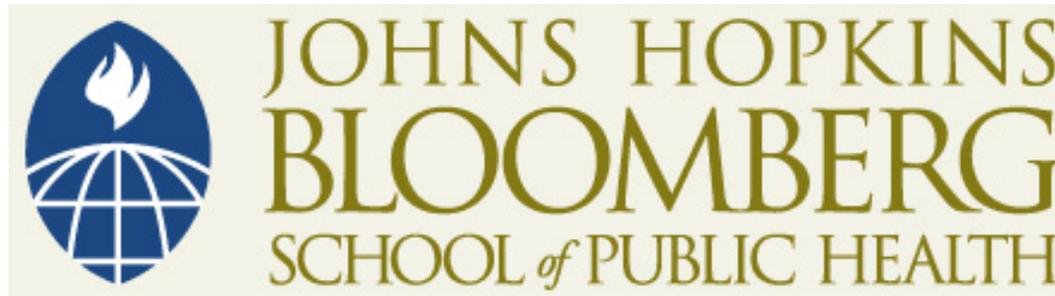


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Session 6:

Quality, Accountability & P4P In the Managed Care Context

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Presentation Goals

- Offer a Managed Care Perspective on the Themes of Quality and Accountability
- Describe Elements of Pay for Performance (P4P) Programs
- Review an Exemplary National P4P Initiative that Focuses on Physician Groups



“Quality” Defined

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Institute of Medicine, 1990

“The only definition of quality that matters is the consumer’s.”

W. Edwards Deming

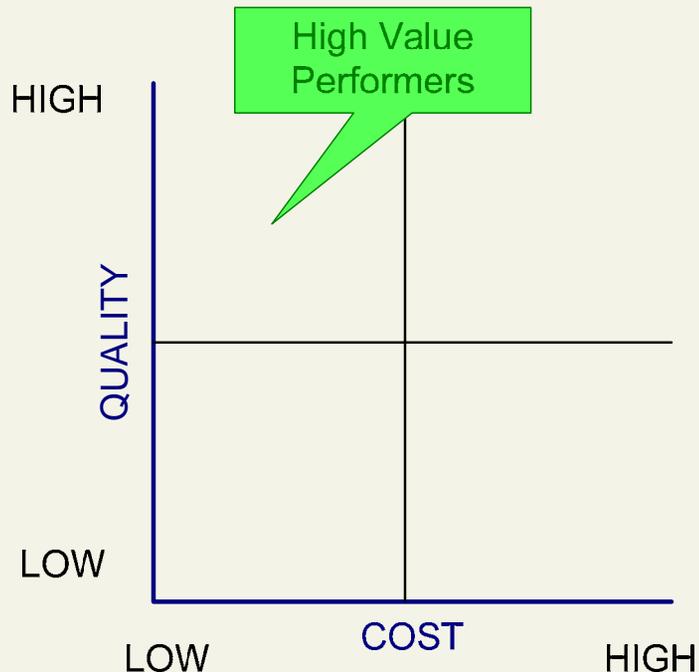


What are the Dimensions of Quality?

IOM Goals for the US Healthcare System ...

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

The "Value" Perspective on Quality



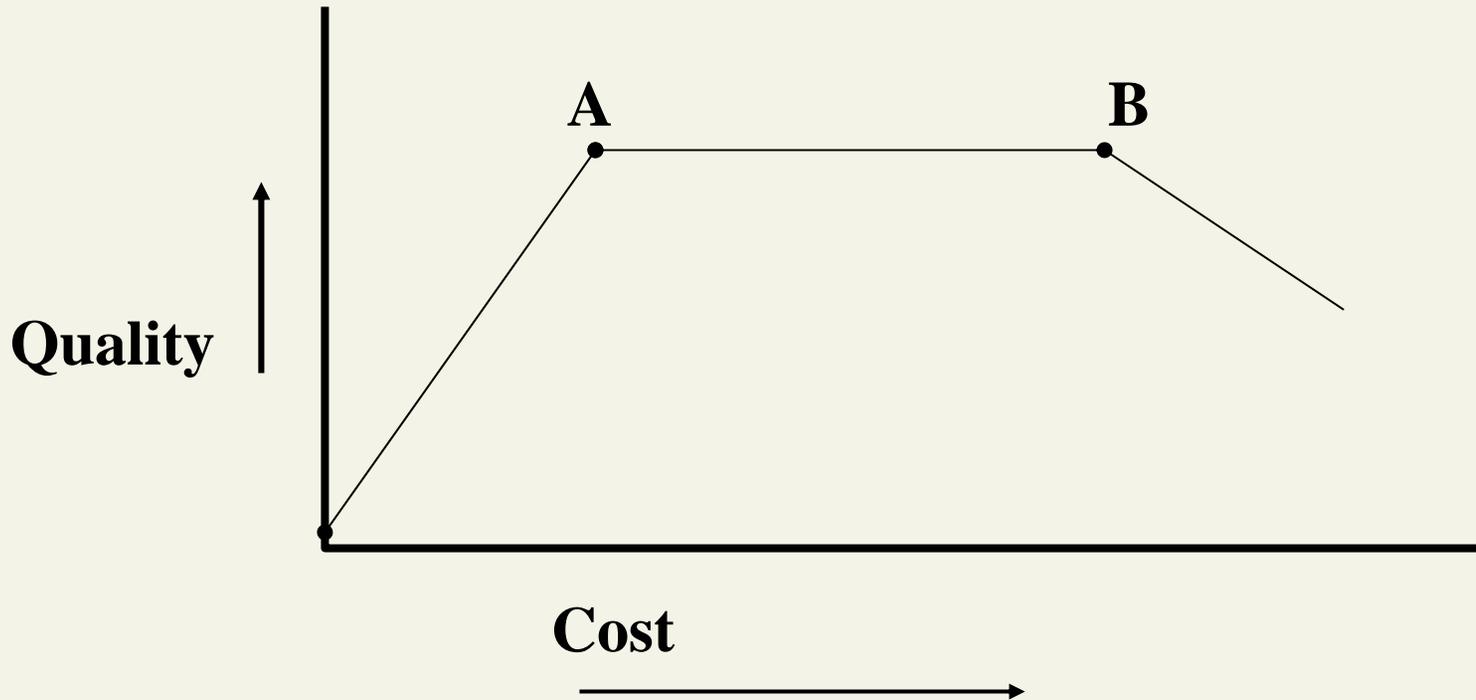
Economists like to express quality per units of cost. How much of a valued outcome do you receive per dollar spent?

This is becoming synonymous with efficiency, which heretofore had just been about resource use as a function of cost

About 10% of hospitals delivered high quality at relatively low cost; arguably have a "culture of quality"

Goal of some quality-based initiatives is to identify and describe these high performers so that others might learn

The Theoretical Cost/Quality “Plateau” Relationship



There are limits to how much quality you can buy

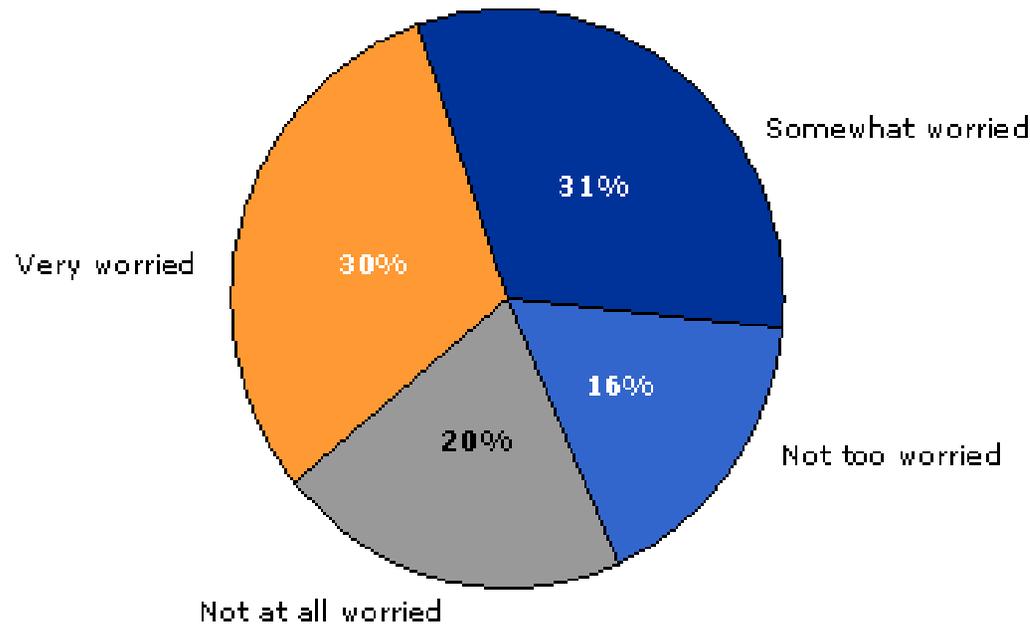
What interest in the optimal level of quality you can get at the lowest cost, i.e., right at inflection point A?

Throw a lot of money at a quality issue and may end of with overuse of “evidenced-based” tests and procedures?

US Public's Perceptions

Worry About Health Plan Being Mainly Concerned About Saving Money

How worried are you about your health plan being more concerned about saving money for the plan than about what is the best treatment for you?

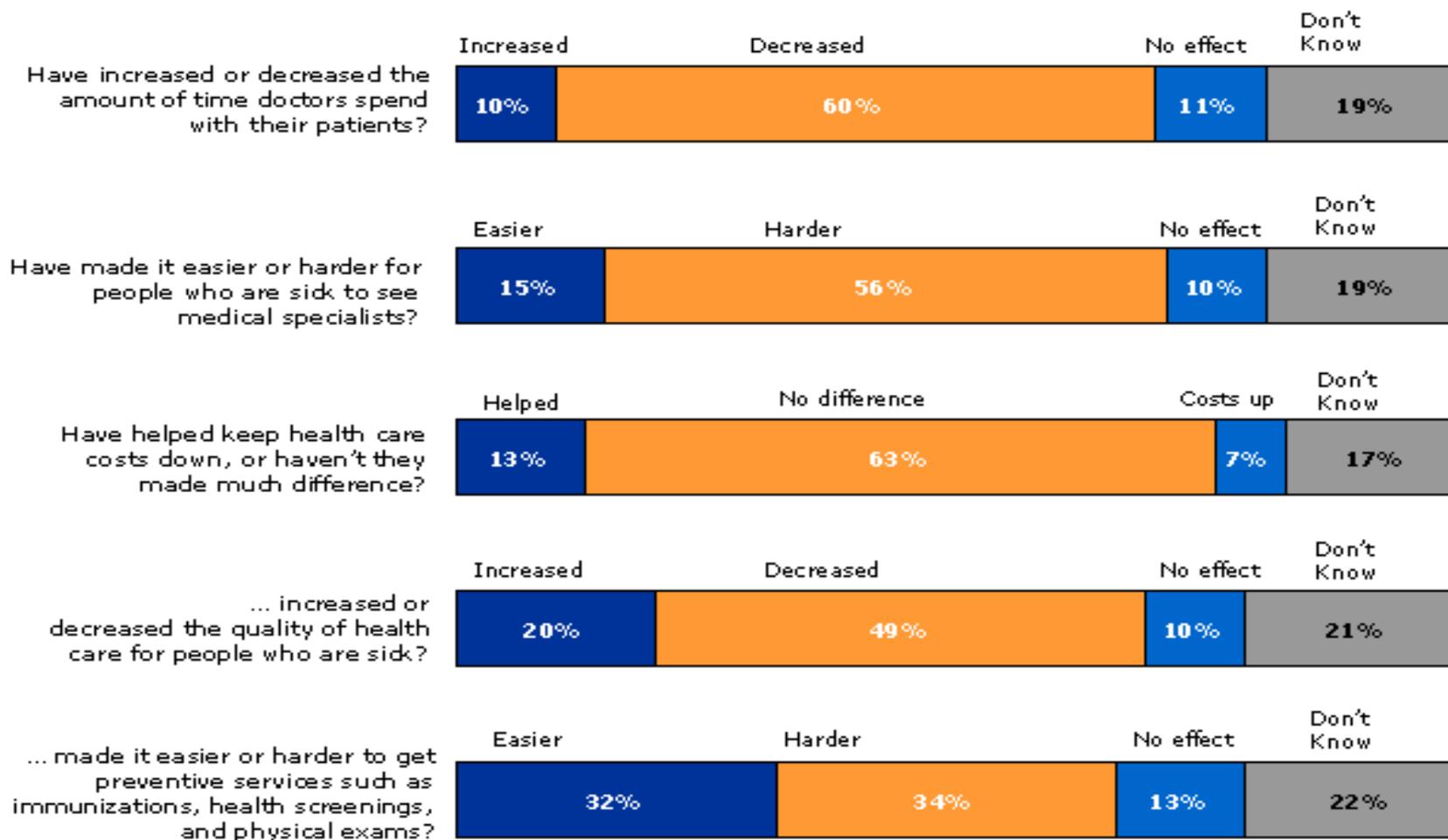


Note: Based on adults with health insurance. Don't know responses not shown.

Source: Kaiser Family Foundation *Health Poll Report* survey (conducted October 4-9, 2005)

Views About Managed Care's Impact

During the past few years, do you think HMOs and other managed care plans...



Source: Kaiser Family Foundation *Health Poll Report* survey (conducted August 5-8, 2004)





Quality Represents an Important Dimension of Health Plan Accountability

A Working Definition of Health Plan Accountability

The responsibility that the MCO has for the provision of health care services to its defined population governed by the complex regulatory, legal, medical and potentially ethical framework that governs the relationship.

In common usage, an MCO is held accountable for key provisions of the health benefit contract, for ensuring that its providers meet reasonable standards of care, for staying within the government's regulatory boundaries and for attaining financial and quality performance targets set by payers/ sponsors.



US Public's Perception - *continued*

- **Who would you like to regulate managed care?**
 - **Feds** **19%**
 - **States** **18%**
 - **Independent entity** **34%**
 - **No one** **16%**

Source – Kaiser Family Foundation



Some Key Players in the MCO Quality and Accountability Arena

Involved in Accreditation and Oversight

NCQA -	National Committee for Quality Assurance
URAC-	Utilization Review Accreditation Commission
JCAHO-	Joint Commission on the Accreditation of Health Care Organizations
States -	

Some Key Players in the MCO Quality and Accountability Arena

QIOs -	Quality Improvement (aka Peer Review) Organizations
AHRQ -	Agency for Health Care Research & Quality
IOM -	Institute of Medicine (NAS)
FAACT -	Foundation for Accountability
NQF -	National Quality Forum
NAIC -	National Association of Insurance Commissioners

- **Founded by HMO industry to avoid external government regulation**
- **Now employer/ payer perspective is key**
- **Two main activities:**
 - **Accreditation (heavily internal QI oriented)**
 - **HEDIS (Health Employer Data Information Set) Performance Monitoring**
- **Performance Data are Publicly Reported Annually in Quality Compass**

“Report Cards” as a Dimension of Accountability

- HEDIS & HEDIS-like measures very widespread
- Medicaid & Medicare & large employers distribute widely
- Consumer Survey (e.g. CAHPS)
- Several statewide reports (see Maryland Health Care Commission - MHCC)
 - <http://mhcc.maryland.gov/hmo/index.aspx>

Evidence of impact decidedly mixed

So What Are Plans Doing Right Now to Address Quality Issues?



The List Includes ...

- Accreditation Activities
- Measurement and Reporting
- Quality Improvement Initiatives
- Consumer and Community Engagement
- Care Management and Disease Management
- Pay for Performance

Incentivizing Performance: “Pay for Performance” (P4P)



What Is Pay for Performance?

“The use of incentives to encourage and reinforce the delivery of evidence-based practices and health care system transformation that promote better outcomes as efficiently as possible.”

American Healthways, 2005



What Were the Historical Precedents?

- Physicians have had aspects of their performance under scrutiny for years
 - Licensure and certification
 - Economic profiling
 - Report cards
- Hospitals and health plans have also been subject to performance review
 - Accreditation process
 - PSRO/PRO/QIO
 - Report cards



What Do We Mean By Performance?

Performance is a function of ...

- Quality
- Safety
- Access
- Satisfaction
- Cost
- IT Infrastructure



Elements of Pay for Performance

- Targeted Entity
- Measures
- Methods
- Incentives
- Reporting



Types of Incentive Strategies

- Bonuses (most common form of incentive)
- Tiered Co-Payment
- Increased Reimbursement Rate
- Quality Infrastructure Grants

P4P in Action: IHA

To create a business case for quality improvement through a compelling set of incentives that will drive breakthrough improvements in clinical quality and the patient experience.



- Established under the auspices of the Integrated Healthcare Association (IHA).
- Collaborate with six large insurers in California (Cigna, Aetna, Health Net, PacifiCare, Blue Cross, and Blue Shield).
- Represents 60% of California managed care market.
- Completed first year of P4P program in 2003.
- \$50M paid to California physician groups to reward first year's performance.



P4P in Action: IHA Measures

Targeted Entity

Physician Groups

Measures

- *Clinical Quality (Adapted from HEDIS)*
 - Preventive Care
 - Chronic Care
- *Patient Experience*
 - Communication with doctor, timely access, specialty care, care coordination, and overall care ratings
- *Investment In and Adoption of IT*
 - Point of Care and Population Management



P4P In Action: IHA Clinical Quality Measures

- Childhood Immunizations by Age 2 w/ 24 Months Continuous Enrollment
- Appropriate Treatment for Children with URI
- Cervical Cancer Screening
- Breast Cancer Screening
- Asthma Management
- HbA1c Screening & Control
- LDL Screening & Control <130
- Chlamydia Screening



P4P in Action: IHA Methods

- Largely rely on process measures
- Common measures and common data processing center
- Measures rolled into composite indicators
- Administrative data only, no record review
- Consumer Assessment Survey for patient experience
- No risk adjustment but metric populations defined to ensure fairly homogeneous population
- Incorporates auditing step



P4P in Action: IHA Incentives

- Each plan sets its' own incentive structure
- Weighting of measures is suggested
- Some plans set provider group volume thresholds to participate
- Most pay annually on prior year performance; some quarterly
- Bonus either allocated based on single measures or attainment of all
- Maximum PMPM bonus of around \$3
- Beginning in 2006 will not be able to pay bonuses to individual physicians without performance review
- In first year, 2003, \$50M paid to California physician groups to reward first year's performance

Reporting

Highly summarized results for provider groups publicly reported on state of California web site (www.opa.ca.gov).

Issues

- Improvements seen but without controls difficult to assess whether real and whether worth modest \$1,100 in physician incentives.
- Very difficult to get started and still marked differences in choice of measures and use of incentives
- Provider group participation only partial
- Associated report cards add a potentially punitive dimension based upon a simplistic methodology



P4P Implications: Some Pros

- Better access to and delivery of preventive services
- Potential for reducing waste and inefficiency
- Reduced practice variation
- Increased use of electronic information systems, including medical records and disease registries
- Move frontline practitioners to more of a population management approach
- Stronger connections with community resources that patients may call on to enhance chronic care self-management
- Improved primary care management of chronic disease with more practices specializing in chronic care
- Better quality and improved outcomes



P4P Implications: Some Cons

- Disincentives for physicians to practice in areas with socially complex patient populations or high levels of health care needs
- Focus on one disease at a time
- Fragmentation of care from management of metrics
- Providers who are on the top have little incentive to improve and may be on top for unrelated factors
- Widening performance gap between achieving and poor performers
- Poorer quality of care for un-incentivized conditions
- Higher practice administrative costs to generate P4P metrics
- Very difficult for solo practitioners to participate



And What Is the Current State of P4P?

- Depending on who you ask, there are between 100 and 150 P4P programs in the U.S.
- Several high profile initiatives are underway
- The largest P4P “experiment” in the world is currently underway in the U.K.
- Program growth is way ahead of the ability to demonstrate sustained savings and improvement

Will P4P Work?

- “There is no question that pay for performance will work” (Thomas Scully, 2003)
- For each health plan to have its own measures, rules, payment method and payment target creates major administrative hassles
- Physician acceptance likely determined by the extent to which health plans commit new funds to reward quality
- Where physicians do not belong to physician organizations, the numbers of targeted patients in a health plan seeing a particular physician are too small for reliable measurement
- Evidence for the effectiveness of paying for quality is still mixed



The Last Word

“The problem with pay-for-performance is not that it doesn’t mold behavior. The problem is that it does mold behavior. You get exactly what you’re paying for, which might not, in the end, when you’re finally on your deathbed, be exactly what you wish you’d gotten.”

Don Berwick, 2005