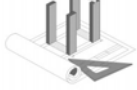




Building for Excellence (BFE) 2006

Pay for Performance
September 12, 2006



Upcoming Opportunities

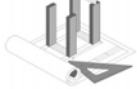
Essential Quality Improvement Workshop

October 18, 2006
9:00-3:00 p.m.
Minnesota Landscape Arboretum, Chaska, MN

October 25, 2006
9:00-3:00 p.m.
The Lodge, Brainerd, MN

Data & Measurement 102 WebEx

November 28, 2006
12:00-1:30 p.m.



BFE Advisory Group

- Blue Cross and Blue Shield of Minnesota (BCBS)
- First Plan of Minnesota
- HealthPartners
- Institute for Clinical Systems Improvement (ICSI)
- Itasca Medical Care
- Medica
- Metropolitan Health Plan (MHP)
- MN Community Measurement
- Minnesota Healthcare Quality Professionals (MHQP)
- Minnesota Hospital Association (MHA)
- Minnesota Medical Association (MMA)
- Minnesota Medical Group Management Association (MMGMA)
- Preferred One
- PrimeWest
- Stratis Health
- UCare Minnesota

Trends in U.S. Health Care Quality

Pay for Performance

Christine Bechtel
Director of Government Affairs
American Health Quality Association



Summary

- Context: Pressure to Reform
- Overview of major reforms
- Focus on Pay for Performance
 - Congress
 - The Administration
 - Private Sector
- Key Issues in P4P



What is Quality?

- IOM Definition:
 - *“the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”*
- I.E.: Every patient receives the right care every time.

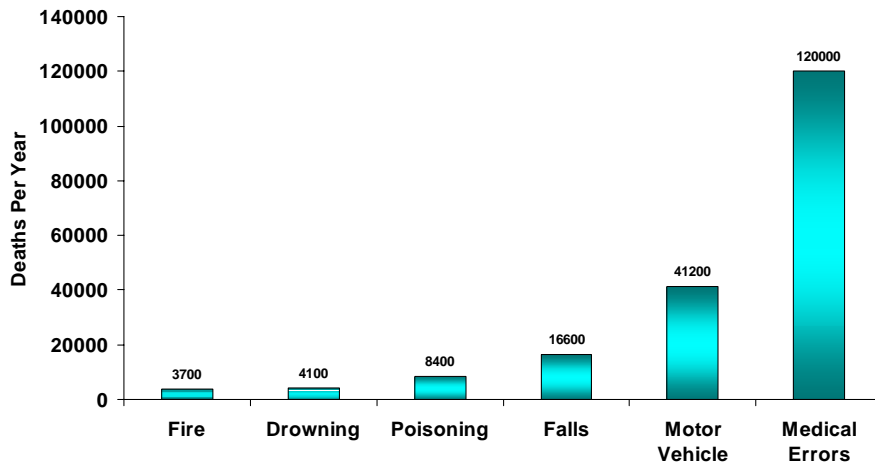


Quality in US Health Care

- Americans receive only 55% of the care recommended for their conditions
 - Translation of medical research into practice is slow—average of 17 years
- Preventable medical errors in hospitals cause 120,000 deaths per year
- 1.5m preventable adverse drug events every year (IOM, 2006)



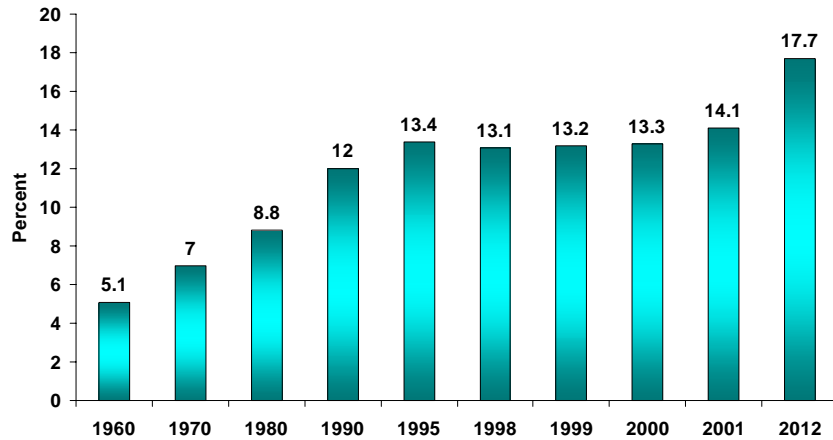
Deaths Per Year



Source: National Safety Council, 1998; Lucian Leape, MD; Philadelphia Inquirer.



Health Care Expenditures as % of GDP



Costs in US Health Care

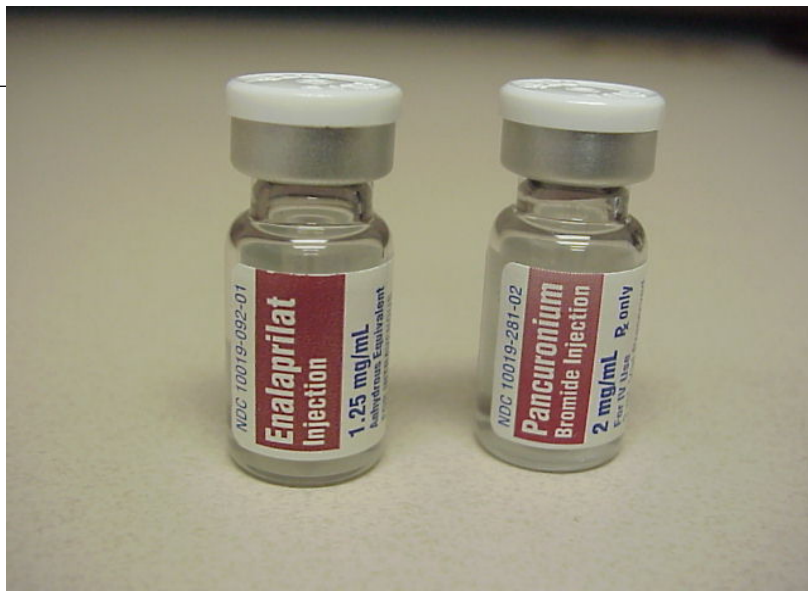
- US spends +15% of GDP on health care
- Wide variations in cost and spending
 - Spending more on health care doesn't guarantee improved quality, better outcomes, reduced mortality
- Health care costs rising at 2xs rate of inflation
- IOM: medical errors alone cost:
 - \$38-\$50 billion per year
 - \$17-\$29 billion per year in preventable errors
- And yet, Americans still receive only 55% of the right care for their conditions



Major Causes of Poor Quality

- Unsafe Systems: 9 in 10 quality problems caused by system of care
 - Systems redesign needed
 - Health IT and health information exchange can help
- Physicians are human:
 - amount and complexity of new information is beyond bounds of human cognition
 - Health IT is one tool
- US Reimbursement System doesn't reward quality of care
 - Current payment based on volume
 - Keeping patients healthy is not financially rewarded





THE AMERICAN
HEALTH QUALITY
ASSOCIATION

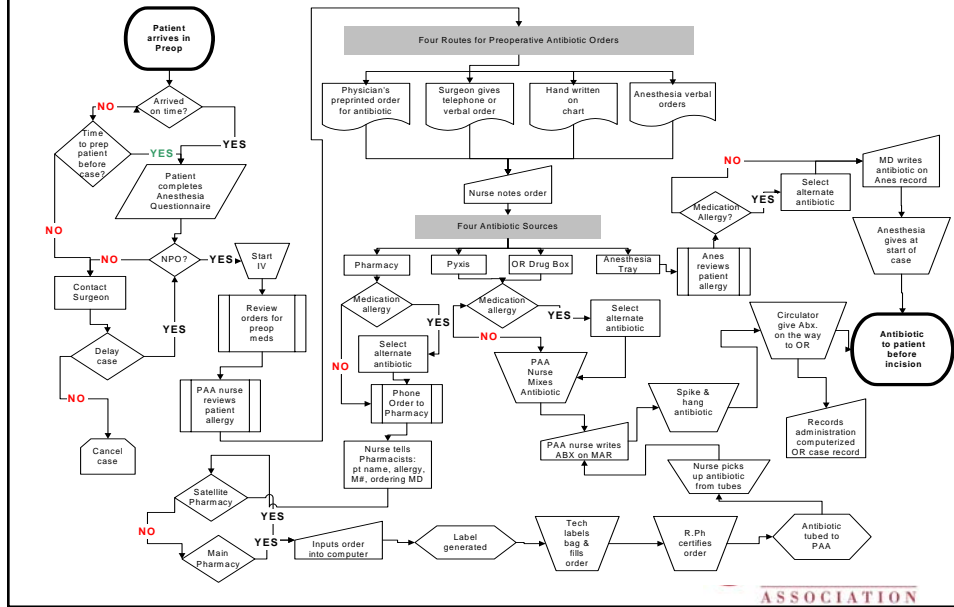
Paper Kills

Carvedilol 4 mg po qd

Regimen 4R Drug PDpe!

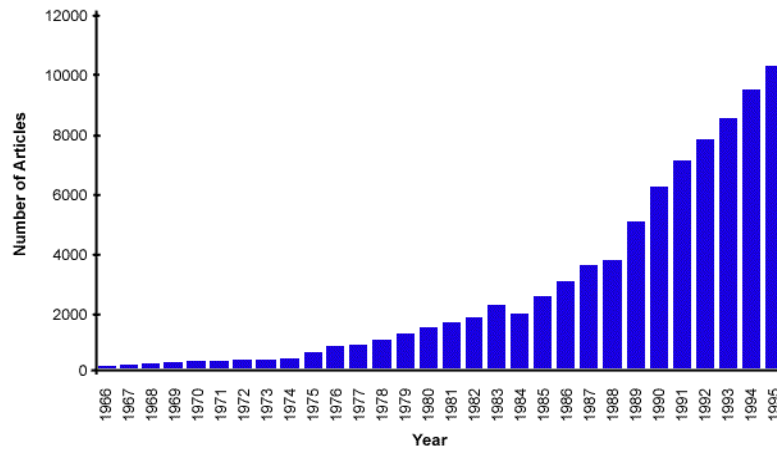
THE AMERICAN
HEALTH QUALITY
ASSOCIATION

Systems of Care are Complex!



Medical Information Pace Increasing

FIG. 1. Articles published from randomized controlled trials: 1966 to 1995



Source: Chassin, M.R., Milbank Quarterly; 76 (4) 1998, p.565-91



Good News: Quality Pays

- Premier Hospital Demonstration Project:
- If clinicians followed best clinical practices, they can:
 - Prevent 5,700 deaths
 - Avert 8,100 complications
 - Avoid 10,000 hospital readmissions
 - Save \$1.35 billion per year
- Problem: Much of the savings accrues to payers, not the hospital.



Result?

Medical errors
+ poor quality
+ high costs
+ realization that quality saves money
= **Pressure to reform the system**



Major Reforms under Discussion:

- Health IT and Health Information Exchange
 - Address quality & efficiency via systems redesign
- Public Reporting of Quality Data
- Transparency – Cost & Quality data
- Pay for Reporting
- Pay for Use
- Pay for Performance (P4P)
 - Demand and Reward quality care
- Consumer Strategies: differential co-pays, shared savings, public reporting on cost & quality (transparency).



Pay for Performance:

- Linking some part of provider reimbursement to their performance on valid measures of clinical quality (and efficiency)

Administration on P4P:

- P4P can help three areas:
 1. Inform Consumer Choice
 2. Reward Quality
 - And the investment it takes to get there
 3. Identify Opportunities to Improve



Pay for Performance:

1. Process Measures
 - Completion of tasks or recommended treatments known to improve outcomes.
 - E.g. Current set of 10 annual payment update measures reported to CMS
2. Outcomes Measures
 - Ultimate results of care, such as patient health status
3. Structural Measures
 - Resources assembled to deliver care, such as personnel, facilities, materials, information systems
4. Patient Experience Measures
 - E.g., Hospital Consumer Assessment of Health Plans Survey (HCAHPS)
5. Efficiency Measures
 - Cost of care associated with a specified level of quality.

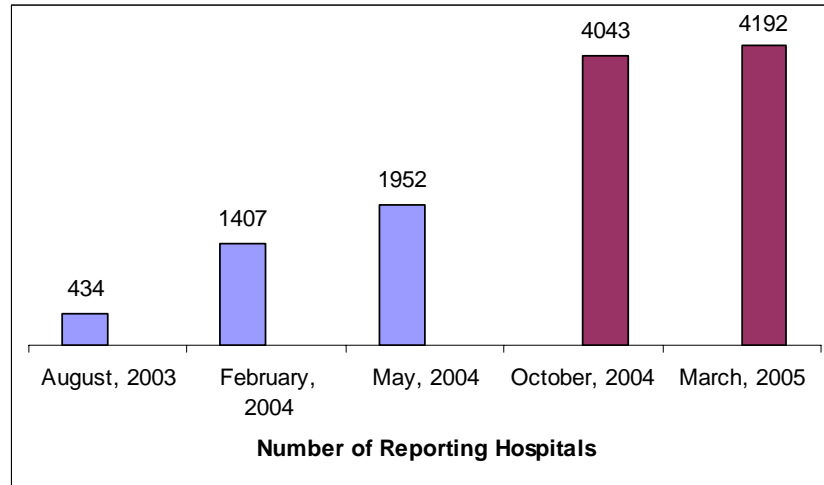


Trends in Performance Improvement: Hospitals

- Voluntary Public Reporting
 - Hospital Quality Initiative November 2001
- Pay for Reporting
 - 2003 Medicare Modernization Act (2004 start)
- More Reporting, Plan for P4P
 - Deficit Reduction Act of 2006



Hospital Public Reporting 2003-2004



98.3% of PPS hospitals now reporting



Deficit Reduction Act 2006

Hospital-Acquired Infections:

- October 1, 2007: hospitals required to report any secondary diagnosis of a patient at admission in order to receive payment
- HHS Secretary, with CDC, shall select diagnosis codes for at least two conditions that, when paired with secondary diagnosis code, result in assignment to a higher DRG.
- Codes must be
 - for high volume and/or high cost cases,
 - result in a higher payment when paired with a 2ndary diagnosis,
 - describe conditions that could reasonably be prevented by using evidence based guidelines.
- As of October 1, 2008, for the selected conditions/codes, if a secondary diagnosis code was not present at admission, then the case will not be eligible for a higher DRG payment.



Deficit Reduction Act of 2006

- **Expanded hospital public reporting**
 - MB minus 2 percentage points (vs. .4%)
 - Secretary can expand and replace current measures to include
 - Process, structure, outcome, patient experience, efficiency & cost of care
- **Secretary to develop plan for hospital P4P to begin in 2009**
 - Consider thresholds for improvement & public reporting.
 - Develop process for selecting quality & efficiency measures



P4P at the National Level

Key Players:

1. **Congress**
 - Health care costs and safety problems put payment reform on Congress's Radar
2. **The Administration**
 - Committed to reducing costs, improving quality but lacks authority for national P4P
3. **Private Sector**
 - Laboratory for innovation; home to much payer data



Congress

- Three bills specifically on P4P in last Congress:
 1. S. 1356 – Sens. Grassley/Baucus
 2. HR 3617 – Rep. Johnson
 3. S. 1481 – Sens. Enzi/Kennedy
- S. 1932 – Deficit Reduction Act of 2005
 - Passed; Included P4P Provisions
- FY2007 Budget Reconciliation
 - Created Reserve Fund for HIT or P4P



Key Points in Past P4P Bills:

- Require Secretary of HHS to develop process, structural, and patient experience measures
- Require measures to be risk-adjusted
- Require creation of NQF-like body
 - Private, non-profit entity to build consensus and receive public comment on proposed measures
- Require input from external stakeholders
 - Organized medicine, quality organizations, etc. House bill requires specialties to submit own measures
- 2 of 3 bills cover all care settings, including plans. House bill covers physicians only.



Congress & the AMA

- Signed agreement December 2005
- In exchange for SGR fix, AMA to propose 140 measures
 - Covering 34 clinical areas
 - By end of 2006
- Agreed to report data to feds in 2007
 - At least 3-5 measures per physician
 - AMA notes physicians “should receive” add-on payment for reporting



Congress & the AMA

- AMA told Senate May 22nd they are on track to have measures by year end
- Key Member of Congress predicts another SGR fix this year
 - Physicians currently scheduled for 5.1% cut for 2007
- Questions remain:
 - One year fix or permanent?
 - What Congress will require in exchange for SGR fix?



Key Players: the Administration

CMS committed to P4P

- Four Broad Strategies for Quality:
 1. Measure and Report
 2. HIT Use
 3. Process Redesign
 4. Transforming Organizational Culture
- Three mechanisms today:
 1. Assistance through Quality Improvement Organizations (QIOs)
 2. Reporting Initiatives
 3. Demonstration Projects



Price Transparency

Aug 22nd Executive Order Directs Federal Agencies To:

- 1. Increase Transparency In Pricing.**
 - Share with beneficiaries information about prices paid to providers for procedures.
- 2. Increase Transparency In Quality.**
 - Share with beneficiaries information on the quality of services provided by health care providers.
- 3. Encourage Adoption Of Health IT Standards.**
 - Use improved health IT systems to facilitate the rapid exchange of health information.
- 4. Provide Options That Promote Quality And Efficiency In Health Care.**
 - Develop and identify approaches that facilitate high quality and efficient care.



The Future

There is no way today for a patient to compare the value of health care choices. In the future, people will get information that will allow them to compare cost, quality, and related facts necessary to find high-quality, low-cost health care. Likewise, physicians and hospitals will have the comparative information they need to improve.

Surgical Care Consumer Guide

Search Results: Hip Replacement

[What's included in the cost?](#)

Summary

Average Cost in Network Facility: \$11,249 - \$15,895

Out of Network Facility: \$18,889 - \$23,460

Results sorted by: Quality

Sort by: Distance

GO

Key

Quality: ★★★★★ Highest | ★ Lowest

Cost: \$ Least Expensive | \$\$\$\$ Most Expensive

Patient Assessment: ★★★★★ Highest | ★ Lowest

Distance (miles)	Facility Name	Patients per year	Quality	Cost Estimate	Insurer Pays	Patient Pays	Patient Assessment of Care
6.2	Good Samaritan Hospital 1111 E. Samaritan Drive Tampa, FL 22222	232	★★★★	\$ \$15,895	90% (\$14,306)	10% (\$1,590)	★★★★
13.2	All Saints Medical Center 123800 All Saints Way Tampa, FL 22122	86	★★★★	\$\$ \$20,700	80% (\$16,560)	20% (\$4,140)	★★★
25.6	Clearwater General 14280 Bay Drive Clearwater, FL 22131	400	★★★	\$ \$15,895	85% (\$13,511)	15% (\$2,384)	★★
26.3	Tampa Hip Hospital 1400 East Tampa Boulevard Tampa, FL 22211	170	★★★	\$\$ \$20,700	75% (\$15,525)	25% (\$5,175)	★★★
27.3	Orthopedic Clinical Hospital 1444 Goodie Drive St. Petersburg, FL 22113	432	★★	\$ \$11,600	70% (\$8,700)	25% (\$2,900)	★
33.2	Valley General Hospital 1400 Tampa Bay Way Tampa Bay, FL 22031	135	★	\$\$\$\$ \$22,000	70% (\$15,400)	30% (\$6,600)	★★

* Sample for illustrative purposes only.

AQA Pilots on Transparency

- “Better Quality Information” Pilots
- Six Sites
 1. California Cooperative Healthcare Reporting Initiative
 2. Massachusetts Health Quality Partners
 3. Indiana Health Information Exchange
 4. Minnesota Community Measurement
 5. Phoenix Regional Healthcare Value Measurement Initiative
 6. Wisconsin Collaborative for Healthcare Quality
- Test methods for aggregating public & private payer data
 - to publicly report on cost & quality
- Likely future influence on P4P:
 - Data collection, measurement, reporting



Physician Voluntary Reporting Initiative (PVRP)

- Significant step toward P4P
- Initiative began January 2006 – can submit data
- Creation of temporary HCPCS Codes (G-Codes)
 - 16 measures (starter set)
 - Physicians report G-Codes on claims, receive feedback via reports on quality from CMS.
 - Reporting is NOT public
 - EHRs intended to be future method for data collection
 - As of May 2006, CMS says 3,000 docs have indicated interest. Registration begins in October '06.



CMS P4P Demonstrations

- Premier Hospital Quality Incentive Demo
 - (Operational since 2003)
- Physician Group Practice Demo
 - (Operational since 2005)
- Medicare Health Care Quality Demo
 - (Open Solicitation)
- Nursing Home P4P Demo
 - (RFI)
- Medicare Care Management Demo
 - (in Design)
- AQA Pilot – (MA, IN, MN, AZ, WI, CA)
 - Operational. Data aggregation across multiple plans for public reporting; expected to serve as national template



Coming Together: Trends for Physicians

- Physician Voluntary Reporting Program began January 2006
 - Precursor to P4R, P4P
- AQA Pilots will include ambulatory data on cost & quality
- Physician Payment Formula Needs Fixing by Congress
- Big push for Health IT
 - Needed for best performance measurement
 - DOQ-IT, HIE, NHIN



Private Sector

- Over 100 programs to date
 - In various operational phases, varying designs
 - Bridges To Excellence, Leapfrog, United, IHA, etc.
- P4P tends to take root in areas with large medical groups, integrated systems or IPAs
 - Difficult for smaller practices to invest required resources for improvement
- Variable nature affects reward size:
 - For meaningful rewards, more payers must participate
 - Must pass cost/benefit analysis to get doc participation
- Private initiatives help inform national debate



Issues in P4P

- Design Issues Remain:
 - Size of reward & number of participating payers
 - Pay for target vs. improvement
 - Measures (type & alignment); adverse selection?
 - Provision of technical assistance
- Get beyond the money - P4P must include:
 - Technical assistance
 - Public reporting & incentivized consumers
 - Engage and incentivize lower performing providers
- Health IT and HIE needed
 - Data collection, care coordination, etc.



Issues in P4P

- Is P4P really reform?
 - Doesn't get at root of payment system
- Not a lot of evidence indicating it will work
 - Advocates argue it makes too much sense not to work
 - Other efforts to examine and reform payment system underway:
 - Ex: PROMETHEUS



For More Information:

- <http://www.ahqa.org>

Christine Bechtel
Director of Government Affairs
202-261-7569 direct
cbechtel@ahqa.org

