P4P – the Driver for Clinical Integration

Elizabeth Simpkin
Vice President, Consulting Services
Valence Health

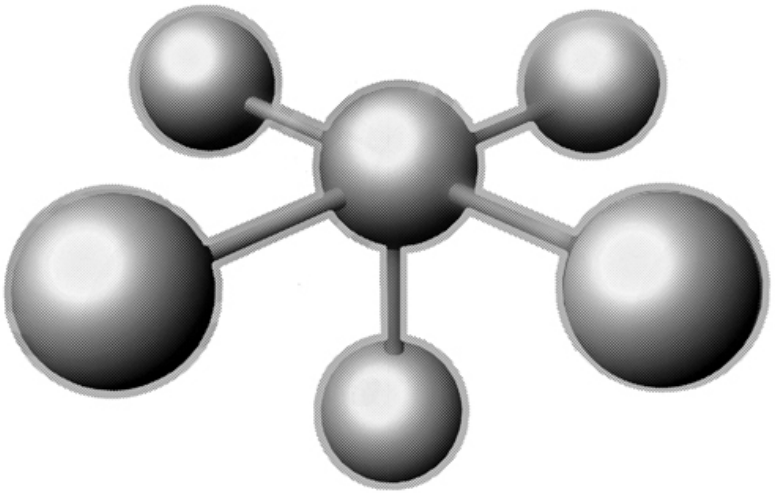
Lori Fox Ward
Vice President, Clinical Integration
Valence Health

Valence Health

Overview of Valence Health

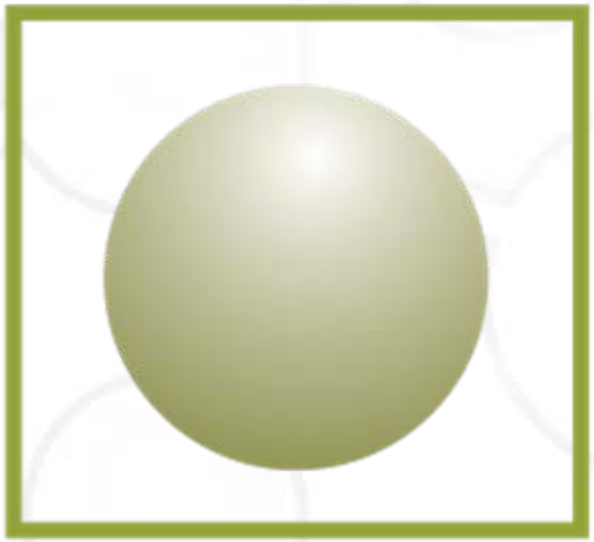
- **Formed in March 1996**
- **Staff of over 100 with 3 offices**
- **Focus on Assisting Provider Organizations:**
  - Manage Risk
  - Clinically Integrate
  - Manage their business
- **What We do:**
  - Core Competency - Data/Actuarial Analysis
  - Clinical Integration data collection and warehousing
  - Applications Development
  - TPA Operations
  - Medical Management
  - Pay 4 Performance

Topics for Today

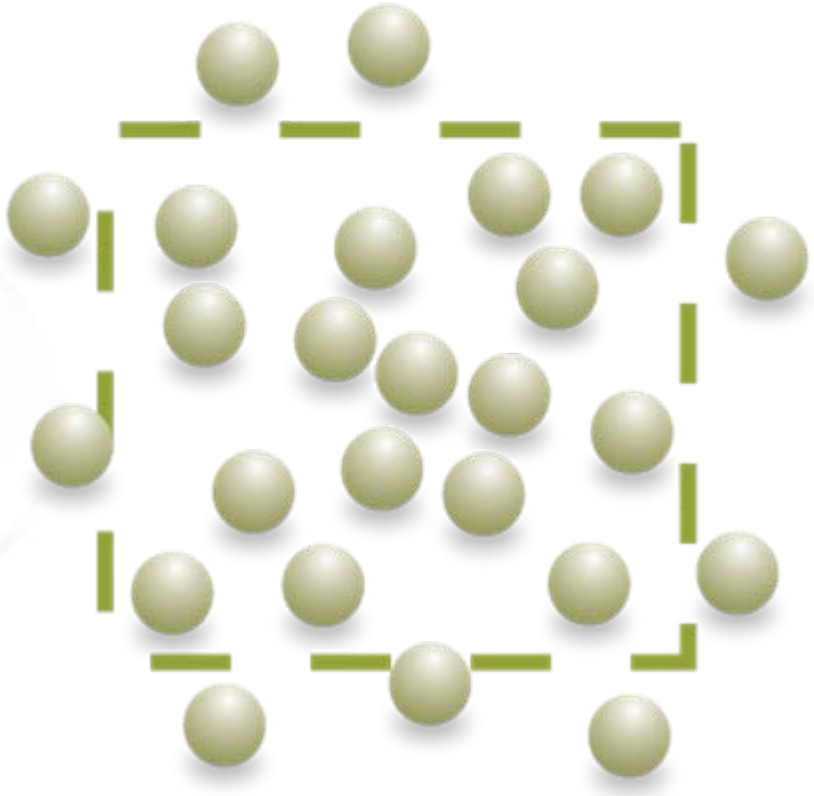


- Changing healthcare delivery
- Clinical Integration and P4P
- Designing a successful internal P4P model
- Getting P4P contracts
- What next? Opportunities on the horizon

Integrated Healthcare delivery today

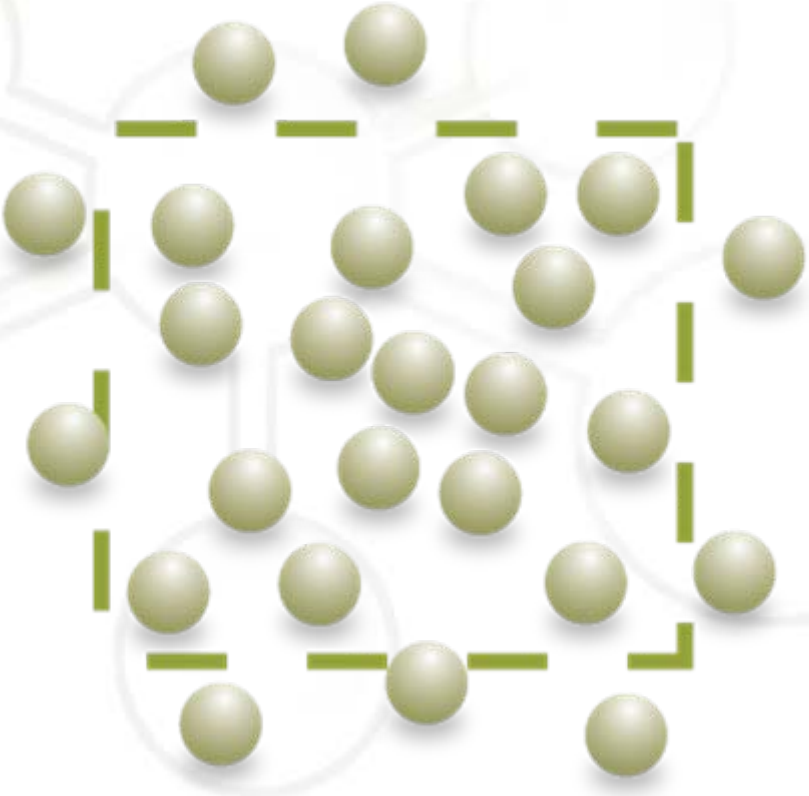


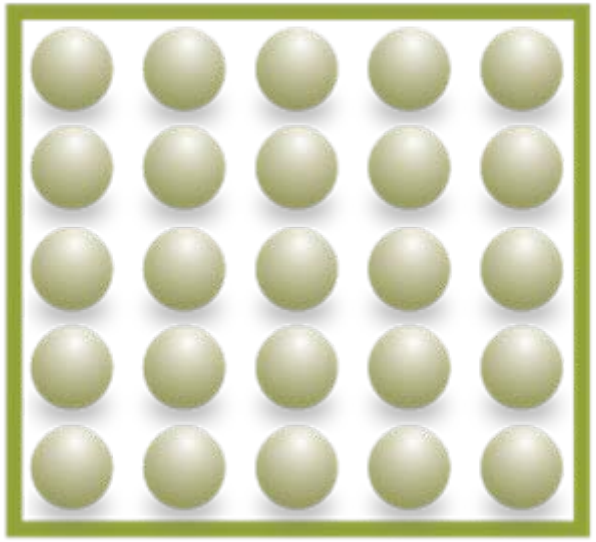
- Cleveland Clinic
- Geisinger
- Mayo Clinic
- Intermountain Health Care



Typical Networks

Can we move from here to there?



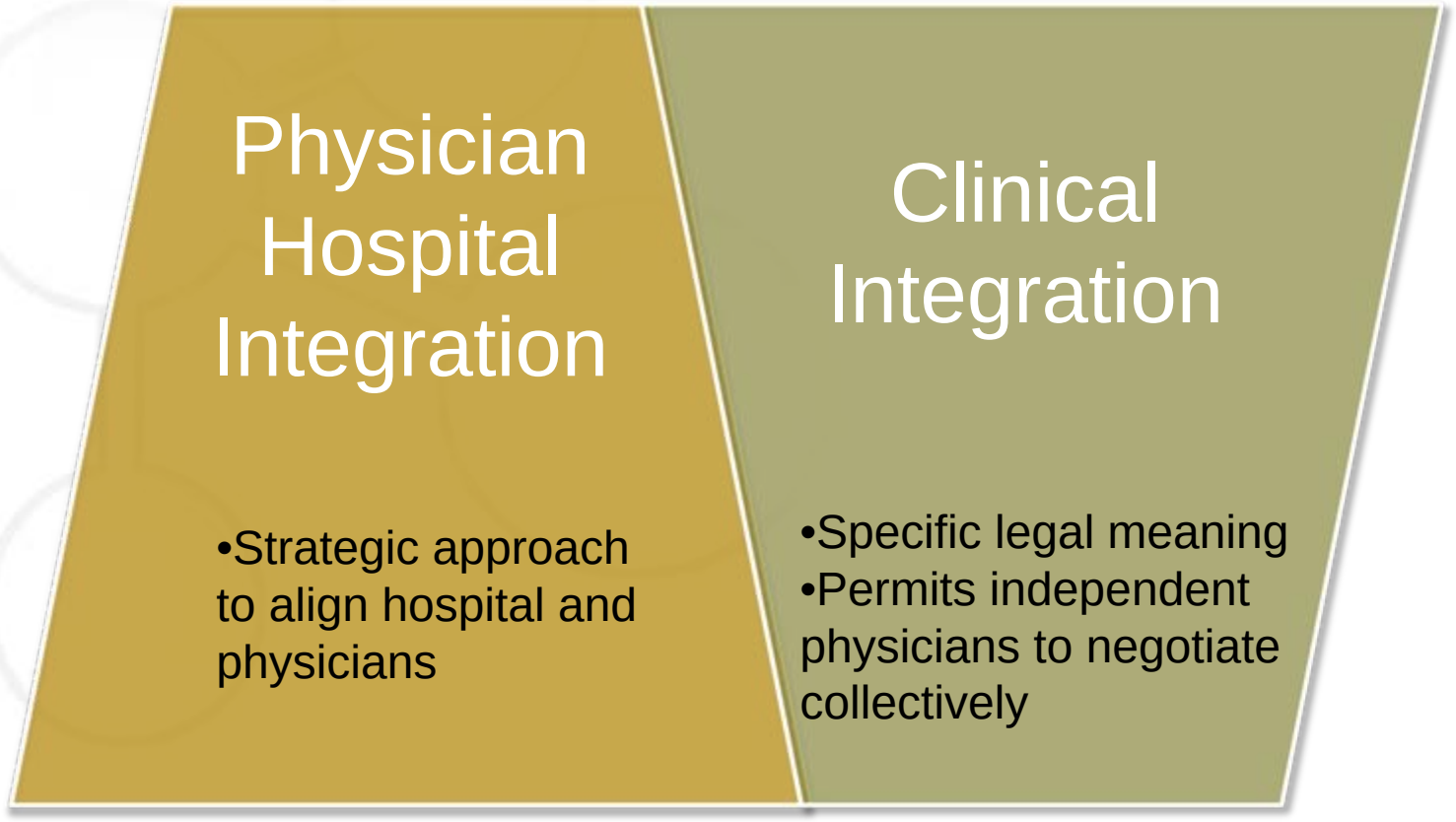


- Brown & Toland
- Partners Health Care
- GRIPA
- Advocate
- Tri State Partners

Clinical Integration

- **Organized Provider Group that:**
  - Agrees on how care should be provided
  - Measures actual performance
  - Compares actual to agreed upon performance
  - Addresses providers that do not meet standards
- **Allows independent physicians to negotiate contracts collectively**

Integration Models



Clinical Integration

- **"... an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."**

Taken from Statement of Antitrust Enforcement Policy in Health Care, FTC & DOJ, August 1996

Why pursue clinical integration?

Mission

- Improve quality of care
- Improve patient safety
- Create efficiencies in delivery of care
- Promote wellness and preventive medicine
- Create community benefit

Money

- Create efficiencies and cost savings
- Enhance marketing and branding efforts
- Contract collectively
- **P4P**

Integrate to improve quality

- **Improve quality by coming together to….**
  - collectively create standards of care
  - measure performance against those standards,
  - provide tools to improve compliance
  - educate physicians and require compliance
  - do things physicians cannot do alone
- ***Provides justification*** **for collective negotiation**
- ***Requires collective negotiation*** **to make it possible**

P4P as the driver

- ***Improve quality and efficiency***
  - Core Measures, patient safety and other benchmark measures
  - reduce costs and improve efficiency
  - physicians' compliance with quality initiatives and use of tools such as clinical pathways and standardized order sets.
- ***Demonstrate quality to patients and community***
  - demonstrate higher quality
  - show collaboration with physicians
  - position the system favorably relative to other hospitals and physicians
- ***Build physician support for hospital initiatives***
  - engage physicians to work with the hospital on quality and efficiency projects
  - tap into a motivated subset of physicians to pilot new initiatives before rolling out to full medical staff

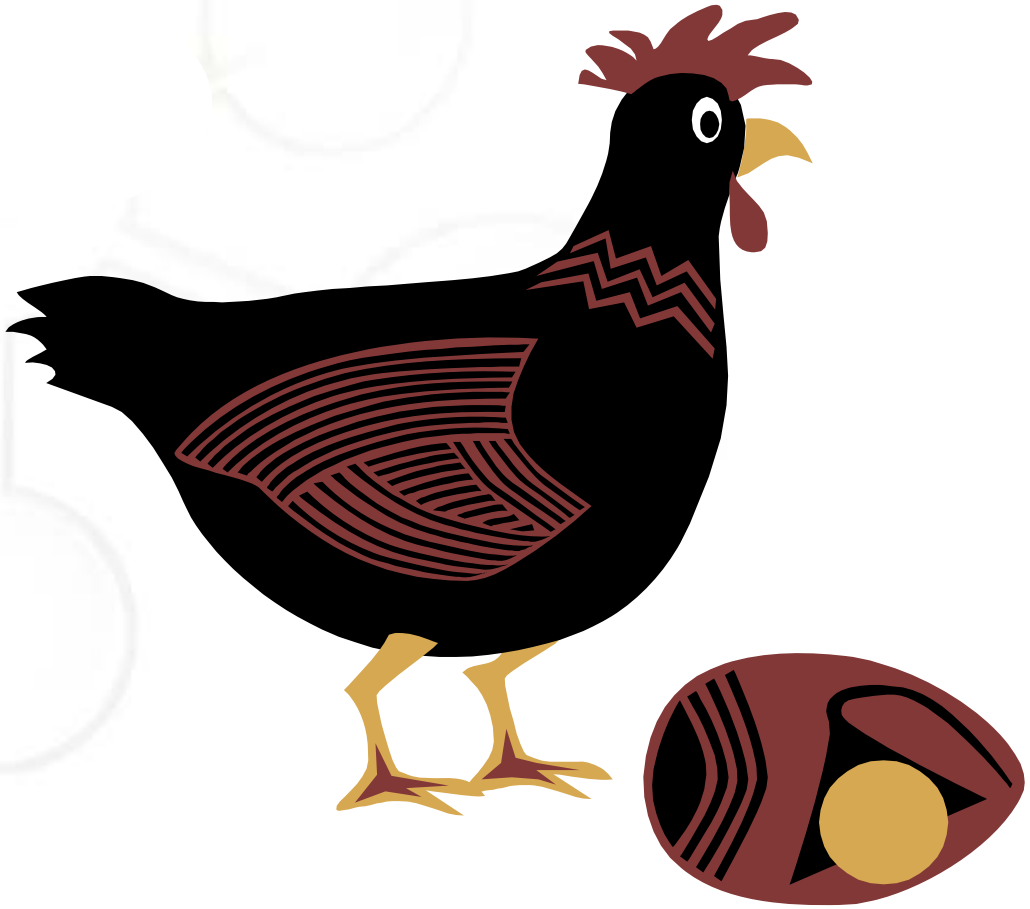
You get what you pay for…

- **Fee-for-service payment buys … SERVICES**
- **Capitation buys… same, with downstream risk**
- **A well designed P4P program – base payment plus targeted incentives – buys**
  - Attention to the right goals
  - Physician engagement
  - Alignment between facility and professional providers

Opportunities with physicians and hospital

Improve scores on Core Measures, other external report cards	→	Improve patient satisfaction; Increase reimbursement under P4P contracts
Decrease LOS	→	Improve Medicare margin
Improve efficiency	→	Reduce costs, especially in Lab, Radiology, Surgery
Engage physicians	→	Better design, better physician acceptance of new programs

Internal P4P or External P4P?



Quality

“Doing it right when no one is looking”

- Henry Ford

“Quality is the result of a carefully constructed cultural environment. It has to be the fabric of the organization, not part of the fabric.”

- Philip Crosby

Elements of a P4P Program

- Transparent
- Easily understood
- Clinically relevant (or at least credible)
- Uniquely attributable at the physician level
- Targeted to incentivize the right behavior
- Sufficient $ to motivate

Setting Goals

- **"Enhance total reimbursement opportunity by adding voluntary bonus opportunity"**
  - No downside risk, base fee schedules PLUS performance incentive
- **"Enhance integration between physicians and hospitals"**
  - Initiatives to involve physicians in hospital priorities
- **"Reinforce existing CI program"**
  - Incentive measures expand upon base requirements

Designing the program

- **Choose initial measures**
  - Process, outcome, efficiency, cost
  - Time frame
  - Availability, practicality
  - Ease of administration
- **How many?**
  - Less is more
  - More is more

P4P Measures

% of diabetic patients who received all expected services during a given period

% of diabetic patients whose HgA1c remained in good level of control

utilization of specific services, or total resource use
Generic Rx, Imaging,
LOS, readmissions

Reward adoption and use of EHR, CPOE

Patient safety initiatives - Medication Reconciliation, SCIP/ HOP etc.

patient satisfaction with access and service issues (eg, HCAHPS)

business processes such as electronic claims submissions

Designing the program - continued

- **Determine your data sources**
  - Internal/external
  - Self-reporting
  - Reporting period and lag
  - Frequency of updates
  - Interim reporting
  - Data validation process

Designing the program - continued

- **Establish your budget**
- **Estimate likely bonus amount per participant**
  - How many will participate
  - Will it be enough to be meaningful?
- **Payment schedule**
  - Smaller, more frequent payments
  - Or one big check

Implementing the program

- **Establish eligibility criteria**
  - Member in good standing
  - All physicians or subset
  - Are employed physicians eligible?
  - What if insufficient data exists for some providers?
- **Require some initial action**
  - Attend a kick off meeting
  - Affirmative sign up

Implementing the program

- **Training**
  - Explain the methodology – no black box
  - Address the skepticism – you're not being "dinged"
  - Tie the measures back to program goals
  - Timing and roll out
- **Interim progress reports**
- **Payout**
  - Make a splash
  - Provide for challenges
- **Raise the bar for next year**

Getting P4P Contracts

Getting the contracts

- **Payers are not lining up to offer P4P contracts that actually pay more**
- **Looking for ROI on a short time horizon**
  - Generic Rx and/or formulary
  - Imaging utilization
  - Referrals to lower-cost providers
  - Use of their case management programs
- **No New Money!**

P4P- It's all in the definition

	Providers think ……	*Payers think ……*
"Pay"	More money to invest in improving performance	Need to demonstrate improved performance to justify current reimbursement
	Unit price changes per unit of services	Total cost (including utilization increases)
"Performance"	Process of care	Outcome for a population
	Relative	Absolute
	Individual measures	Groups of providers
	Actions the individual provider can take	Systemic change

Educate the payor on the value of CI

Old System	New System
Fragmented	Brings physicians together with physicians and hospital(s)
Lacks quality metrics	Uses nationally and locally recognized measures for care
Incentivized overuse	Promotes quality and appropriate utilization over volume
Lacks systematic approach to care	Uses technology to promote consistent patterns of care

P4P Measures

Goals:

- Single set of measures across all payors
- Lump sum payment to the IPA/PHO
- IPA/PHO will distribute funds to physicians

Show THEM the money!

- **WIIFM? – you have to market to the payer**
- **Understand their needs**
  - ASO vs. insured, national vs. local/regional accounts
- **Show how you can help control claims expense**
  - shorter LOS, fewer 1-day stays, appropriate use of Observation
  - case management across continuum
  - reduced imaging, redirected to lower-cost place of service
- **Express in terms of their clients' interests**
  - what do employers want? how can you help the health plan achieve that?
- **Help the contractor “sell” the idea to Corporate**

Legitimate concerns

Providers

- Risk adjusted data
- Small population size
- Finding the resources to invest in data collection
- Responding to inaccurate or incomplete information

Payors/Purchasers

- Competitive nature of quality - don't want to pay for "free riders"
- How to fund P4P or incentive pools
- Timeframe to see cost reduction

Trust but verify…

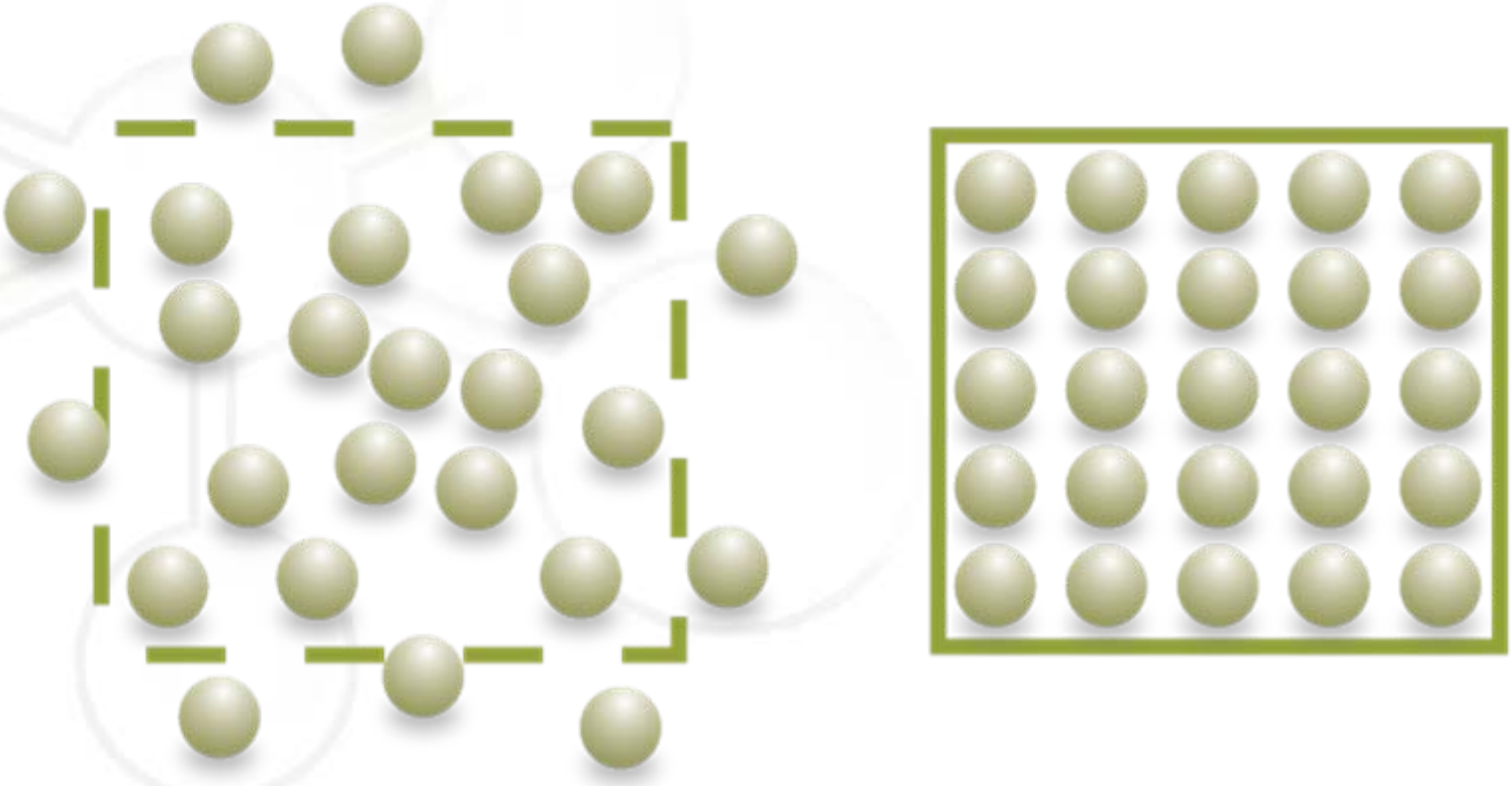
- Process-of-care or outcome measures
- Threshold attainment and/or performance improvement targets
- “Efficiency” measures (cost, utilization, other) and relative weighting
- What products are included
- Time periods for measurement
- Process for reconciliation/challenge
- Joint marketing to employers
- Data sharing/validation
- Public release of results

What's on the horizon?

New models, new opportunities

- **Pay for Integrated Care**
  - Bundled payments
  - Medical Home
  - Accountable Care Organizations
- **Non-payment for errors and preventable complications**
- **Price and Quality transparency**
- **True value based purchasing**

How can we move from here to there?



Clinical Integration with P4P

THANK YOU !

Lori Fox Ward, RN, BSN
VP, Clinical Integration
Valence Health
312-277-6304
Lfox@valencehealth.com

Elizabeth Simpkin
VP, Consulting Services
Valence Health
312-277-6340
esimpkin@valencehealth.com