

P4P Research Summary

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Executive Summary

(Includes descriptions of programs, juicy validating quotes from research, and cites)

1. I found five types of programs in 19 entities but they really amount to two with some variations (descriptions attached):

a. Paying extra for something which hasn't been done

- i. Paying for HEDIS scores based on benchmarks or not
- ii. Paying for something else clinical but not specifically HEDIS – (e.g., diabetes flow sheets, asthma action plans)
- iii. Paying more in a tiered system where better performers get more than others
- iv. Paying extra for quality with non-clinical things (epay submission, openness to company's members)
- v. All of the same plus patient satisfaction
- vi. All the same sort of thing with extra pay for IT, EMR or PDAs or providing them at no cost

Comments for our chart: Only works on underuse;

Where you only get the money based on a tier you have no certainty you will get anything and no control over the pool;

It increases cost to the group (see quotes)

b. Guidelines based behavior

I found one plan (Excellus) which claims it will pay for performance of community based guidelines of care for chronic conditions combined with an automated reminder system ; but it's still underuse only

c. CMS Model which is, not surprisingly, a gainsharing % of savings model and more complex than I care to learn about for our chart; but the basic idea is it's complex; it's undecided in the details but will be when bid in response to the RFP; it's about cost savings and not following guidelines.

2. It was surprisingly difficult to get real information about these programs even having spent about 6 hours or more mucking around about it.

3. Most of these programs are very new with few results to report although what data there is demonstrates that if you pay physicians to produce measures, they will. The question is at what cost to them, at what cost to things they aren't paying attention to, and you still only get the underuse problem solved and not overuse or misuse.

Types of P4P Programs

1. “Tiered” Normative Comparisons of Performance regarding numbers of patients receiving services and patient satisfaction

Anthem New Hampshire (since 1999)

If 100 members in the plan between \$10-\$30 per enrollee (max \$20,000) if physician is in top 25% of practices re: specific measures. To get the pay, practice must be above 50th %ile. Top quartile gets at least double the middle (3d) quartile; breast and cervical screening, retina exams for diabetics, well child exams, childhood immunizations

Blue Cross Blue Shield of Illinois

Pap smear rate, flu vaccines, use of asthma action plans; use of diabetes flow sheets. Additional money for top performers.

Central Florida Health Care Coalition (beginning 2003)

Three tiered fee schedule, platinum, gold and silver for groups producing performance measures on diabetes, asthma and CHF –inpatient and outpatient data; Highest group gets lower co-pays, lowered administrative hassles – no formulary or prior auth; just do PDA based prescribing and lab studies ordering after 2 years (also participate in mini-residences?)

Bridges to Excellence GE-Ford-UPS : Boston, Cincinnati Louisville

Bonus if in top tier on diabetes measures, additional \$50/patient per year to invest in IT

Independent Health in Buffalo

Up to \$1.50 pm/pm for measures on five scores. Average physicians get one rate, higher get more.

CIGNA-Promina Atlanta

How long pneumonia patient waits before receiving an antibiotic
CHF patients getting ACE inhibitors
Physicians placed in three payment categories with a 5% pay differential among the tiers.

Blue Cross Blue Shield of Massachusetts

* Quality - The insurer will review claims from primary-care physicians for eight types of care, including whether the doctors gave HMO Blue female patients mammograms and pap smears, and whether they saw children with asthma to adjust their medications and asked teenagers about their drug and alcohol use.

* Patient satisfaction and access - Blue Cross will survey 200 patients who see specialists in each group, asking 10 questions, such as whether their doctors explained their treatment options and discussed the side effects of medications.

* Cost - The plan will tally the money it spent to treat HMO Blue patients in each physician group, including dollars that went to prescription drugs, surgery, overnight hospital stays, lab tests, and imaging tests. Blue Cross will calculate how much costs increased for all the groups, on average, during the year.

Groups whose costs increased less than the average will receive a bonus. Groups that perform better than average on the quality and satisfaction and access measures will earn an even larger bonus - up to the 15 percent. The plan will pay the bonuses for 2003 during the middle of 2004.

Blue Cross will reward doctors more for limiting costs than for excelling on the quality and satisfaction measures. (From Boston Globe) So then how quality oriented is it?

2. *Money for measures of a combination of things not all quality related*

Highmark of Pittsburgh

Physicians must achieve a minimum score on quality and satisfaction measures: internists have 8 HEDIS based measures, FPs have 12; peds have 6. Points are also earned for night and weekend office hours and for submitting claims electronically.

Aetna

Pt satisfaction, medical records, access to care; 'burden if illness'(?); office open to Aetna; e-pay participation. Weights of measures vary across markets. Local variation in some measures

2. *Money for HEDIS Scores:*

Originally I thought this was the basis for BCBS of Mass and Highmark but upon further research even they are benchmarking and not paying purely for the scores. I'm going to leave this here because it is a way of doing it, I haven't found purely, but that must exist somewhere.

3. *Money for Other Measures and Patient Satisfaction*

Touchpoint of Wisconsin (best HEDIS scoring health plan in the country in 2002)

Five years ago they identified some chronic illnesses began to offer bonuses of 5-15% to PCPs, specialists could earn 10%

Trigon of Virginia (can't find data on Anthem website - they've merged)

More money for reducing sinusitis/ rhinitis, patient satisfaction, tobacco screening

Hawaii BCBS PPO

up to 5.5% of their annual billings up to \$12,500

Integrated Health Association (California)

5-10% bonus in 2004 for 2003 data

improved patient satisfaction and clinical measures on 3 chronic care measures (asthma, diabetes, CAD) 3 preventive measures (breast, cervical cancer screening and childhood immunizations)

Clinical indicators = 50% of score; 50% = pt satisfaction

6 plans agree to same measures (not necessarily to what to do with them)

NCQA gets grant from CHCF through PBGH to develop the measurement system

Employers' Coalition on Health (Rockford Illinois)

Care flow sheets completed for at least 95% of diabetic encounters;

65% of diabetics have hemoglobin A1c below 7.5

Tri-Rivers Employers Health Care Coalition (Dayton, Ohio)

Bonus pool for medical groups that meet specific quality performance thresholds;

New FFS reimbursement for care planning activities

Blue Cross of California (Rewarding Results Grantee)

Each physician has at least 10 patients in each measure in the PPO program;

Up to \$5000 per doctor. Non-financial incentives may be added such as free internet based tools to give access to most current clinical and scientific data

“The proposed quality improvement program is currently targeted toward approximately 15,000 physicians of the following specialties in the Blue Cross PPO network: Family Practice, General Practice, Internal Medicine, Obstetrics/Gynecology, Pediatrics, Cardiology, Pulmonology, Gastroenterology, and Psychiatry.

The measures were selected because the indicated care processes are directly linked to improved health outcomes and reduced burden of illness (i.e., functioning, reduced disability, survival). To improve the credibility and validity of the proposed clinical measures, we selected standardized measures from HEDIS® and Medicare's Health Care Quality Improvement Program (HCQIP) when possible.” (*From their press release)

70% of bonus based on combination of clinical and patient satisfaction measures including antihypertensive medications or long term control drugs for asthma patients, and diabetic retinal exams

Other 30% for changing admin and filing electronically, using internet eligibility system participating in other HMSA products

Blue Shield of California

Smoking cessation and easy access to appointments will get year end bonus of 5% of cap or \$2 pmpm

4. *Guidelines Based Behavior Rewarded*

Excellus Health Plan/Rochester Individual Practice Association (Rewarding Results)

“Rochester Individual Practice Association and Excellus will develop a physician reimbursement program based on the community care guidelines for chronic conditions developed in collaboration with the Rochester Health Commission. RIPA provides physician services to members of Excellus' Blue Choice managed care plan. RIPA physicians will receive reports every four months allowing them to benchmark their practice against the community care guidelines. RIPA and Excellus will also offer consultations and guidance to individual physicians and physician groups seeking to stay current in caring for chronic illness. Excellus' Blue Choice members will receive an annual summary of their care.

The automated reminder system is proprietary technology first developed by Univera Healthcare, a health plan owned and operated by Excellus in western New York (Buffalo). With this grant, Excellus is expanding this program to its Rochester based health plan, BlueCross BlueShield of the Rochester Area. The system will provide RIPA physicians with information for the plan's Blue Choice members.” (From Excellus website.)

5. *Gainsharing?*

CMS demonstration project with 6 groups of at least 200 physicians over three years. They are paid FFS. IF they can generate at least 2% of savings they can keep the money and there is an additional bonus for a percentage of patients getting quality benchmarks. Because patients go in and out of FFS arrangements, they get more if they do more E & M visits than other practices.

“Under the 3-year demonstration, physician groups will be paid on a fee-for-service basis and may earn a bonus from savings derived from improvements in patient management. Annual performance targets will be established for each participating physician group. Bonuses for financial performance and quality improvement may be earned if actual Medicare spending for beneficiaries assigned to the group is below their performance target.”

Description of the methodology is 211 pages. That says enough for me. I ain't reading the whole thing.

Useful Quotes

RE; Touchpoint approach of paying for HEDIS measures to improve them

“This is a tough sell to customers.”

---Managed Care Magazine article.

RE: IHA program: new money or old.

“Tapping money doctors already earn and shifting it into a new program, says Bangasser, is formula that won’t motivate anyone.”

--Managed Care Magazine

“If we were paying doctors what they needed for the services they provide, along with the bonuses, then we would be somewhere,” says Jerry Flanagan, senior health care advocate for the not-for-profit California group [Foundation for Taxpayers and Consumers Rights] which has been harshly critical of the growing profits posted by regional health plans. “Adding a marginal bonus,” he adds, “won’t make a difference. The key issue is that health plans are paying doctors the same amount for sick patients as they do for healthy patients. We need risk-adjusted capitation in order to give incentives to physicians to spend more time with those who need care.”

--Managed Care Magazine

“Dr. Berwick looked at eight quality improvement initiatives undertaken by health plans, hospitals or employers. While many were undertaken because of their clinical rather than financial benefits, virtually none of the interventions saved money for the organization that launched them. “most of the improvements saved money somewhere,” Dr. Berwick said. “Almost none of the programs returned money to the innovating provider.”

Brent James describes moved to improve treatment of community acquired pneumonia in Medicare. Costs fell by \$1.2 Million, but revenues fell by \$1.5 million for that class of patients. By improving quality of care it kept patients out of DRG for long-term ventilator support (\$16,400 per case). They got \$4,600 per case but the actual cost was \$5,200 per case.

---AMNews 11-4-2002

In a study released last year by the NHCPI ten of 30 markets are cited as ripe for incentive plans Pittsburgh, Minneapolis, Boston, Los Angeles/Riverside, Buffalo, San Diego, Portland, Philadelphia, Sacramento and San Francisco. Factors included positive experiences with incentive plans, high levels of health plan participation and competition among PCPs.

--Greene, Healthplan article

“The only concerns physicians have with the incentive plans are data accuracy and the administrative burden of tracking different plans, says Bangasser of the CMA.”

-- Greene Healthplan article

“Dr. Charles Welch, president of the Massachusetts Medical Society, said a bonus of at least 10 percent is required to persuade physicians to do the extra work. Internists in the Northeast earn an average of \$150,000 annually, according to the American Medical Group Association. Welch also worries that plans simply are holding back money they would have otherwise put into regular fees and requiring doctors to earn the dollars back through bonuses. This outcome is entirely possible, plan executives acknowledge.”

-- Boston Globe

“The seven-physician group earns only about \$15,000 a year from Anthem’s quality bonus, Dr. Kelsey said. The practice spends some of that money paying staff to fill out plan forms and double-check claims data, all of which are necessary to earn the bonus.”

--ACP-ASIM Observer

“The data we usually get are junk,” said Dr. Kelsey, the New Hampshire internist. While the incentive program he participates in with Anthem relies on the plan’s claims data, the group’s own support staff does some chart reviews to make sure the plan’s information is accurate.”

--ACP-ASIM Observer .

Since 1994, Blue Cross of California has offered physicians a bonus of up to 70 cents per patient per month. The old bonus was based on measures such as patient satisfaction, HEDIS scores and management of both utilization and appeals and grievances.

The new program will still reward groups based on patient satisfaction and clinical measures, but it will also give groups bonuses for collecting quality information on their individual physicians and implementing a pay system that compensates physicians based in part on how well they meet those goals. Through the new program, Blue Cross hopes to encourage groups to link physicians’ day-to-day reimbursement to their performance in certain quality measures.

“We have many administrative costs related to dealing with unhappy customers who file grievances and change doctors,” explained Jeff Kamil, MD, Blue Cross vice president and medical director. “This program provides incentives directly to physicians to treat our members well, and we think having more satisfied members should help grow our enrollment.”

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Gainsharing

