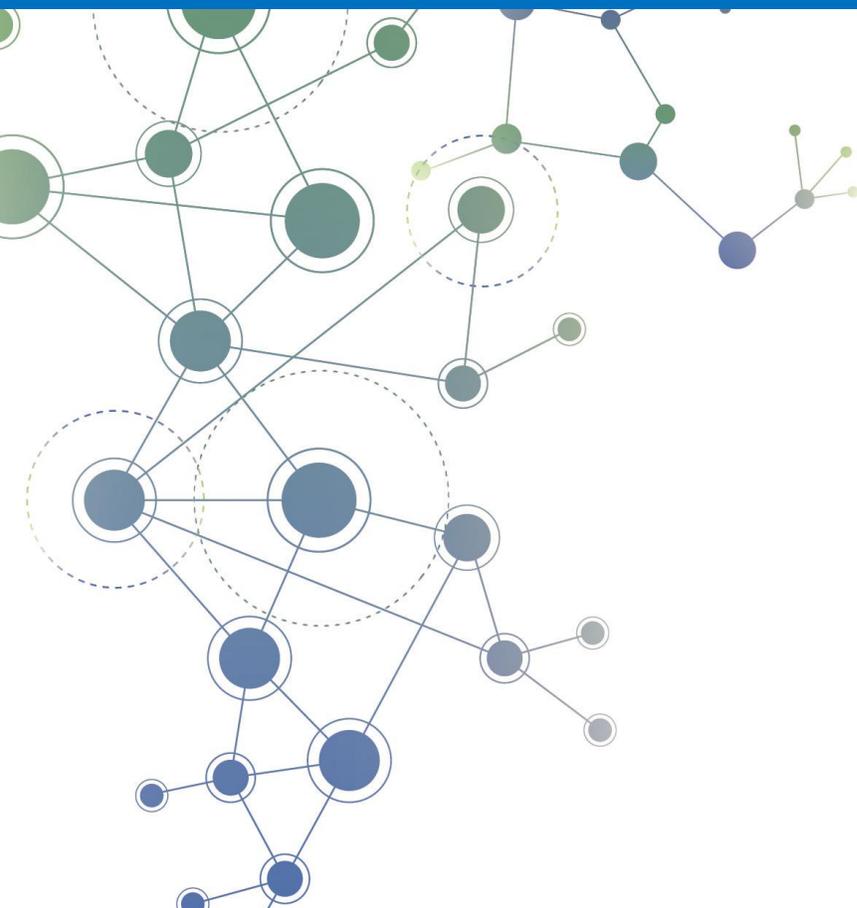
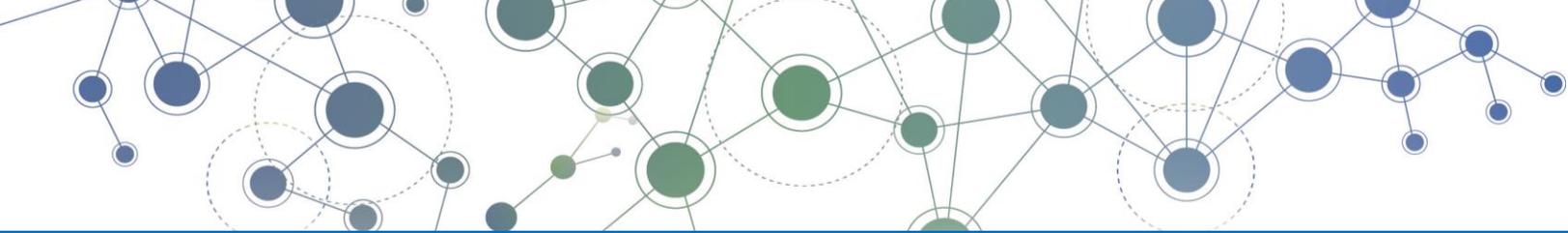


Pay-for-Performance (P4P) Strategies for Health Plans and Provider Networks

Building Collaboration through Technology, Shared Value, and Trust





Introduction

Healthcare spending in the United States continues to skyrocket at an unsustainable rate - projected by experts at 19.85% of GDP by 2021¹. Pay-for-performance (P4P) programs sponsored by health plans that reward their provider network for the quality of the services they provide versus the quantity of those services are becoming more prevalent to help contain these rising costs. Many provider networks have already or are in the process of adopting these valued-based care models. It goes without saying that this transformation has been a challenge as these organizations try to navigate uncharted waters.

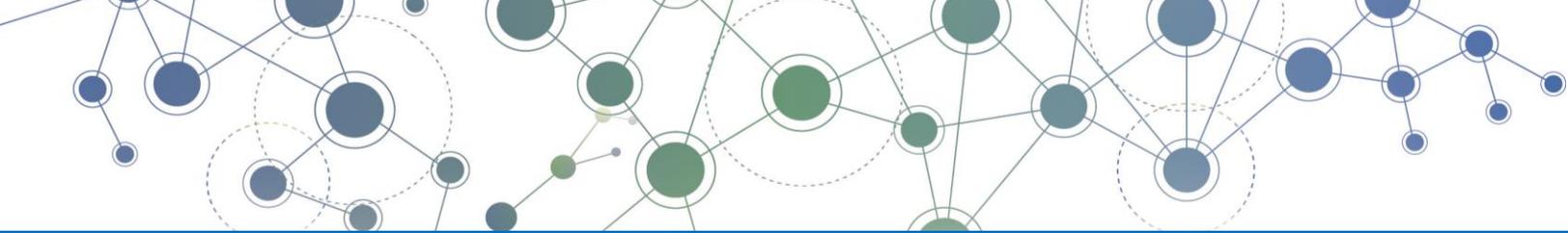
As the landscape of healthcare continues to make this shift, health plans, health systems, and individual providers are being asked to change the way they provide care to align with the incentives of these new programs. Under these new models:

1. Providers are shifting to a proactive, population-based care models.
2. Health plans are paying providers based on the measured risk of their population and/or the quality of care they are rendering.

Although the ultimate goal of all stakeholders is to improve care while reducing costs, there has been resistance by both parties to change. Providers first and foremost want to deliver the best possible care to their patients, but they also want to maximize their own quality of life (including income and workflow). For these (and other) reasons, they are often resistant to plan-driven changes to the way the practice and are concerned they will be punished at contracting time if plans have too much access to their data. Similarly, plans are hesitant to invest too much in incentive programs for providers that are heavily resistant to change and are not willing to objectively prove beyond self-reporting they are moving the needle on quality and cost reduction.

To bridge this gap, both health plans and providers must have clear visibility into this shared risk and reward, as well as the measurable impact that quality initiatives are having on their patient/member populations. A trusted, high-quality, and objective data asset that accurately captures and reflects the health of patient populations and the quality of care rendered is the foundation for success under these new payment models.

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Before diving into some specific challenges associated with building a high-quality data asset – including data capture, aggregation, population reporting, and IT strategies - it's important to take a step back to understand the core structure of pay-for-performance programs and the different payment models that currently exist that are supporting this transformation.

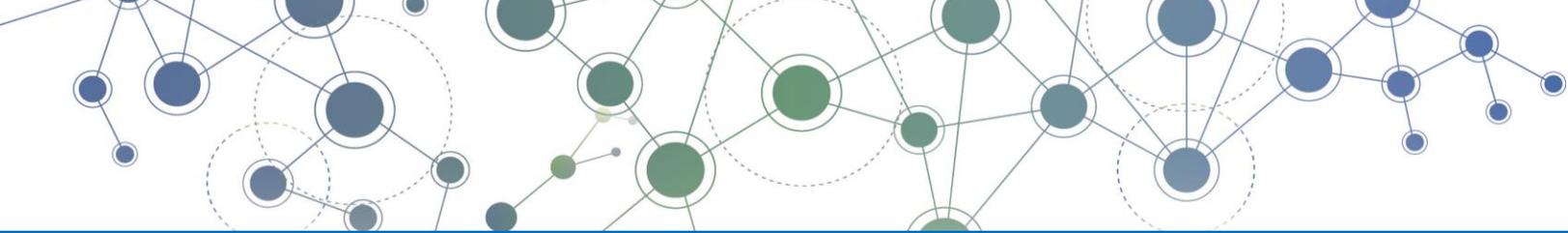
What is P4P?

The Agency for Healthcare Research and Quality (AHRQ) defines Pay-for-Performance as “programs designed to offer financial incentives to physicians and other healthcare providers to meet defined quality, efficiency, or other targets.” Although the concept of healthcare reform seems fairly new, P4P programs have been in play for well over decade in a number of different care settings. P4P is rooted in three core principles: measurement, transparency, and accountability².

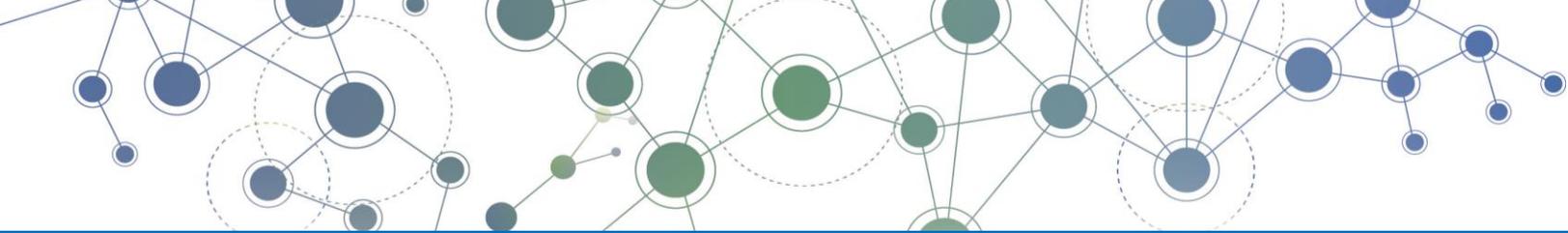
- **Measurement** serves as the baseline level of quality to gauge improvement.
- **Transparency** ensures that quality data is translated into measures and reports that consumers and purchasers can understand and use to make informed decisions.
- **Accountability** requires those who deliver health care be accurately measured – as they cannot be held accountable without the transparent measurement of their performance.

As P4P programs continue to evolve, different models have been adopted and adapted from these core principles. The chart on the next page breaks down a few of the more well-known models being utilized today, outlining some of the fundamental differences between them.

“The Agency for Healthcare Research and Quality (AHRQ) defines Pay-for-Performance as ‘programs designed to offer financial incentives to physicians and other healthcare providers to meet defined quality, efficiency, or other targets.’”



Program	Reimbursement Model	Clinical Metrics	Financial Metrics	Examples
Global Payment Program	Quality Incentives	<ul style="list-style-type: none"> - Clinical Quality - Patient Outcomes 	<ul style="list-style-type: none"> - Resource Utilization - Quality improvement based on designated set of measures 	Massachusetts Alternative Quality Contract (AQC) - Founded in 2009 by Blue Cross Blue Shield of Massachusetts, the model includes 11 provider organizations from the state. Researchers at Harvard found that the model can slow the growth of medical spending and improve the quality of care for patients, as well as improve the quality of chronic care management, adult preventive care and pediatric care ³ .
Commercial Quality Contract	Quality Incentives	<ul style="list-style-type: none"> - Chronic Care - Preventative Health - Patient Safety 	<ul style="list-style-type: none"> - Quality performance 	California P4P – Approximately 200 physician organizations (POs) participate in the program, which covers approximately 9 million Californians enrolled in commercial HMO and POs products. The organization has paid out over \$450 million in incentives through 2012 based on performance results, which have shown a steady, incremental improvement in quality metrics over time ⁴ .
Pioneer ACO Program/Medicare Shared Savings Program	Shared Savings	33 performance measures outlined by CMS in four quality domains: Patient Experience of Care, Care Coordination/ Patient Safety, Preventive Health, and At-Risk Population.	<ul style="list-style-type: none"> - Claims Data - Performance against clinical benchmarks - Total Cost of Care 	Montefiore ACO (NY) – A Pioneer ACO comprised of physicians in the community and across the health system, the organization improved the quality, outcomes and cost of care for Medicare patients. The savings represent a seven percent reduction in cost of care and based on its success in the first year, the organization will receive about \$14 million of the savings it generated for Medicare.



Building a Case for P4P

In “Pay for Performance: A Promising Start,” a 2006 document produced by the Alliance for Health Reform, National Committee for Quality Assurance (NCQA) president Margaret O’Kane states “We do not have a neutral payment system today. We have a payment system that actually rewards poor performance.” The document goes on to argue that a fee-for-service payment system actually penalizes a doctor who follows evidence-based guidelines and performs fewer services.

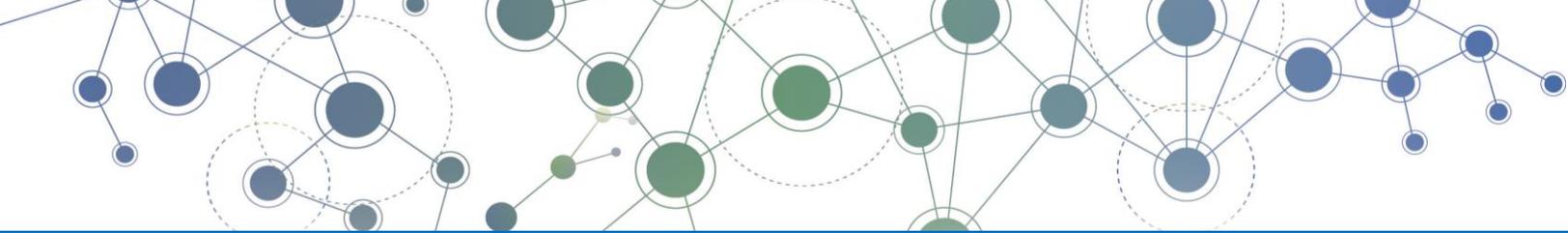
P4P programs aim to directly address these deficiencies in our healthcare system. When executed properly, these programs can create mutually-beneficial outcomes for all parties involved, including health plans, providers and patients.

For Health plans

Health plans are typically driving P4P programs, as they have the most to gain financially. By incentivizing providers to use preventative procedures, this ultimately reduces the amount of unnecessary tests, procedures and medications administered to patients, which are costly to the health plan. P4P programs also aim to effectively manage chronically-ill patient populations - also very costly to the health plan. Many health plans have already implemented incentive programs that target specific conditions and at-risk patient populations. In 2013, Reuters reported that major health plans, including UnitedHealth Group, Humana Group, Cigna Corp. had already started to compensate providers who meet targets for such conditions as cancer screening and managing cholesterol levels in diabetic patients⁵. Although the long-term impact of these programs is yet to be seen, health plans are already seeing positive implications. In the article previously mentioned, Reuters also cited a 2012 study published by *The Journal of American Medical Association* that showed that these compensation programs can produce a 5-10% shared savings between the provider and health plan.

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*- Margaret O’Kane,
NCQA President*



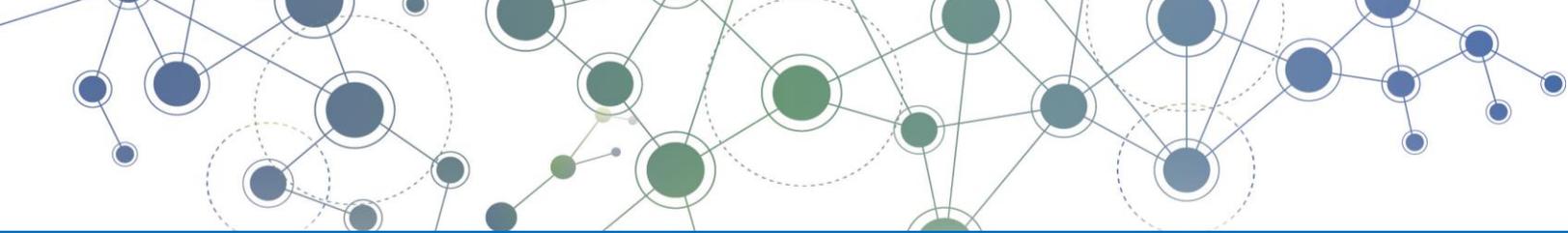
For Providers

Under P4P models, providers are incentivized to provide the “right” care to their patients. Fee-for-service programs encourage providers to provide more services, which can be costly and do not always have the patient’s best interest in mind. This is especially rings true chronically-ill patients. The primary goals for these chronically-ill patients are typically to reduce emergency department visits, hospital re-admissions and repeat procedures for the same condition within a set time period. Fee-for-service programs reward physicians financially for performing these avoidable complications. P4P programs reward providers for how they want to practice medicine – by providing the best care for their patients at a minimum of cost.

For Patients

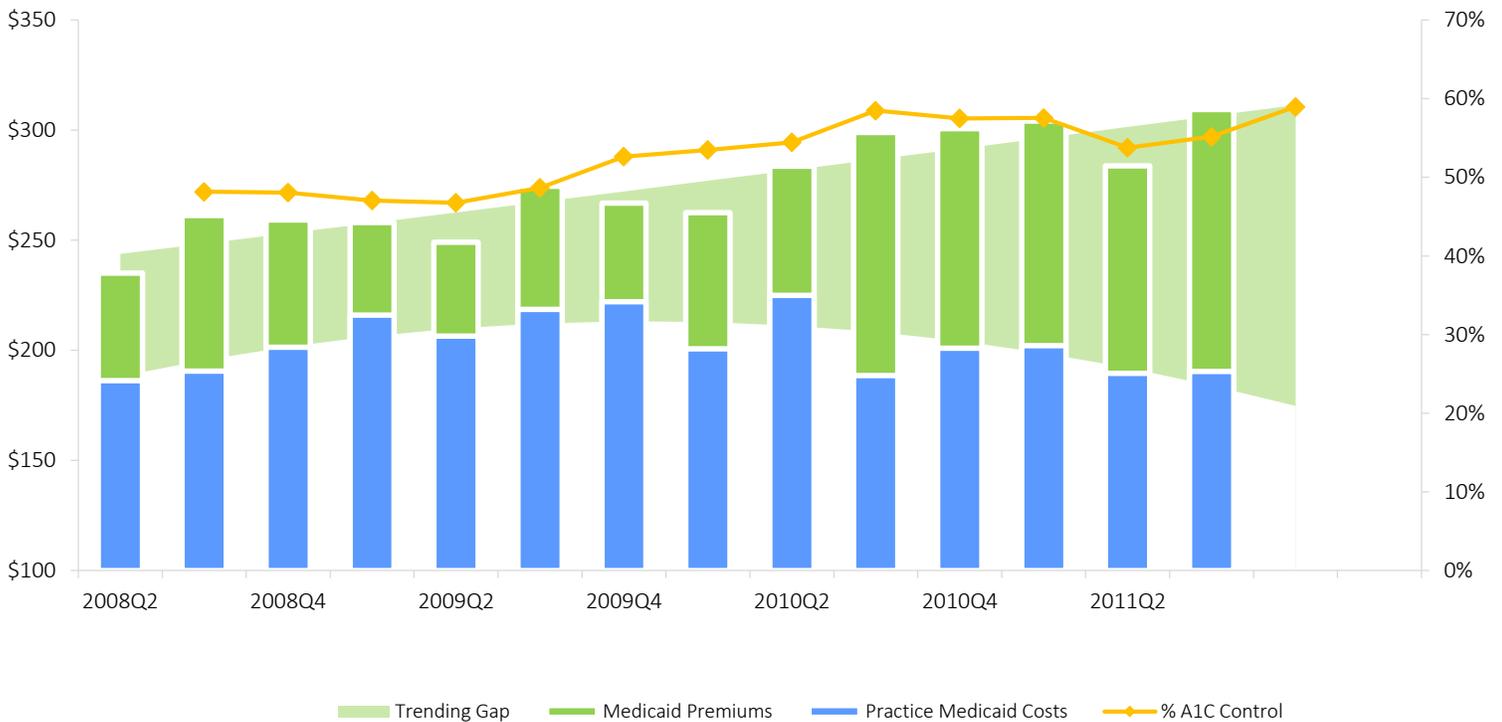
Patients can also benefit greatly when their healthcare providers participate in P4P programs. As physicians are incentivized to provide better care in aggregate, individual patients ultimately will receive that better care. Patient engagement is critical element of this formula. Providers that proactively engage patients to provide preventative care will prevent them from developing more serious chronic conditions. The direct impact of P4P programs on patient care is already being measured. Two randomized trials published in the *Journal of the American Medical Association* showed improved cardiovascular risk factors in all patients, including those with type 2 diabetes, in patients seen at practices that used "pay-for-performance" (P4P) incentives⁶. The studies concluded that financial incentives can not only increase adherence to pre-specified treatment algorithms, but also improve clinical outcomes. Although the long-term impact of P4P programs is yet to be seen, early research indicates these programs can result in a better quality of life and lower healthcare expenditures for the patient.

“P4P programs reward providers for how they want to practice medicine – by providing the best care for their patients at a minimum of cost.”



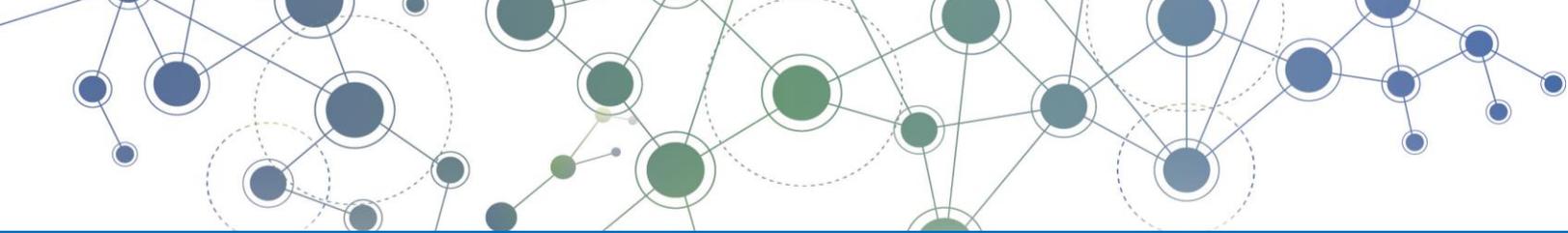
What Does Success Look Like?

In the below example, a community health center (CHC) with 5,500 Medicaid patients entered into a P4P like contract with a Medicaid Managed Care Organization. By implementing robust technology, care team redesign, and other quality improvement and cost reduction initiatives, the CHC saved \$1M in their first year, returning \$5M to the health plan reserves, while improving quality overall (like % of diabetics with A1C in control).



P4P Programs Are Neither Flawless nor Easy

Although P4P programs sound perfect in the abstract, and have shown short term promise, they are not perfect (or else everyone would be doing them). A core issue is that health plans struggle to provide, and provider networks struggle to adopt the required technologies to support these types of programs. As a result, there is a sense of fear among provider organizations due to lack of quality data, which causes distrust of these payment models.



Lack of Data

As much promise as P4P programs have shown, there is still a significant lack of data that supports its effectiveness, and when it exists the lack of trust in the data is the ultimate issue. Providers do not feel claims data accurately reflects the care they are delivering, but are reluctant to provide the EHR data that does reflect their practice. Health plans don't trust easily manipulated self-reported quality measures as they are burdensome to gather and more prone to fraud. This is where linking heterogeneous EHR and claims data, brokered by a trusted third party is key for success.

Lack of trust between providers and health plans

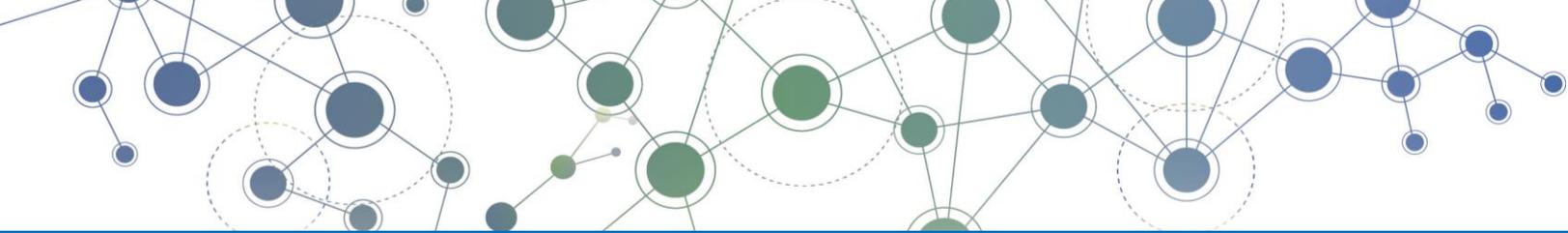
Although in theory P4P seems like a win-win situation for providers and health plans, there are a number of underlying issues between both parties behind the scenes. Providers fear that health plans do not have their or their patients best interests in mind when outlining performance measures. They feel that health plans are only concerned with containing costs through lower reimbursement rates and draconian contracts to improve their bottom line versus actually improving quality, which negatively impacts patient care.

On the other hand, health plans are concerned that providers are not making the appropriate changes they need to for these new payment models to work and are finding creative ways to "beat the system" instead. When providers manipulate performance measures, it skews the view of the quality of care they are providing by only focusing on the patients they benefit the most from.

Fear of Rationing, Cherry Picking

Health plans are concerned that providers will only focus on or "cherry pick" the patients that they will receive the most financial incentives from. The obvious concern is that only a small sample of the provider's patient population will determine reimbursement. Serious concerns have been raised about the impact of these practices on poorer and disadvantaged populations. In particular, there are fears that these programs may exacerbate racial and ethnic disparities in healthcare if providers avoid patients that are likely to lower their performance scores. There is also fear of rationing among providers. They feel that the incentives outlined by health plans reduce high-cost procedures encourage budget-based care, ultimately limiting the services required to properly treat these high-risk patient populations.

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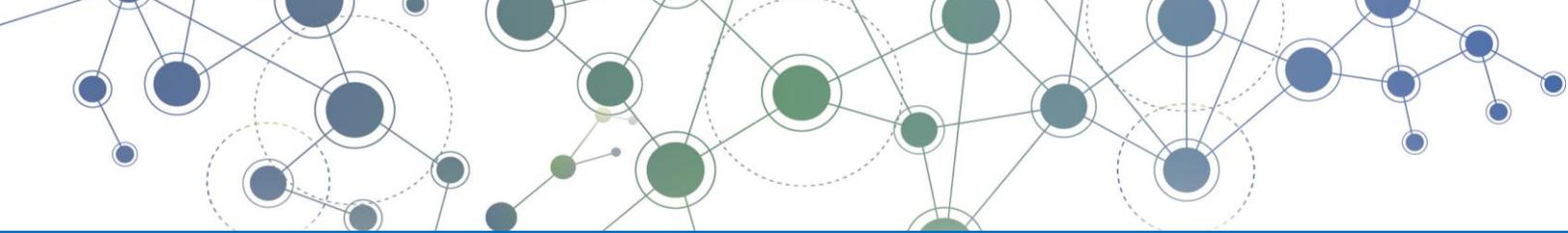
Insufficient Incentives

Although the general consensus is that a change needs to happen to control healthcare expenditures, providers do not always see the immediate benefit from P4P programs, but are still forced to bear the upfront brunt of this transformation. According to the Centers for Medicare & Medicaid Services (CMS), when considering P4P program incentives, “the size of the incentive should be sufficient to cover costs that are incurred to earn the incentives or peg the incentive to an amount that is deemed necessary to motivate a change in provider behavior⁷.” Lower-performing providers are often getting less than they would under FFS models, creating further resistance to change⁸. Providers also feel the performance measures they have to meet do not always reward them for the level of care they are providing to their patients. This means that the aspects of quality that are hard to measure may suffer if providers are only reimbursed for the aspects that can be measured⁹. In his blog, Dr. Ashish Jha, Associate Professor of Health Policy and Management at the Harvard School of Public Health, addresses some of these concerns surrounding P4P and states “if you really want hospitals and other provider organizations to change behavior, put real money at risk.” He goes on to say that size of the incentives matter and if incentives for a performance goal are small, organizations will only make small changes¹⁰. For P4P programs to be successful, health plans and providers must come to a mutual agreement on incentives and not hesitate to put some skin in the game.

Provider organizations can move past the challenges of P4P programs by implementing the proper tools to drive change. Three critical elements for success are: technology, processes, and people.

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Critical Success Factors

Provider organizations can move past the challenges of P4P programs by implementing the proper tools to drive change. Three critical elements for success are: technology, processes, and people.

Technology

Data is the driving force of any performance-based program. But the quality of that data can make or break the success of that program. The data generated should accurately reflect the quality of care delivered within an organization, otherwise, it defeats the point of implementing a value-based contract in the first place and will destroy the required level of trust early on. The first step is to develop a structured way to capture data through the EHR. There are many downstream processes, including EHR configuration, data transport, aggregation, normalization, and reporting process, that can have flaws that can negatively impact data quality.

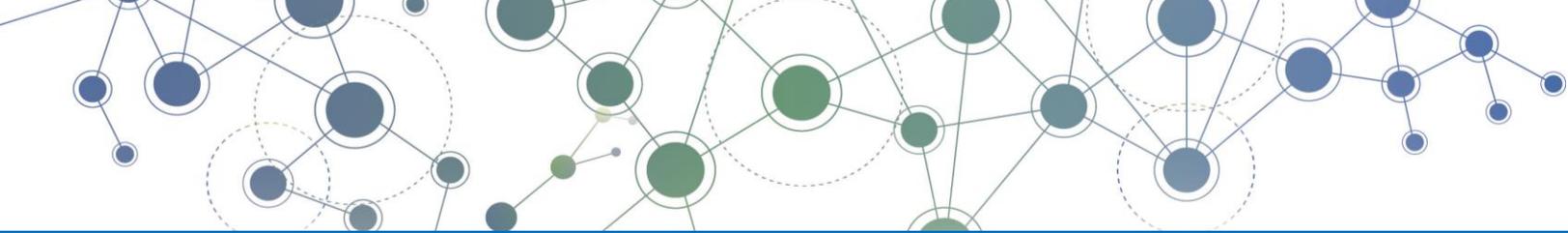
Having an integrated data set that combines both claims and clinical data is crucial, as it allows providers to manage patients across the entire care continuum, while leveraging the level of detail captured in the EHR. Leveraging EHR data is also critical for timeliness. Managing a population solely on claims data is ineffective, as there is at least a 30-day lag before claims data is available, while EHR data is real-time. The data set must also be robust and incorporates data from all EHRs across the entire system to give a more accurate view of the organization's patient populations. These systems provided to physicians must also cover their entire patient panel, while health plans only need to see data for their members.

Proper technology and an IT strategy in place helps to ensure accurate data. To deliver maximum value to providers, analytics technology should also be designed to address multiple initiatives beyond the specific P4P program to increase provider adoption, such as meeting Meaningful Use requirements and supporting Patient Centered Medical Homes (PCMHs) and other Accountable Care Organization (ACO) programs.

Processes

There are certain processes that need to be in place for provider organizations to properly gauge the success of P4P programs. Data validation and quality monitoring processes are both critical to ensure the data is accurate to track progress. Providers must also play an active role in this process, both to ensure

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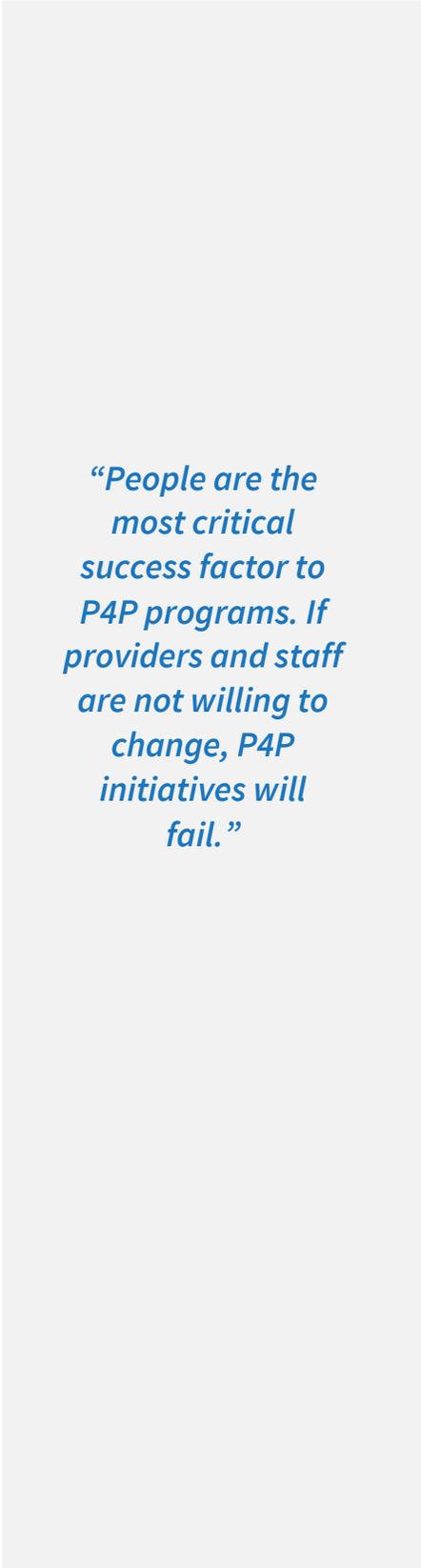


data integrity, as well as build trust in the data they are using. Proper testing of system changes are also critical to ensure downstream data is consistent with its source.

As P4P programs continue to evolve, organizations must anticipate change and have the frameworks in place to respond quickly and efficiently. Organizations looking to adopt P4P payments need to have operational change management processes in place to be able to quickly meet future demands. A quality data set is key to driving these changes within an organization. This data can help identify areas of opportunity to improve care data, which, in turn, gives organizations the foundation to build strong internal processes for quality improvement. The data also gives organizations the ability to scale these efforts across their entire system, enabling them to measure the impact over time.

People

People are the most critical success factor to P4P programs. If providers and staff are not willing to change, P4P initiatives will fail. Stakeholders must understand the how, what, and why of the initiative and the supporting data systems at all levels, and understand the value in transforming to better align with value-based care and reimbursement. In addition, people must embrace and leverage both technology, as well as change methodologies in order to effectively carry out the necessary changes required to be successful under P4P.



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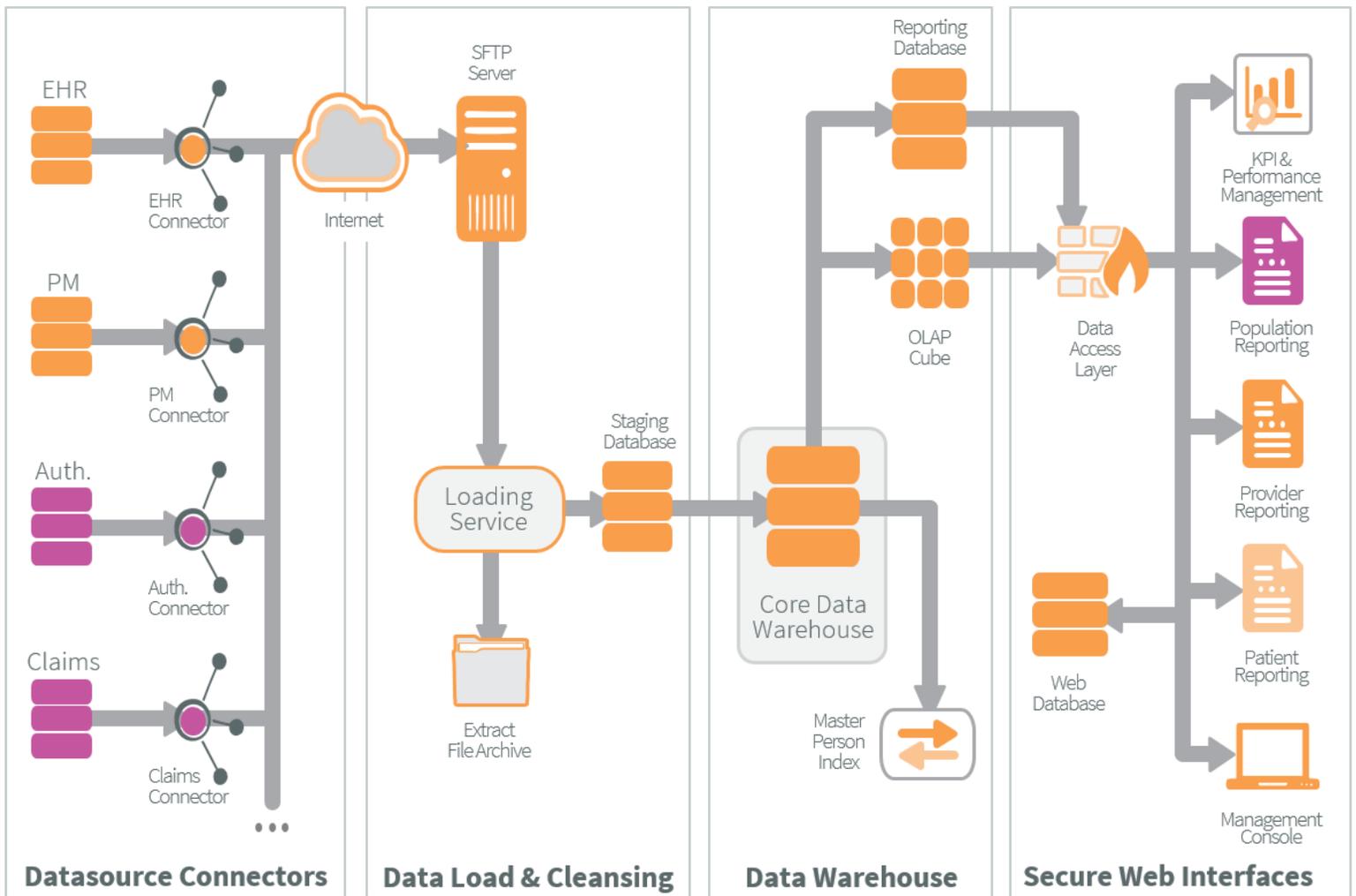
Architecture

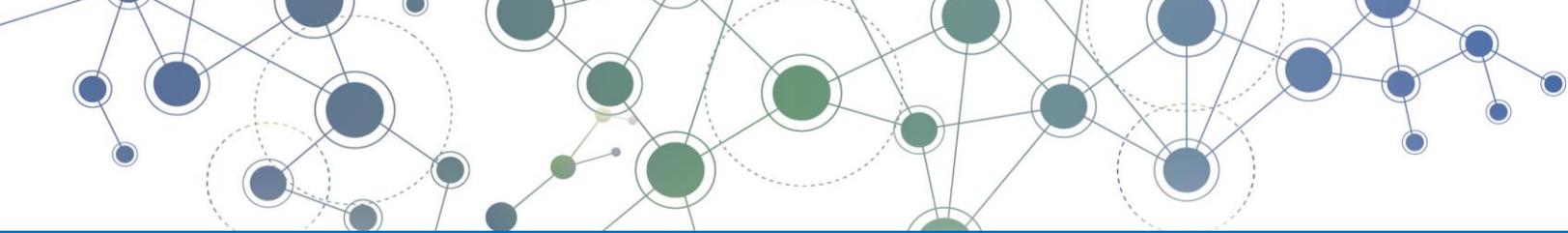
Business

Once all three critical success factors are in place, organizations that leverage objective data from **both** EHRs and claims sources to manage performance will be most successful under P4P. This “single source of truth” is crucial for directing interventions and quality improvement initiatives.

An enterprise data asset should provide full transparency into all opportunities to improve quality, efficiency, maximize reimbursement and control cost.

Technical Architecture





A centralized data asset and analytics platform are critical for performance monitoring and improvement under P4P contracts. These tools consist of three integrated components – connectors, a data warehouse, and a Web-based reporting interface.

1. Connectors

Having the ability to pull data directly from many EHR platforms is critical in gaining full transparency into quality across a provider organization. Relying solely on single data sources like Continuity of Care Documents (CCD) is problematic, as the information may not capture a patient’s full medical history. EHR data gives the organization visibility into their care measurements, allowing them to identify and manage at-risk patient populations. For example, if an organization is looking at measurements like vital signs, this enables them to identify patients at risk of being hypertensive.

They can then proactively take the necessary steps to properly treat these patients before they fall into the high-risk category. In addition, integrating this data with claims data creates an extremely powerful dataset that not only gives visibility into these metrics, but also gives organizations the ability to track patient interactions with providers across the entire care continuum outside of their network.

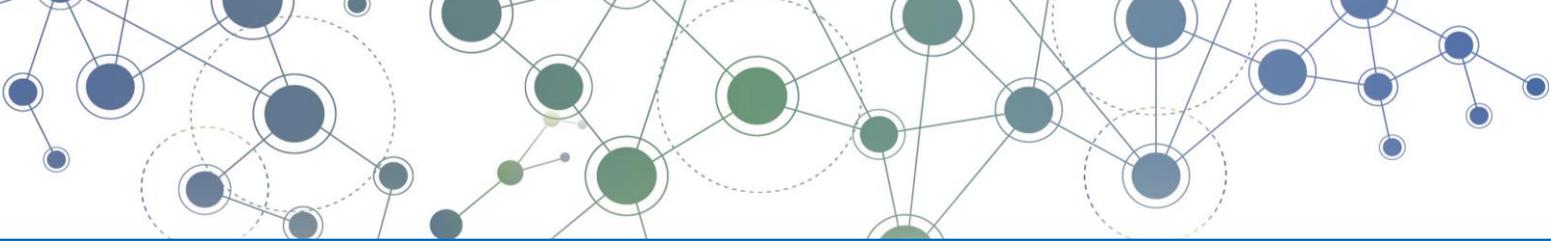
2. Data Warehouse

Once data is extracted, it’s important that it’s normalized and stored in a data warehouse in a uniform way. Normalization lets providers aggregate data across disparate EHR’s and various source systems and measure the performance of providers, clinics, and networks using an “apples-to-apples” comparison, eliminating variability between systems.

3. Reporting/Analytics Interface

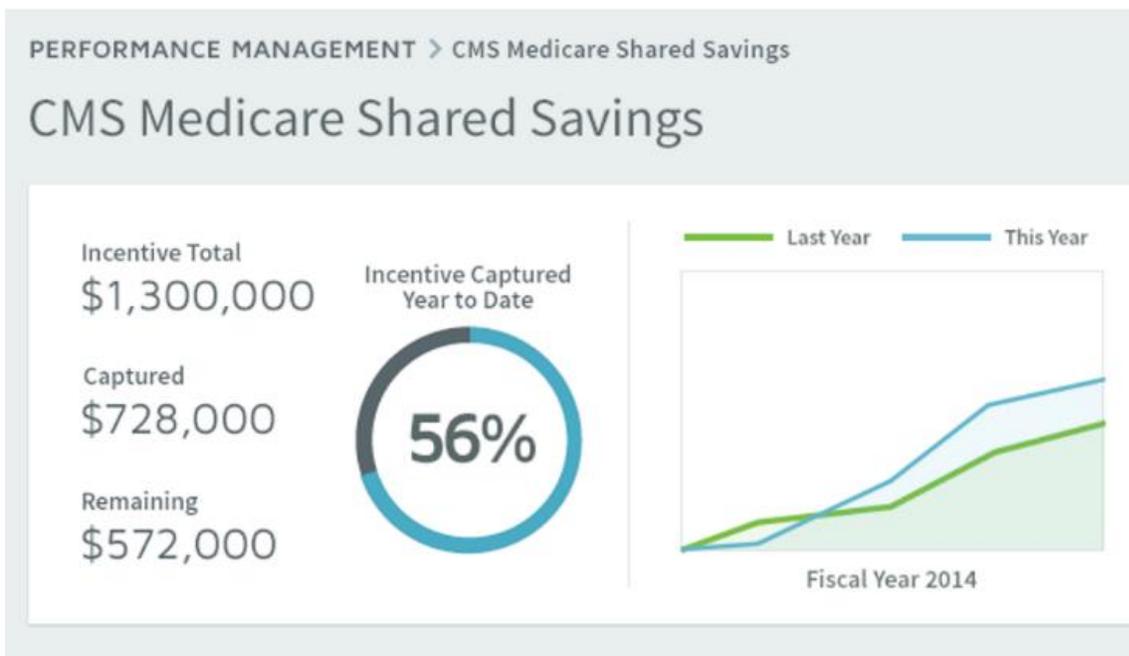
Reporting tools must be customized for various stakeholders in both the provider and health plan organizations. Having a user-friendly interface is critical for adoption, as this tool should ultimately become a part of their everyday life. When selecting a vendor, it is important to ensure that they have taken the time to maximize user experience and create an optimal design that best suits unique user’s needs.

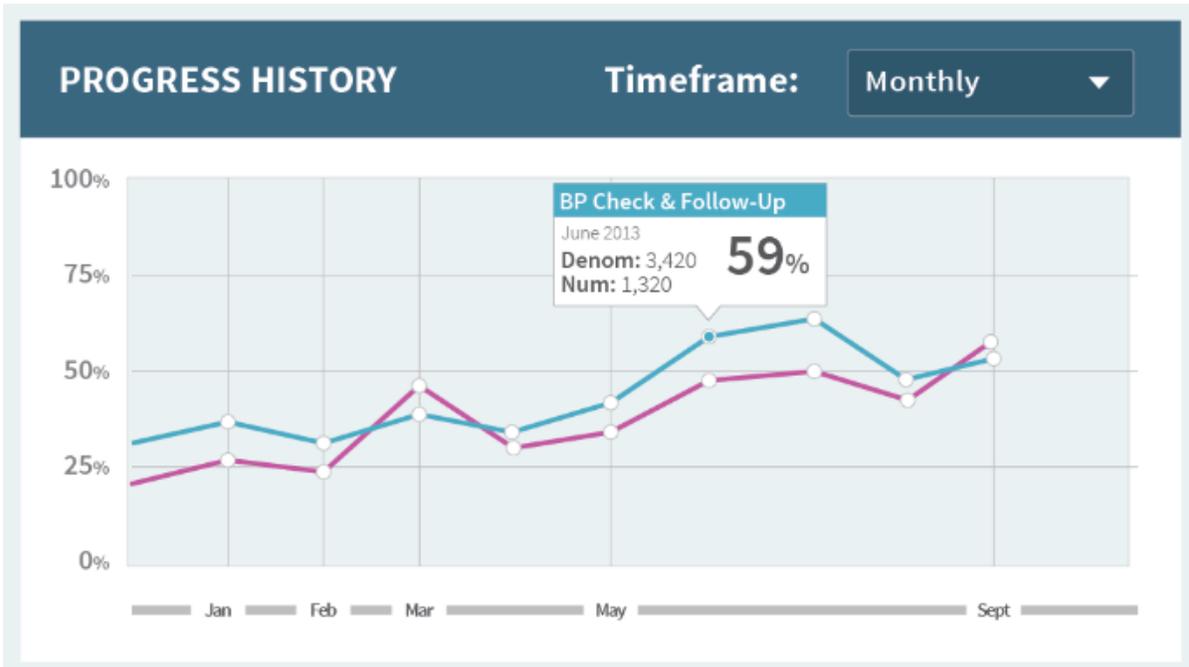
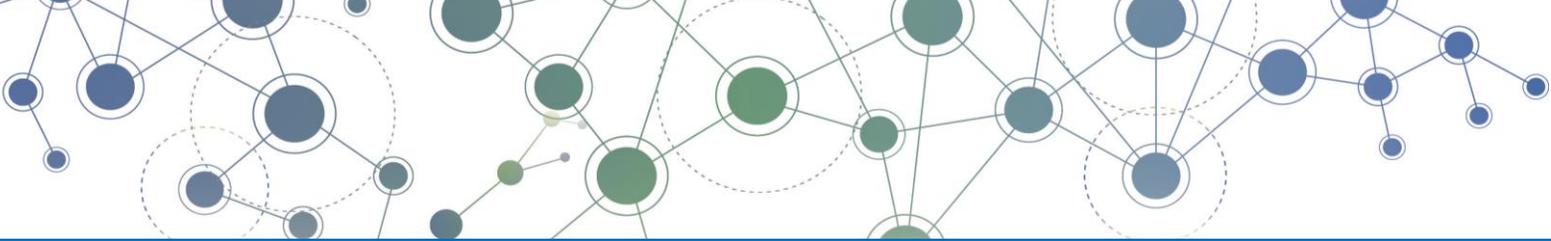
The reporting tool should be able to easily track and compare the progress across all sites within the provider organization.



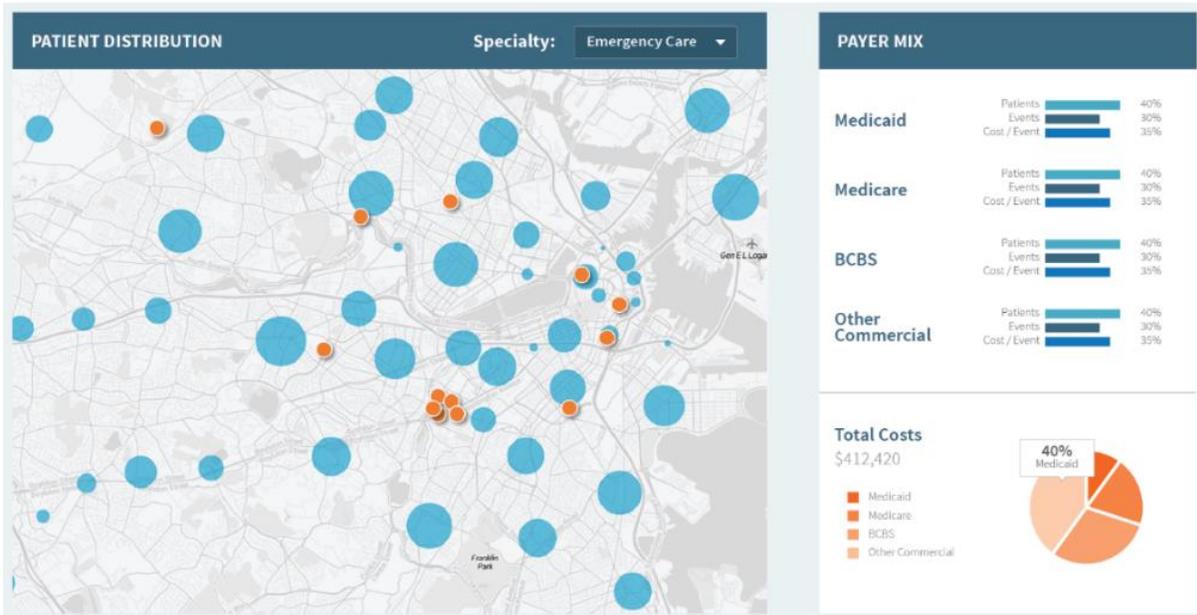
All	Site	Performance	Total	% In Network
<input checked="" type="checkbox"/>	St. Augustine's	Cost +80% Evts. +15%	\$2,250,000 4,725	86%
<input type="checkbox"/>	St. Mary's	Cost +5% Evts. -30%	\$2,125,000 3,604	45%
<input type="checkbox"/>	St. Elizabeth's	Cost +15% Evts. +3%	\$1,900,000 3,701	72%
<input type="checkbox"/>	St. Catherine's	Cost -8% Evts. -5%	\$1,300,000 2,580	35%

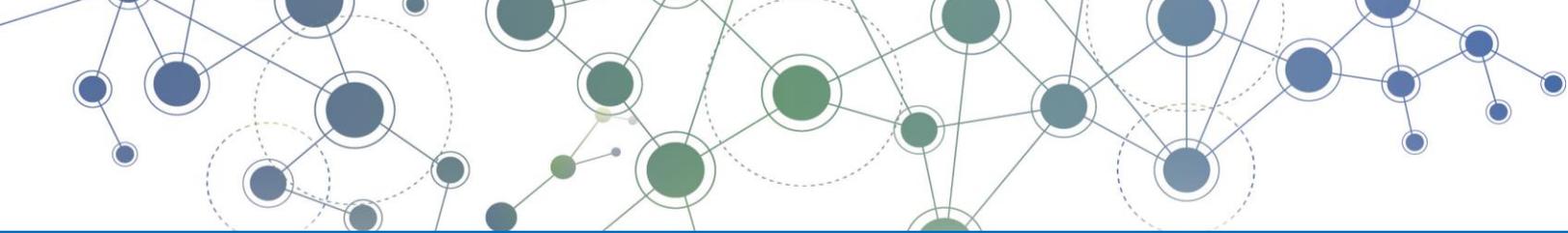
The tool should also provide a snapshot into incentives captured throughout the year and give a historical overview of the organization's progress.





The tool should also be able to capture patient distribution and give insight into the health plan mix of those populations.



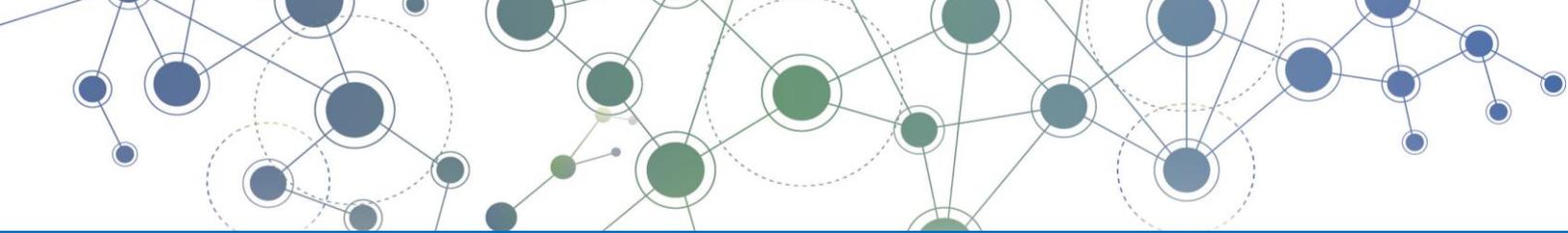


Conclusion

As healthcare costs continue to rise, early evidence shows that P4P programs have the power to help control these expenditures. For this model to be successful, organizations need have the fundamental pieces in place. To cause real change, health plans and providers must first form a true partnership and trust that each party is working towards a common goal. This involves transparency into incentives and quality measures and the willingness from both parties to take on shared risk whole heartedly.

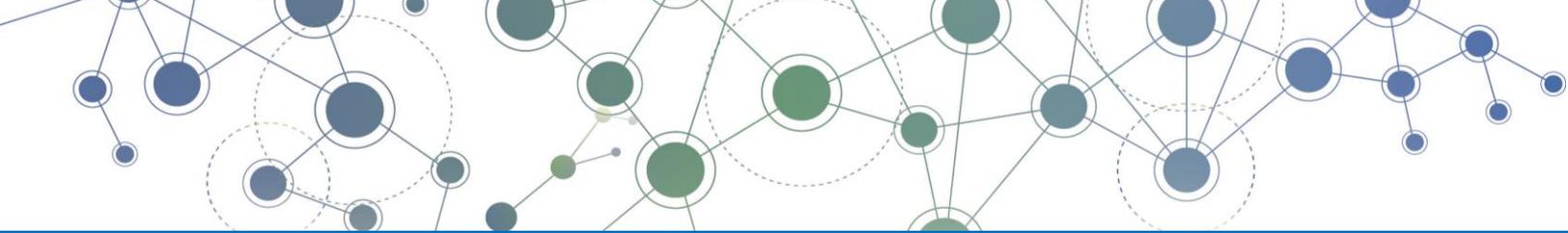
Having a validated data asset is key for both health plans and providers to gain this transparency into the health of their patient populations and gauge performance. However, the proper tools must first be in place, including technology, processes, and people.

If properly executed, P4P programs have the potential to reduce medical expense, increase the quality of care and ultimately improve patient satisfaction, plus improve the overall health of the patient population. Once these strategies are in place, and organizations gain synergy and momentum, P4P has the potential to solve many of the problems healthcare is currently facing.



About Arcadia Healthcare Solutions

Founded in 2002 and headquartered outside Boston, with offices in New York, Seattle, and Nashville, Arcadia Healthcare Solutions is an innovative and nationally recognized leader in the healthcare technology and services industry. Arcadia provides services and technology for EHR Outsourcing and Consulting; Data Integration and Population Analytics; and Care Delivery Transformation and Coaching. With a focus on both healthcare provider and health plan solutions, Arcadia has a unique cross-industry perspective on using data to drive healthcare transformation. For more information, visit www.arcadiasolutions.com.



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