



2010 National P4P Survey

Executive Summary



Overview

Med-Vantage's fifth survey of pay-for-performance (P4P) programs, conducted in the fourth quarter of 2010, describes programs that have not only survived the recession, but have also continued to dynamically evolve by increasing the numbers of lives covered as well as the number of measures used to rate the quality and efficiency of care. Most importantly however, the programs responding to our survey are now poised to drive needed changes in healthcare by adopting new models of payment such as the Patient-Centered Medical Home (PCMH) and the Accountable Care Organization (ACO) that harmonize with the plans set forth by the federal government.

Since our survey in 2008, there has been a dramatic shift in the healthcare landscape. The country experienced a terrible recession from which it is now slowly recovering. Landmark legislation was passed. The HITECH Act and Patient Protection and Affordable Healthcare Act (PPACA) extend health insurance coverage to many more Americans, and provide significant incentives for providers to adopt HIT. In addition, both initiatives are intended to drive needed changes in the quality and cost of medical care by reforming the way we pay for medical services.

Health plans appear to have quickly adjusted their priorities for action. Survey respondents now report:

- New emphases on the medical home for physicians and avoiding "never" events in hospitals.
- Plans to adapt P4P programs for new payment models such as accountable care organizations and shared savings.

Med-Vantage has conducted surveys of health plans' P4P programs five times since 2004, thus providing a unique view of changes to these programs over time. The voluntary survey provides a snapshot of how plans are conducting P4P and, increasingly, other value-based purchasing activities, and what results they have attained. This paper presents a summary of Med-Vantage's survey findings for P4P in 2010 compared with previous years.



Summary of Survey Results

1. P4P is a mainstream business practice of health plans and is continuing to grow

Pay for performance is no longer just a means to raise health plans' HEDIS® rates or Medicare star ratings. It is an established business technique that health plans are using to shift from fee for service to value-based reimbursement. The trend toward including more measures, more physicians and more patients in P4P was highlighted in the last report. The 2010 data reflects even more extensive changes. Plans are using a range of incentives to purchase value, as they begin to answer the call for providers to be paid based on results rather than volume of services.

More members are included

The 2008 survey saw an increase in the percentage of plans including more of their products and product lines in P4P programs. In 2010, 55% of plans said they include all covered lives in their P4P programs, a sharp increase from 10% in 2006 and 11% in 2008. Including all covered lives has the effect of increasing potential rewards for providers, making the incentives more valuable.

Physician incentives more ubiquitous

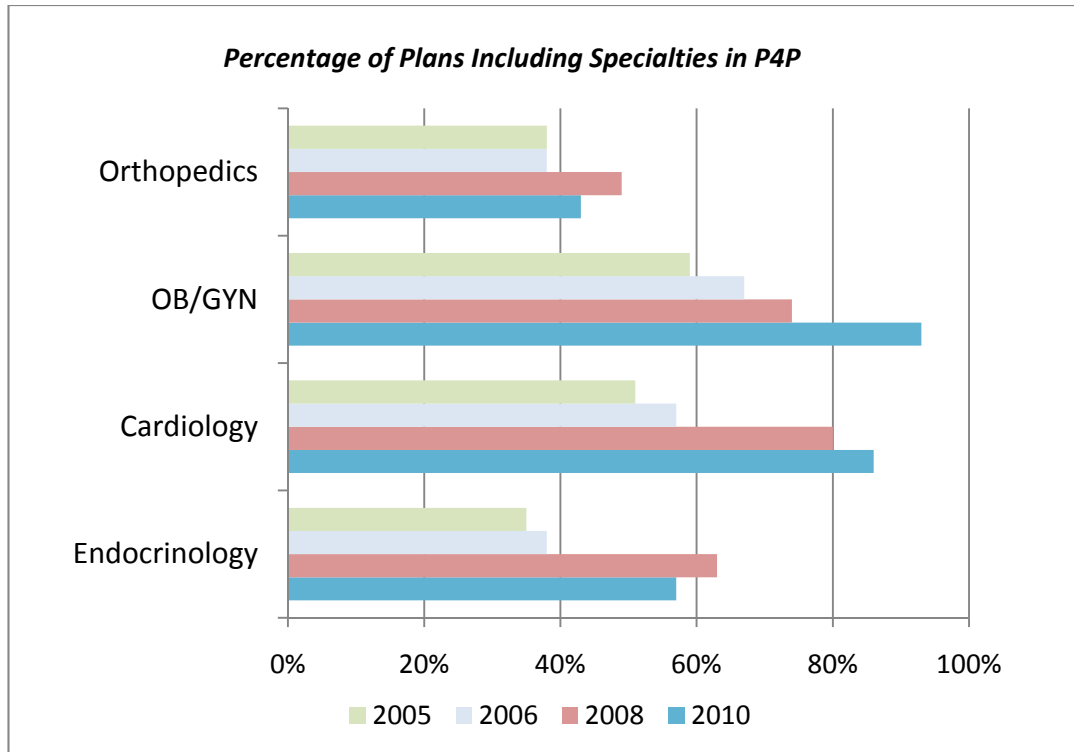
Throughout all the P4P surveys, more plans reported having P4P for physicians than for hospitals. In 2010 96% of all plans in the survey reported having incentives either in operation or in development for physicians. Of those responding to a specific question about primary care physicians, 98% said they had a P4P program either in the market or in development. The data show growth over 2008 in programs for primary care only and for specialists only, but a decrease in programs for both primary care and specialists. This may indicate an increase in programs focused on one or the other. (The 2010 survey could be interpreted as asking about multiple physician "programs," while the 2006 and 2008 surveys forced a choice for the respondent's physician "program.")

As in 2008, more than half the physician programs have been in operation five or more years. The amount of incentive paid, as a percentage of physicians' total compensation, is holding steady since 2008 at just over 7% of total reimbursement.

Specialists' participation continues to grow

Now, 32% of plans report that they have P4P programs in operation just for specialists, compared to a negligible percentage in 2006 and 2008. When we include the 2010 questions regarding programs just for specialists ready to go or in development, the percentage rises to 61%. Again, the data suggest that P4P programs themselves have become more "specialized." The percent of plans including cardiologists and OB/GYN specialists in P4P has consistently grown to over 80%.





Programs for hospitals grow more slowly

The same percentage of plans has P4P for hospitals in operation in 2010 as in 2008—40%. But the more detailed questions in 2010 indicate that another 13% have hospital P4P either ready to go by 2011 or in development. That would indicate a steady increase, to 53%, but this is still a far lower percentage than plans with programs for primary care physicians. The reported amount of incentive changes little here also, at about 2% average reward as a percent of total reimbursement.

2. Incentives are a tool for value-based purchasing

The 2010 survey results show health plans dynamically adjusting incentives to align with priorities such as cost savings, quality improvement and preparation for the post-reform environment.

Rewards are more focused on a single level of physician organization

Plans were asked at what level they measure and reward performance—individual physicians, group practices or large IPOs. In the past plans have assessed and rewarded performance at multiple levels, averaging 1.69 levels in 2006 and 1.85 levels in 2008. However, in 2010 we see more of a tendency to measure at a single level—the average number is 1.12. This is consistent with making rewards more targeted. The most common level is the group practice; 52% of plans measure and reward at the group practice level compared to 36% at the individual physician level and 24% at the level of the large IPO organization.



Plans are shifting from bonuses towards value-based reimbursement

Although bonuses are still the most popular form of incentive, the 2010 data show a decline in the use of bonuses for both physicians and hospitals and a steady increase in the use of higher fee schedules instead. Fee schedules rewards providers on a continuous basis rather than in one year-end sum. Use of fee schedules reflects the trend toward ongoing, established value-based reimbursement. It is compatible with the tendency to measure and reward at just one level of physicians' performance, as plans pay claims at just one level.

Both carrot and stick incentives sharply target results, reflecting national initiatives

Along with the shift to fee schedules, new incentives both positive and negative are widely used. Responding to new questions in the 2010 survey, 18% of plans say they offer a carrot: a per-patient care management fee for physicians who have demonstrate skills in managing patients' care comprehensively, such as by becoming a patient-centered medical home. Some plans also use the stick: 44% said they *reduce* payments to hospitals in response to "never events" that endanger patient safety.

Rewards for Physicians: Percentage of Plans Using Each Type

	2006	2008	2010
Percentage paying bonus	71%	72%	55%
Percentage paying higher fee schedule	10%	17%	33%
Percentage paying care management fee			18%

Rewards for Hospitals: Percentage of Plans Using Each Type

	2006	2008	2010
Percentage paying bonus	60%	52%	44%
Percentage paying higher DRG	28%	39%	30%
Percentage cutting payment for "never events"			44%



Overall domains of performance measurement evolve

As in the previous surveys, we asked plans to allocate the percentage of incentives that they pay to providers by domains of measurement. The options were as follows:

- Clinical Quality (process or outcome measures)
- Patient safety or medical error reduction
- Efficiency or cost of care
- Utilization (hospital programs only)
- Patient satisfaction or experience of care
- Clinical health information technology adoption (EHR, e-prescribing, e-lab, etc.)
- Administrative capability, such as electronic claims submission
- Member access, such as open panel or evening hours (physician programs only)
- Patient-centered medical home (physicians only)
- Community service (hospital programs only)
- Use of disease or procedure registries (hospital programs only)
- Other (please describe)

Clinical Quality continued to be the most heavily weighted domain at just under 60% for both physicians and hospitals. The next most heavily weighted domain, efficiency or cost, has also shown little change since 2006, with the percentage weight averaging in the mid 20s.

In 2008 we reported an increasing weight on the use of health IT by physicians. The 2010 survey showed that trend continuing, so that the average weight for use of health IT has doubled: from 8.8% on average in 2006 to 17.5% in 2010.

In addition to the most common domains of physicians measurement, new domain choices were selected, such as the patient-centered medical home, and continued significant weight of "Other." The survey gave options of both the traditional and the newer domains for P4P, plus "Other." The roughly one-half of plans that chose Other, giving it an average weight of 24%, cited many different types of measures. The most often mentioned measure was generic prescribing or pharmacy performance (technically a cost or efficiency-related behavior), chosen by 30% of plans choosing Other. Additional entries in the Other category included specific programs of states and local consortia, including the New York State Medical Home program and the Integrated Healthcare Association P4P Program in California.

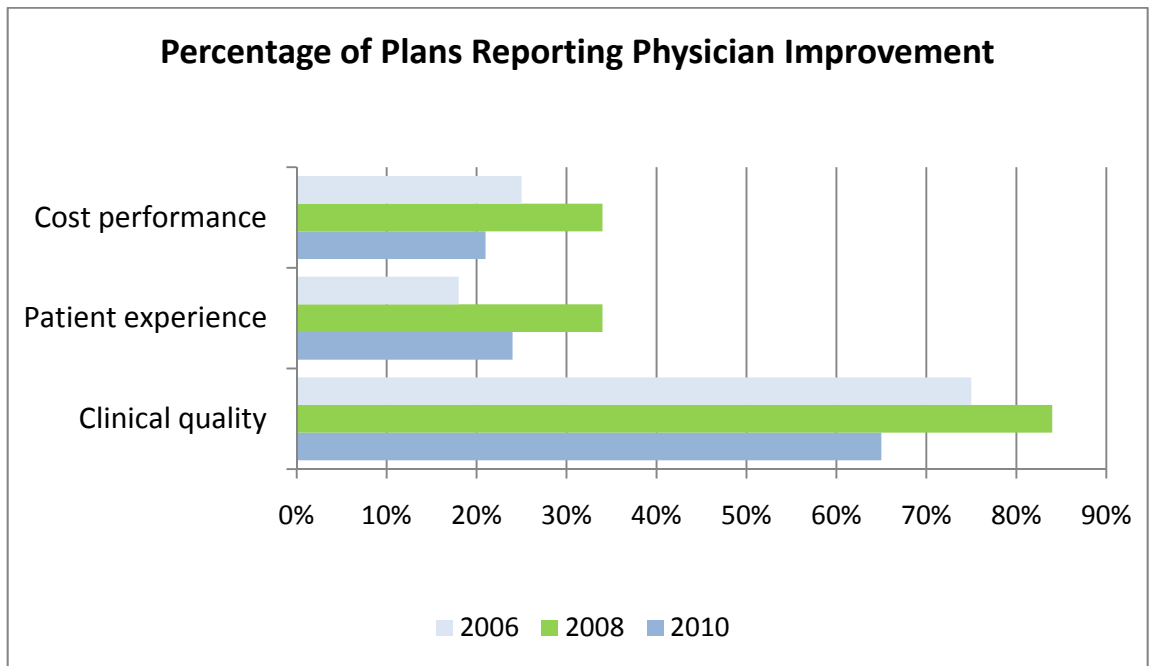


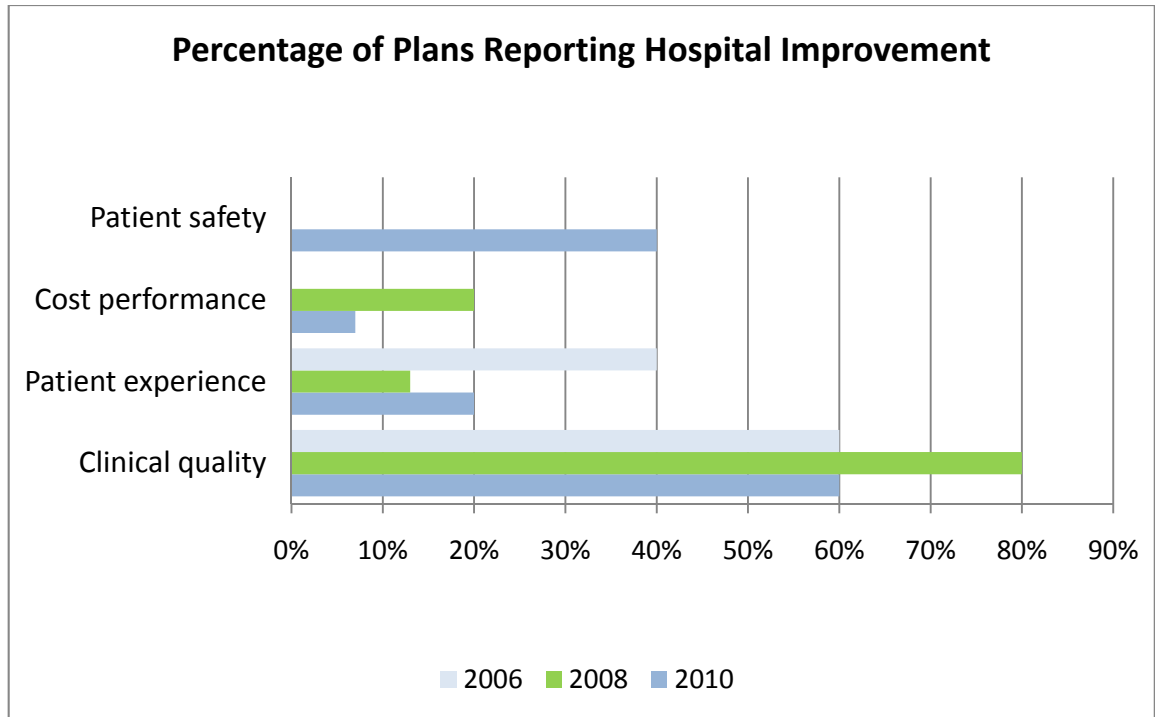
3. P4P yields more improvement in new domains of measurement

Plans continue to attribute improvements in both hospitals' and physicians' performance to P4P, particularly improvements in clinical quality and investment in HIT. The difference is that the trends for the older domains are either downward or level, and the trends for the newer domains are upward.

Clinical quality, patient surveys, and cost performance results level off

Somewhat lower percentages of plans report improved results in these three areas than in 2006 and 2008. Clinical quality still has the highest percentage of plans reporting improvements, but the percentage is about the same in 2010 as in 2006. Similarly, reports of improvement in patient surveys, often cited as difficult to "move," remain at about 20% for physicians and hospitals after somewhat higher results in previous years. Cost performance showed similarly small changes.





HIT and Quality Improvement (QI) investments by physicians are up

Looking at the newer domains, plans reporting physicians had invested in “QI or HIT” jumped from 25% in 2006 to 55% in 2008. In 2010, we gave separate options for QI and HIT, and 41% of plans said that physicians had invested in QI, while 47% of plans said physicians had invested in HIT.

Patient safety results for hospitals are up

Of the plans with hospital P4P, 40% claimed an improvement in patient safety performance, about the same percentage that implemented a penalty for “never events.



Accountable Care Organizations Offer Opportunity & Challenge

Interest is high in accountable care organizations (ACOs) as a mechanism to slow the unsustainable increases in health care costs

The concept of an ACO arose from the documented success of integrated delivery networks such as Geisinger Health System and Intermountain Health Care in holding the line on health costs by better coordinating care. These systems include primary care providers, specialists and hospitals. Being paid as an integrated system, usually through capitation or a shared-savings arrangement, they have a built-in incentive to avoid unnecessary care. The creation of ACOs in the broader, non-integrated medical community tests the idea that, with appropriate connectivity and incentives, more diverse organizations also can accomplish better care and cost control.

A white paper on the subject from Deloitte Consulting comments as follows:

“While ACOs are not radically different from other efforts to improve the cost-effectiveness of health care delivery, such as health maintenance organizations (HMOs), physician-hospital organizations (PHOs) and independent practice associations (IPAs), their innovation lies in the flexibility of their structure, payments and risk assumption.”¹

Two accompanying trends may help to support the care coordination that is necessary to realize better cost control: first, the development of health information exchanges both public and private, and second, the actions of hospitals buying physician practices and equipping them with interoperable health IT. Large medical groups and physician-hospital organizations (PHOs) have begun to define themselves as ACOs. The Dartmouth-Brookings Institute ACO Learning Network has five featured pilot sites, including Healthcare Partners in California and Carilion Clinic in Virginia.

Various kinds of shared-savings incentives, many connected with ACOs, have become part of value-based purchasing. As shown in this year’s national survey of P4P, many health plans either are already paying providers according to ACO principles or are actively preparing to work with ACOs. Proposed regulations March 31, 2011 emanating from PPACA set up Medicare ACO payment demonstrations: where the ACO takes risk for just producing savings against trend (the up side), it can earn up to a 7.5% additional payment. Note that this is close to the roughly 7% incentive that plans reported paying physicians in 2008 and 2010. If the ACO also takes risk for the down side, including a penalty for cost increases greater than trend, its maximum potential reward is 10%.

. If they work well, ACOs provide better ongoing care for patients with chronic conditions. They should prevent some hospitalizations for exacerbations, re-admissions and duplicative care. Key components for making this prevention possible is primary care practices functioning as medical homes and healthcare IT. The national surveys in 2008 and 2010 show an increasing interest in and weight given to incentives for Health IT and the patient-centered medical home.

Future plans indicate that a majority of our respondents are preparing to work with ACOs and to share with them the savings to be realized.



4. Changes are planned

Almost all the options given in the P4P survey for planned changes received large responses, again showing dynamic use of P4P as a business technique. The tables below show majorities of respondents indicating that they intended to continue using P4P to adjust to shifting priorities, and to develop P4P in line with the changing landscape of accountable care organizations (ACOs) and broader value-based reimbursement.

Incentives change with plans' priorities

The majority of respondents indicated that they planned to adjust their P4P approach by expanding the scope or number of measures. Significant percentages said that they planned other major changes, with many planning to initiate bundled payment for physicians and hospitals or shared savings approaches.

Planned Changes to P4P Programs	% Saying In Market or In Development
Expand the scope or number of measures used	62%
Pay rewards to physicians for low rates of ambulatory-care-sensitive hospital admissions or re-admissions	47%
Initiate alternative quality provision in certain contracts	46%
Pay evidence-based case rates to hospitals	40%
Pay evidence-based case rates to physicians	21%
Add a program for specialists if there is not one now	32%
Explore or develop new payment models for hospitals alone	22%

Further changes include ACOs and more value-based reimbursement

Large percentages of plans have either already implemented or are planning to implement:

- Bundled payment approaches
- Shared savings models
- ACO payment models
- Rewards for patient-centered medical homes, which provide the care coordination needed for ACOs.



Medicare’s move to provide incentives for ACOs starting in January 2012, through the recently announced ACO Shared Savings rules, echoes a successful model implemented in California and elsewhere. Respondents showed that they are using their incentive programs to both contribute to and respond to this trend.

Planned Changes to P4P Programs	% Saying In Market or In Development
Explore or develop new payment models for accountable care organizations (ACOs)	51%
Share computed savings with physicians, with opportunity for better quality performers to earn more	60%
Share computed savings with hospitals, with opportunity for better performers to earn more	52%
Pay a care management monthly fee to physicians who provide a patient-centered medical home	65%
Bundle payments to physicians and hospitals, such as payments based on episodes of care	49%
Planned Change to P4P	51%
Explore or develop new payment models for accountable care organizations (ACOs)	60%



Employers Hold Health Plans Accountable

Recent national surveys of employers also show major change underway, in slightly different areas than plans are addressing. In particular, those employers that achieve much better cost trends than the average are increasing their value-based purchasing techniques. They are using incentives with both their employees and their health plans to get more value for their benefit dollar, and they express frustration with both.

Both the Hewitt 2010 national survey and the Towers Watson/National Business Group on Health (NBGH) 2011 national survey found that large employers' highest priority area, and biggest frustration, was employees' behavior. In particular, they are focusing incentives on employees' unhealthy lifestyles and on employees making better provider choices. Employers are looking ahead not just to the health insurance exchanges in 2014, but to avoiding the excise tax called for in PPACA starting in 2018. Over the next few years, the Towers Watson/NBGH survey finds, the most successful companies are "taking bold actions to manage costs and offer affordable care." Those companies, among other strategies, plan to base decisions on provider quality indicators (35% of respondents) and on annual performance scorecards or dashboards (65%). Those companies "set themselves apart by making provider quality a top priority. . . . to ensure employees receive high-quality care at a fair price."

Employers expressed the need for better information on cost and quality of providers, and turned to their health plan vendors for it. In the Towers Watson/NBGH survey, large majorities of employers rated health plans unfavorable for changing their members' behavior related to lifestyle decisions, for driving care to higher-quality providers and for driving more efficient use of health care resources.

Clearly, health plans face a challenge in the coming years on both sides of value-based purchasing. By actively measuring the performance of their providers, they will be able to develop provider cost and quality information that can be shared with their members at the point of choice (the provider directory), and will be in a better position to work with providers on improving performance over time.



Conclusion

The fifth Med-Vantage survey of P4P programs has revealed such extensive change that it almost makes the phrase “P4P program” outdated. P4P programs as envisaged in 2004 have advanced rapidly, especially since 2008, to be flexible, sophisticated tools for value-based reimbursement. The plans responding in 2010 report much more widely used incentives for providers. A greater percentage of plans offer hospitals incentives as well as physician incentives. Physician incentives are more precisely targeted to specific measures appropriate to primary care providers and specialists and to one level of physician organization. A much greater percentage of plans apply incentives across all their covered lives, giving incentives more power.

According to the survey, health plans are gearing up for even greater use of value-based reimbursement in the future, anticipating the development of ACOs and the calculation of demonstrated savings to be shared with providers.

Last year’s results, both the revised questions and the greatly changed responses, were influenced by the HITECH Act and PPACA. The next two years will undoubtedly see even more change in the environment, as new payment models are implemented and employers enhance their strategies for purchasing value. Communities may begin to see improvements in quality and moderated costs through the combination of patient-centered medical homes, enhanced data mobility and an incentive-motivated focus on transitions of care.



Appendix A

Methodology

Design. Med-Vantage designed the P4P survey with the help of health plan clients, potential users, and partners the Blue Cross and Blue Shield Association (BCBSA), The Leapfrog Group and the Integrated Healthcare Association. Updating the survey from 2008, Med-Vantage went through several drafts to arrive at sets of questions that were essential and an amount of respondents' time required that was reasonable.

Testing. Med-Vantage tested the survey with a health plan respondent, observing the issues and questions the respondent raised and modifying the questions as indicated.

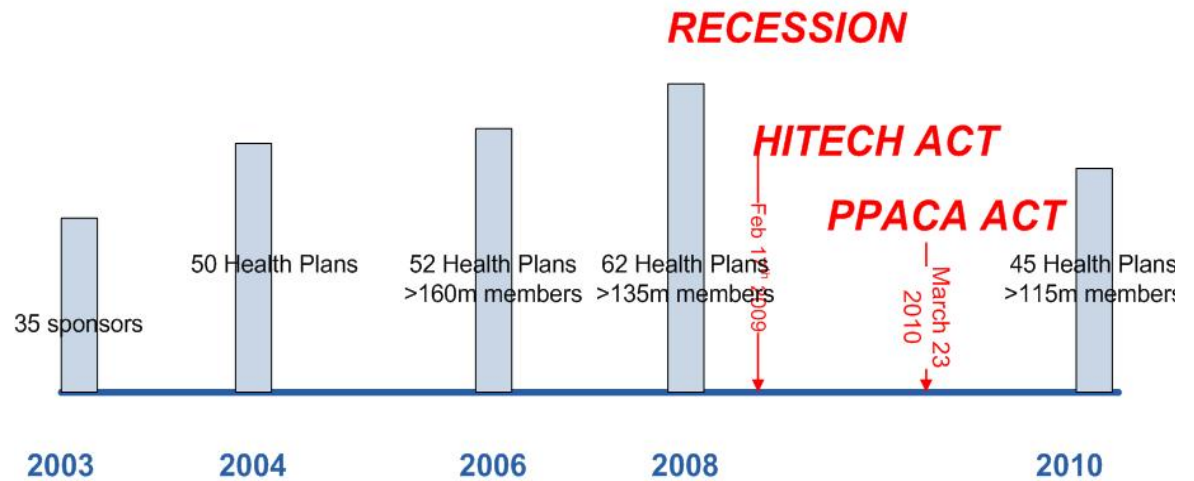
Collaboration with the Blue Cross-Blue Shield Association survey. As in 2008, Med-Vantage worked with BCBSA to agree on questions for the survey. The two organizations then fielded surveys with exactly the same 47 questions on P4P. BCBSA administered the survey to its member plans; Med-Vantage administered the survey to all other respondents. Med-Vantage added 14 questions on transparency programs to the end of the survey, which BCBSA elected not to use (see below).

Voluntary participation and responses. Med-Vantage compiled a list of previous respondents and supplemented that list through telephone-based outreach to identify contacts in Health Plans. Both internal resources and outsourced telesales resources made calls to find contact names. Then Med-Vantage joined with BCBSA to conduct further telephone outreach to encourage participation. We accepted all resulting responders.

Some respondents are local plans, some are national and some are local branches of national plans. The number of plans responding was considerably lower than previous years. We believe that the issues addressed in the report are associated with the lower response: plans are responding to major changes in their environment. Some of those changes are caused by new government programs, and some are caused by the economic climate, in which health care costs are continuing to rise but health plans' customers are less able to fund increasing costs. Consequently, plan staff may have concluded that the time to respond to a survey was not available.



P4P Survey History



We removed several responses in which the respondent logged in but answered no substantive questions. Most of the questions analyzed covered either physician P4P programs or hospital P4P programs, but not both. The resulting data we believe is robust enough to compare physician P4P programs on most of the dimensions covered from 2006 through 2010.

In addition to the lower response rate overall, there was attrition in the number of plans answering questions at the end of the survey, covering hospital programs. There were also fewer plans responding that had hospital programs than had physician programs. Because of the small number of hospital programs in 2006, when many questions had 10 or fewer respondents, and again on some questions in 2010, we have fewer comparisons of data on hospital programs.

Online administration. Most plans took the surveys using Med-Vantage's online tool. Although the callers offered participants the opportunity to conduct a telephone interview, none took the offer. Some respondents printed the survey and sent it to Med-Vantage by fax, and Med-Vantage staff entered the data.

Continuity of questions in P4P. P4P is a dynamic field, experiencing more change from 2008 to 2010 than between past surveys. Due to changes observed in the external environment, and our knowledge of P4P programs, we made a number of changes to the 2010 P4P survey. Some questions we kept exactly as they were to allow us to measure trends. Others we changed to get more information about the status of P4P programs, for instance asking whether a program for specialist physicians was in the market, due to be implemented soon, in development or not



in development. This made the questions not able to be perfectly trended over time.

To lessen the respondent burden, we discontinued several questions that were no longer of use, were a lower priority, or had been answered so consistently that we did not expect new data. This included questions about:

- Drivers for creating P4P programs
- Sources for the measures used
- Feedback mechanisms used to communicate performance with physicians
- Sharing methodologies and seeking input from providers on measures and methodologies

In order to capture trends in the health care environment and their impact on P4P, we added some new questions, and new options for existing questions, on payment reform.

Transparency survey. In 2008, we fielded a separate survey on transparency programs. Because its response rate was lower than the P4P survey in 2008, we combined the two subjects for 2010. We used 14 questions from the former transparency survey, and included them in the survey implementation for the non-BCBSA plans. However, since the final responses included only 18 non-BCBSA plans, and there was survey fatigue at the end, we did not obtain sufficient responses to use the data on transparency.

Analysis. For all questions, the results shown report the percentage of the actual respondents, which is often somewhat less than the total number of either physician programs or hospital programs. In 2008 we made a distinction between questions about the results of P4P and questions about the characteristics of P4P programs. For just the group of questions about *results or outcomes* attributed to P4P, we calculated the percentages of plans achieving results with two different denominators: the number that responded to the question, and the total number of programs. The latter yielded a smaller percentage claiming results. In 2010, we eliminated the questions about what kind of evaluation plans might have done, and simply asked what results they attribute to P4P. Most respondents answered the question, as opposed to 2008, when many did not. To make direct comparisons, we reported the statistic on percentage of respondents to the question about results or outcomes, as with all other questions, for 2006, 2008 and 2010.



Limitations. The methodology results in the following limitations to using survey results:

- There was no attempt to assign respondents to parts of the country or to balance responses by geography, size of plan, type of plan, local vs. national plan. Therefore, we cannot analyze results based on those factors.
- The resulting groups of respondents may be quite different from 2006 to 2008 to 2010, which may limit the applicability of the comparisons.
- There was no follow-up to finish surveys not completed by respondents. We have reported percentages of those responding to a question, with the number that responded.
- Due to the surveys' voluntary nature, we could not conduct significance testing of the differences among the three years' results. Therefore, we have highlighted just the results that show the largest differences, or that show consistent results from survey to survey.

Endnotes

¹ *What is an ACO?* Dartmouth-Brookings institute ACO Learning Network.

<http://www.acolearningnetwork.org/why-we-exist/the-promise-of-acos> accessed May 6, 2011.

¹ *Accountable Care Organizations: A new model for sustainable innovation.*

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¹ *The Road Ahead: Under Construction with Increasing Tolls, 2010.* www.hewitt.com accessed

April 20, 2011; and *Shaping Health Care Strategy in a Post-Reform Environment.* Towers Watson/National Business Group on Health Annual Survey, www.towerswatson.com

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