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New Cost Tool Aims To Boost Pay-for-Performance Model of Care

by Mari Edlin, California Healthline Regional Correspondent

Integrated Healthcare Association recently completed testing for a new payment model that stresses value. The new metric -- Total Cost of Care, or TCC -- is intended to build on the organization's already successful pay-for-performance program and move health care even further away from a focus on volume.

Existing quality measures and the new cost assessment results will produce a single shared savings incentive program by 2013, according to officials of the Oakland-based not-for-profit organization. IHA is a statewide, multistakeholder organization working to improve the quality and delivery of health care in California.

IHA's new value measuring tool is not part of the national Medicare Shared Savings Program under the Affordable Care Act, but it shares many of the same goals and was partly inspired by federal reform.

IHA's current P4P program includes eight health plans covering 10 million people and collects data on approximately 35,000 physicians in 200 organizations.

The program aims to drive improvements in clinical quality by providing financial incentives to physician organizations. It also makes health care provider performance reports public.

As part of IHA's P4P program, the eight participating California health plans provided \$49 million in incentive payments to physician organizations last year based on their performance in 2009.

How TCC Works

"We plan to bend the high cost trend in health care by making physicians accountable for quality, cost of care and the appropriate utilization of resources compared to other organizations, as well as by measuring each organization's TCC trend over the previous year," said Dolores Yanagihara, P4P program director for IHA.

The objective of TCC is to combine cost and quality measures to achieve value by not only having physicians perform quality services, but also by eliminating care that is not cost-effective. The long-term goal is to create sustainability and affordability in the managed care marketplace.

"If the shared savings incentive design is constructed appropriately, those physician organizations that help remove waste from the system will have the potential to share in a significant portion of the savings," Yanagihara added.

"Physician groups will see a tangible payoff," said David Joyner, senior vice president for large group and specialty benefits at Blue Shield of California. He anticipates that through the program, physicians will discover better ways to curb hospital admissions and readmissions and streamline hospital discharge by providing necessary medications, follow-up and home support.

The metric is risk-adjusted to compensate for differences in patient populations -- age, health status and gender -- across physician organizations. Relative risk scores will be used to calculate expected costs for each organization. Results are reported by geographic market to account for differences in their costs of doing business.

TCC combines all covered professional, pharmacy, hospital and ancillary care, along with administrative payments associated with private managed care enrollees served by a physician organization. Its results are broken out for each contracted plan and are aggregated across all plans that contract with IHA.

"Reporting P4P data on both quality and cost can inform referrals to higher-performing providers, while motivating physician groups to assume total responsibility for patient care," said Dennis White, senior vice president, value-based purchasing for the National Business Coalition on Health in Washington, D.C.

'We Have To Go Further'

Wayne Pan, chief medical officer for the Santa Clara County Independent Physicians Association's network of 800 physicians, said P4P measures are embedded into how SCCIPA manages its business and cares for its patients. Pan questioned whether IHA's P4P program has really demonstrated any savings thus far; IHA anticipated it would save money.

"We have to better understand how resources are being used. At the end of the day, physicians do not want to be seen as wasters, but rather, they should be aware of how dollars are being spent," Pan said. He noted, however, that costs are not always transparent.

Donald Crane, CEO of the California Association of Physician Groups, also is skeptical about whether P4P incentives provide enough return on investment for physician groups to invest in building an infrastructure that would promote higher quality and more efficiency.

He noted that California's popular delegated physician model -- under which insurers contract non-exclusively with medical groups on a capitated basis -- already has set the stage for groups to assume responsibility for both administrative duties and clinical care, making TCC more palatable.

David Lansky, president and CEO of Pacific Business Group on Health, said IHA's enhanced P4P program gives physicians an opportunity to take total responsibility for resources across a spectrum of care and to evaluate whether that care is coordinated.

"I'm concerned that health care is not attentive to the efficient use of resources," he said, "but this information complements quality data." While he doesn't criticize the current measures, he said they don't quite hit all the critical issues.

"We have to go further," Lansky said.

Fiona Wilson, chief of clinical transformation at Brown & Toland Physicians based in San Francisco, believes that in theory, P4P is moving in the right direction but some measures are too narrow, providing little differentiation between high and low performers.

Brown & Toland which participates in IHA's program, has 1,500 community physicians, serving 335,000 San Francisco Bay Area residents in either HMOs or PPOs.

Value-Based P4P Aligns With National Agenda

IHA's Total Cost of Care is ideologically similar to the Medicare Shared Savings Program, which will reward participating health care providers for delivering high-quality, efficient clinical care and for reducing costs through accountable care organizations starting in 2015.

The value-based program uses a budget-neutral modifier that would adjust payments to physicians according to the quality of care they deliver and how much it has cost them relative to their peers.

"Total cost of care is consistent with the direction health care is taking today -- how to provide better quality for less or for the same cost," said Laurel Trujillo, medical director of quality for Palo Alto Medical Foundation, which has been a participant in IHA's P4P since it began.

"It correlates with the movement towards accountable care organizations -- how can we as providers be accountable for the value of the care we provide our patients," Trujillo said.

Concerns About TCC

One of physician organizations' major concerns about the new IHA cost component is a lack of control over hospital costs.

"The new Total Cost of Care measure reflects the costs of our associated community hospitals," Trujillo said. "If those hospital partners are more expensive, our total cost of care may appear high even though we have a low rate of admissions. How can we as an outpatient organization be responsible for total cost of care when hospital costs are not under our control?"

She noted that IHA's P4P program uses actual, contracted rates in its calculations that don't level the playing field as Medicare's standard costs do. "Standard costs better reflect our efficiency and quality of care in keeping patients out of the hospital," she said. "Value is providing the highest quality for a given cost."

Only 25% of the Palo Alto Medical Foundation's patients are in managed care, representing six different plans. P4P only reflects the experiences of these patients.

"How can our physicians make the right decision when the hospitals control costs?" asked Wilson at Brown & Toland. "We need to uncover the variations in cost and determine why they exist." On the other hand, she is optimistic that TCC will make Brown & Toland more aware of costs.

Crane said that health care provider groups in areas with more competition among hospitals will have an opportunity to pressure medical centers to take a closer look at high unit costs, readmissions and admissions, and inappropriate resource use.

TCC currently does not take into consideration that some physician organizations are faced with referring patients to more expensive hospitals than other organizations, Yanagihara said. "We explored separating out organizations that only have one hospital available to them, but this is very difficult to determine. In addition, health plans stated that this situation is rare, and that more often than not, organizations have some choice over where their patients are admitted."

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