Preconference I — In Search of the Perfect Union: Merging Quality and Cost Efficiency

Sponsored by
Integrated Healthcare Association (IHA)

The Fifth National P4P Summit
San Francisco, California
March 8, 2010

Agenda

- **Overview: The Quality and Efficiency Measurement Landscape** - Dolores Yanagihara, MPH
- **Case Study: Blue Cross Blue Shield of Massachusetts** - Dana Gelb Safran, ScD
- **Case Study: HealthSpring, Inc.** - Bill Anderson, MD and Sid King, MD
- **Break**
- **Case Study: California and Performance Based Contracting** - Dolores Yanagihara, MPH
- **Panel Discussion**

Overview: The Quality and Efficiency Measurement Landscape

Dolores Yanagihara, MPH
P4P Program Director
Integrated Healthcare Association

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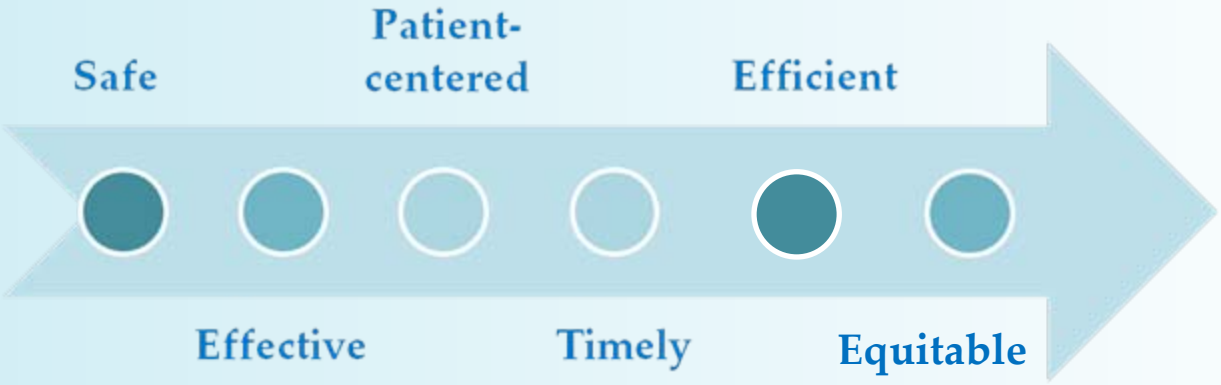
Agenda

- A Challenge is Presented
- The Industry's Response
- Initiatives Merging Quality and Efficiency
- A Foundation for Payment Reform

A Challenge is Presented: Searching for a New Health Care System

March 2001: "Crossing the Quality Chasm: A New Health System for the 21st Century" – IOM request for redesign of the health care system



The Industry's Response: Pay for Performance (P4P)

2008 National P4P Survey conducted by MedVantage revealed:

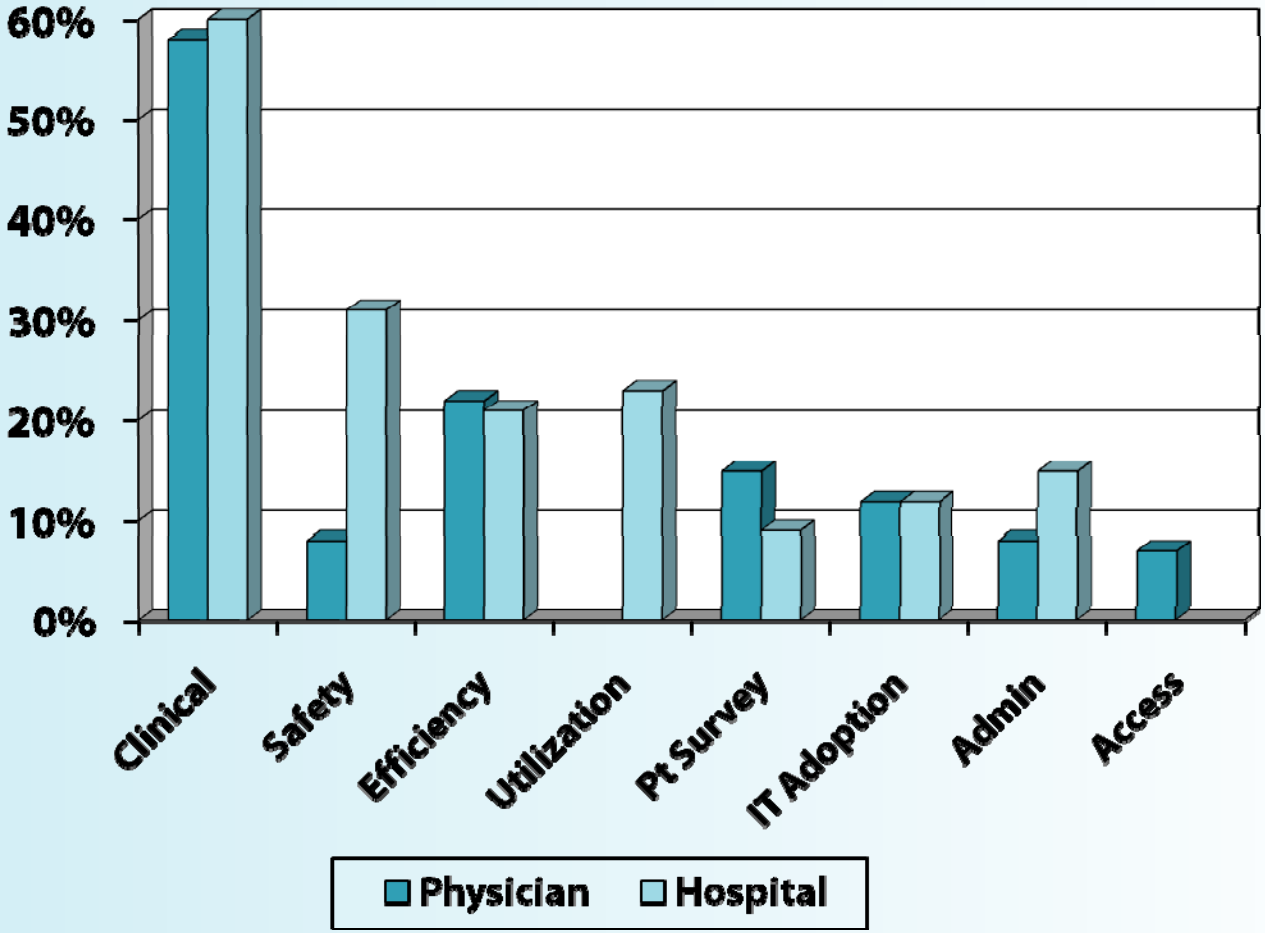
- 94% of respondents* have physician P4P
- 38% have hospital P4P
- Measures are mainly evidence-based and from national sources
- Providers have input and appeal rights
- Half of programs use tiered networks, honor rolls, or public reporting

*** N = 69 respondents**

Summary of P4P Survey Findings

- Strong belief that P4P works to change behavior – but empirical evidence mixed
- Emergence of national standards for clinical quality
- Increasing focus on efficiency and utilization
- Increasing pressure to pool data to support measurement efforts
- P4P evolving into Payment Reform or performance based payment
  - More money at stake
  - Higher proportion of delivery system impacted

Incentive Weighting of P4P Measurement Domains in 2008



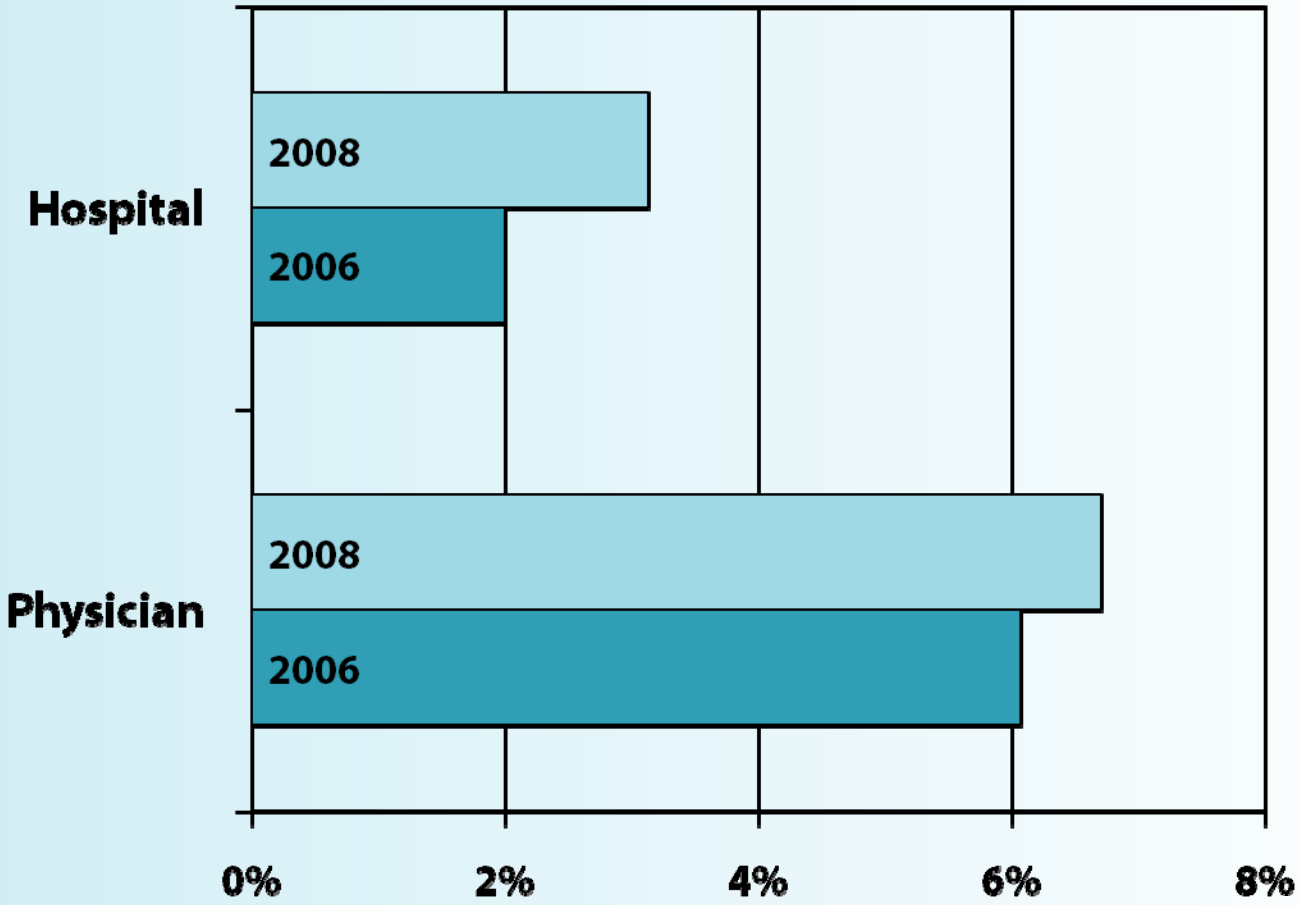
N = 91 programs—65 physician, 26 hospital

Standardized Measures

- National Quality Forum (NQF) endorsement has become the gold standard for nationally vetted standardized measures
- 615 measures currently endorsed
- Many require medical record review
- Only a small fraction are for efficiency

Magnitude of P4P Incentives

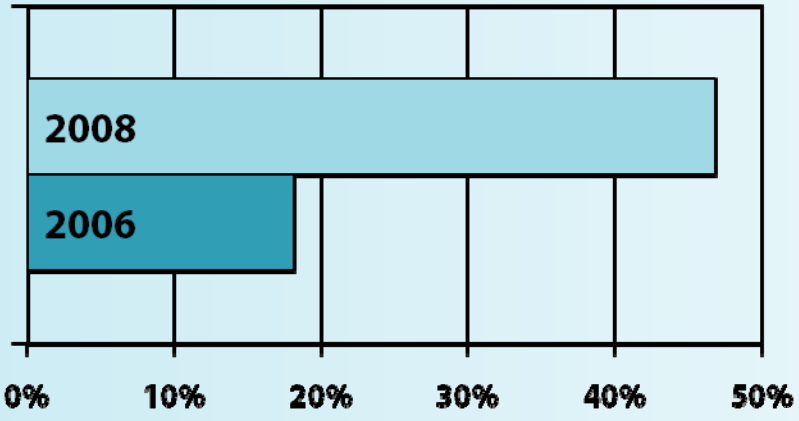
Average P4P incentives as a percent of total compensation



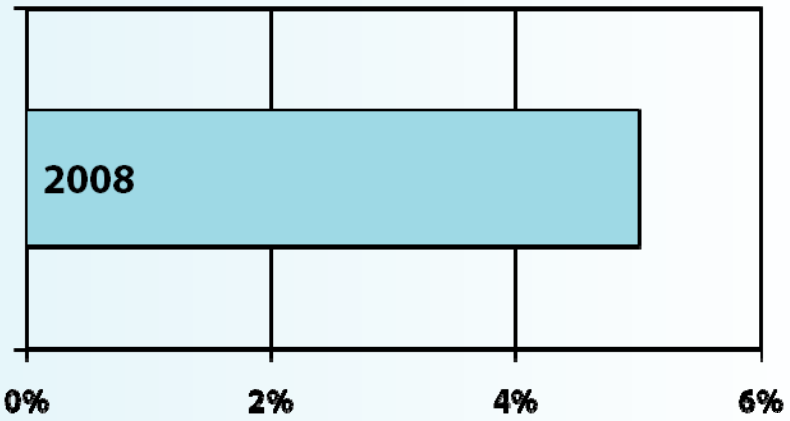
N = 18 hospital program respondents, 50 physician respondents

Special Focus on Physician IT Use

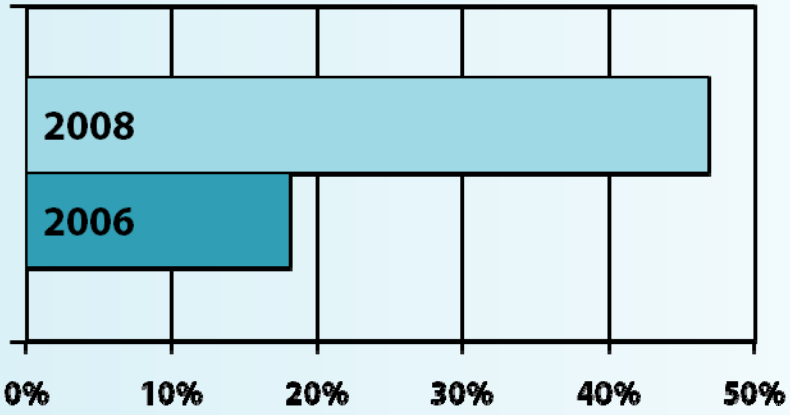
EMR adoption as a measure



E-prescribing as a measure



P4P programs reporting increase in physician investments in IT or QI



N = 60 plans' physician programs

Potential of Information Technology to Impact both Quality and Efficiency

"Wouldn't it be wonderful if the same data collected during the care process could be used automatically to trigger clinical decision support reminders and later aggregated and de-identified to appear in quality-measurement reports? That would be the ultimate in capture-once-reuse-many-times kind of efficiency that would make quality measurement and quality improvement an affordable byproduct of care."

Paul C. Tang, MD, MS

VP and CMIO of the Palo Alto Medical Foundation

Importance of Information Technology on Quality and Efficiency

- The American Recovery and Reinvestment Act of 2009: $19 B in incentive payments to encourage adoption and meaningful use of EHR systems
- NEHI/Massachusetts Technology Collaborative: adoption of CPOE system could prevent 55,000 medical errors and save $170 M a year in MA
- Impact of Kaiser Permanente EHR in Hawaii
  - 26% decrease in face to face office visits due to availability of scheduled phone visits and e-mail visits
  - Quality and patient satisfaction maintained

Aspects of Efficiency

Two aspects of efficiencies – both are important, and they are often interrelated:

- Efficiency of health care processes (electronic scheduling, care coordination, patient outreach, etc.)
- Efficiency of health care resources (number of units of service and unit prices)

Merging Quality and Efficiency

CMS Leadership in Improving Quality and Efficiency

Payment strategy to improve healthcare quality / outcomes while avoiding unnecessary complications and costs:

- Voluntary quality data reporting/feedback
- Pay for Reporting
- Pay for Performance
- Pay for Value

Demonstration projects to improve quality and efficiency:

- Care Management for High Cost Beneficiaries
- Medicare Health Support Program: Consumer-Directed Chronic Outpatient Services
- Medicare Physician Group Practice Demonstration
- ESRD (End-Stage Renal Disease) Bundled Payment Demonstration
- Medicare Coordinated Care Demonstration

Other Initiatives Merging Quality and Efficiency

- Aligning Forces for Quality: Align key players in 15 local communities to measure and report, engage consumers, and improve performance
- The Triple Aim (IHI): Achieve high value health care by improving patient experience, improving population health, reducing per capita costs
- Virginia Mason Medical Center: Focus on customer and reducing waste
- Denver Health: Vertically and horizontally integrated urban safety net system

A Foundation for Payment Reform

Elements of Payment Reform

- A new payment system would require changes to:
  - Delivery of health care (internal provider processes changes, organizational re-structuring)
  - Measuring quality and efficiency
  - Reporting quality and efficiency
  - Consumer Role (employee/patient and employer)
  - Payment Methodology (benefits design and employer involvement)

P4P Helping to Establish a Foundation for New Performance Based Payment Methods

- Standardization of quality measures
- Aggregation of payer data for measurement
- Electronic data collection – merging administrative and clinical data streams
- Public reporting of performance
- Cultural acceptance of measurement and public reporting by physicians and hospitals
- Developing standard efficiency metrics

Evolution of Payment Reform

THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE
Where Knowledge Informs Change

Past and Emerging Models of Accountability in Provider Payments

Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
Pay for reporting. Payment for reporting on specific measures of care. Data primarily claims-based.	Payment for coordination. Case manage-ment fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).	Pay for performance. Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, nonpayment for preventable complications).	Episode-based payments. Case payment for a particular procedure or condition(s) based on quality and cost.	Shared savings with quality improvement. Providers share in savings due to better care coordination and disease management.	Partial or full capitation with quality improvement. Systems of care assume responsibility for patients across providers and settings over time.

Moving from P4P to Payment Reform

- Linking Payment to Performance – movement from P4P incentive bonuses to performance based payments (e.g., MA Blues Alternative Quality Contract)
- Regional Pilots/Experiments – Bundled episode payment (Prometheus), medical home, global capitation, tiering, etc.
- Federal Policy – CMS payment changes (e.g., non payment for never events, DRG adjustments for readmissions, etc.)

Case Studies

1. Blue Cross Blue Shield of Massachusetts
2. HealthSpring
3. California Performance Based Contracting