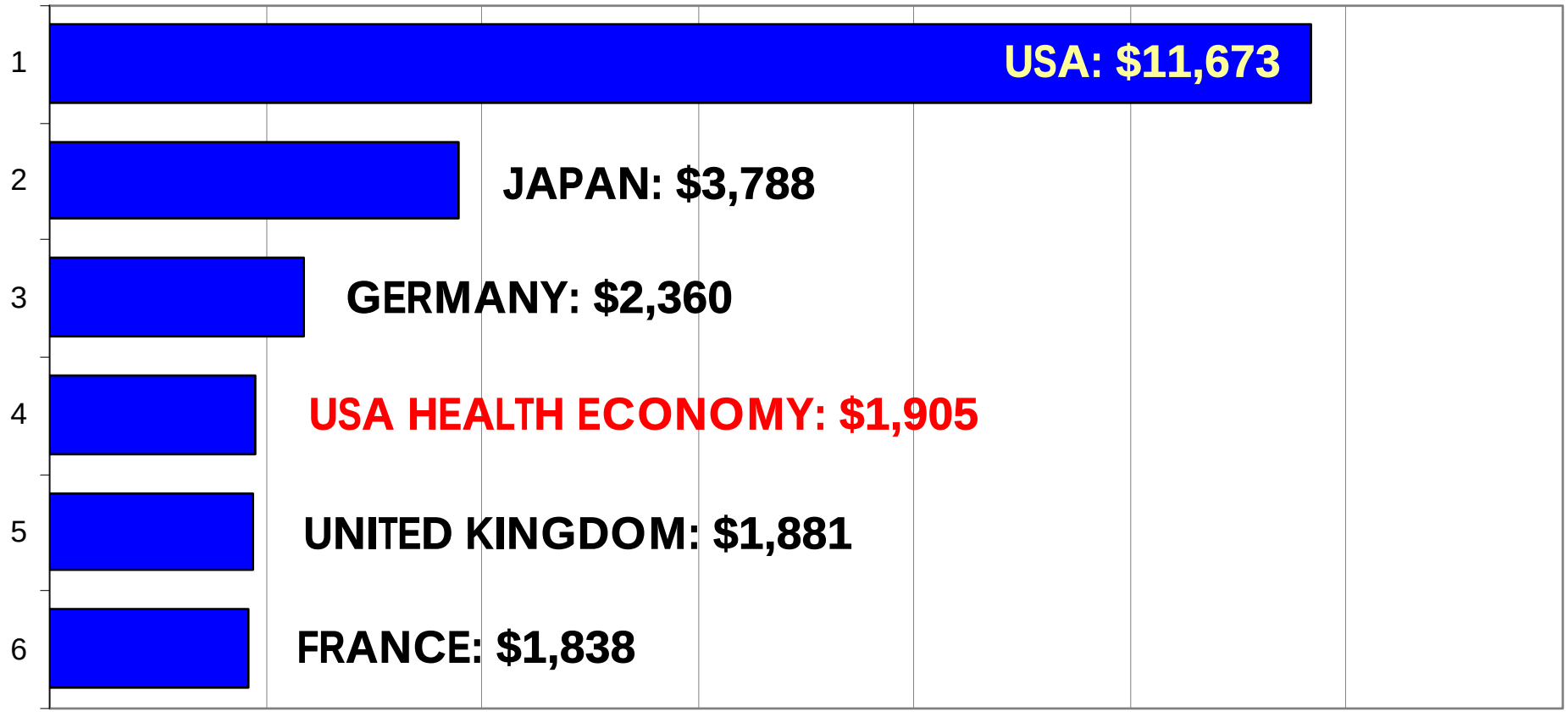
Cumulative Changes in Health Insurance Premiums, Workers' Earnings and Inflation, 2000-2007



Sources: KFF/HRET 2007 Employer Health Benefits Survey, BLS Consumer Price Index

THE WORLD'S SIX LARGEST ECONOMIES

GDP, BILLIONS, 2004



Sources: OECD Fact Book, 2006
US National Health Expenditures, 2004 (CMS, 8/06)

STATE ATTEMPTS AT REFORM UNDERMINED BY COST PRESSURE

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Schwarzenegger's Health Plan Rejected by Lawmakers

By Michael B. Marois

Jan. 28 (Bloomberg) -- California Governor Arnold Schwarzenegger's $15 billion plan to provide health insurance for everyone in the most populous U.S. state was rejected by a Senate committee on concerns it would cost too much.

The Senate Health Committee, controlled by Democrats, voted 7-1 against moving the bill toward a floor vote, with three abstentions. Lawmakers said taxpayers would end up subsidizing the program at a time when the state faces a $14 billion deficit. Schwarzenegger, a 60-year-old Republican, insisted it would fund itself through higher taxes on cigarettes and new fees on businesses, doctors and hospitals.

TWO STEPS FORWARD, TWO STEPS BACK?

- **Missouri**
- **Texas**
- **Tennessee**
- **Maine**

McDonough JE, Miller M, Barber C. A Progress Report On State Health Access Reform. *Health Affairs* 27, no. 2 (2008): w105-w115

LESSONS FROM CALIFORNIA'S P4P EFFORTS

- **Regional variation reflects an uneven playing field**
  - **Population adjustments necessary; extends beyond P4P to capitation strategies**
  - **Paying for achievement *and* improvement a good start**
- **Aggregation of physicians does not necessarily equal integration**
- **Incentives for QI need to be clear**
- **Affordability requires a more comprehensive strategy**

THE OPPORTUNITY IS HERE

- **Rising costs lead to frustration among payers, consumers, providers**
- **Health care reform is at the top of the national agenda**
  - **Access is widely agreed-upon priority**
- **We have more clarity about the relationship between quality and costs**
- **Benchmarking has revealed high performers**

P4P NEEDS TO BE PART OF A LARGER STRATEGY

- **Comprehensive payment reform**
- **Evidence-based benefit design**
- **Evidence stewardship**
- **Clinically accountable entities**
- **Population health strategy**

1. PAYMENT REFORM: TIE IT TO OUTCOMES

- **Bundling of payments (e.g. capitation) desirable to allow integrated systems to gain from their efficiencies**
- **Performance benchmarking also plays an important role**
  - **Facilitates performance comparison**
  - **Transparency critical to trust**
  - **Allows differential rewarding for superior care**
- **Pathway out of Medicare Sustainable Growth Rate**

2. EVIDENCE-BASED BENEFIT DESIGN

- Cover what works
- Cover what's appropriate for this patient
- When in doubt, use coverage with
  - Evidence development
  - Shared decision-making
- Don't pay for avoidable errors

Benefit design can't be an obstacle to effective care

3. EVIDENCE STEWARDSHIP

- **We don't have evidence to support much of the medical care we deliver**

Current model:

- **Investigator-initiated research**
- **Fragmented by specialty, organ systems**
- **Repetitive trials in some areas, no evidence in others**

CONFLICTS IN EVIDENCE

- **Data from ACCORD, ADVANCE trials leave conflicting messages on tight HbA1c control**
- **ACCORD**
  - **Studied high-risk patients with diabetes**
  - **Very strict control targets (<6.0%)**
  - **Found excess mortality**
- **ADVANCE**
  - **Found no excess mortality among those with strict control targets**
- **Needed: more targeted RCTs and study large population experience through learning networks**

POOR EVIDENCE LEADS TO UNPROVEN TREATMENTS

- **Bone marrow transplant/high dose chemotherapy for breast cancer**
  - **Deployed based on inadequate evidence**
  - **Trials in the 1990s showed conventional therapy to be more effective**
  - **30,000 women unnecessarily subjected to ABMT/HDC**
  - **600 died as a result of the treatment**

4. CLINICALLY ACCOUNTABLE ENTITIES

- **Medical Home:**
  - **Wellness**
  - **Complex pediatrics**
  - **Geriatrics**
  - **Cancer**
  - **HIV**
- **Coordinated group practice**
- **Hospital-centered network**
- **Other integrated, accountable systems**

ALTERNATIVE DELIVERY SYSTEMS AND ACCOUNTABLE MODELS

Medical Home

Specialty Care

Hospital Care

Accountable Clinical Entity

5. POPULATION HEALTH STRATEGY

- **We need to treat our collective health as an asset and zealously protect it**
  - **Stepped-down accountability in the delivery system**
  - **Issues go beyond health care**
  - **Tobacco is a model for non-healthcare aspects**
- **Warning signs are there: growing numbers of uninsured, rising obesity rates**

NEXT STEPS

- **Affordable, quality universal coverage is the goal**
  - **Costs will overwhelm reform programs that focus solely on access**
- **Leave room for "buy-up"**
- **Public-private cooperation**
- **Educating the public**

IT'S AN EXCITING TIME TO BE IN HEALTH CARE

"Where would you rather be than right here, right now?"

--Marv Levy

Head Coach, Buffalo Bills (1986-1997)

DISCUSSION