Quality Incentives and the Vermont Exchange

August 17, 2012

Prepared by:

Ann Lawthers

Paul Kirby

.

Table of Contents

1. Background

This report provides Vermont with a review of best practices for rewarding Qualified Health Plans (QHPs) participating in the Exchange for providing high quality care to enrollees. As stated in the contract between the University of Massachusetts Medical School (UMass) and the state of Vermont, the goal of this task is to draft a:

> Plan for rewarding plans that achieve quality goals and potentially penalizing low-performing health plans. The quality goals will include metrics, performance targets, and recommended frequency of monitoring…..the Contractor shall consider a full range of financial and non-financial performance incentives for high-performing QHPs.

With respect to incentives, the ACA requires QHPs to report their quality improvement activities and incentive strategies to the Exchange:

> The guidelines developed under paragraph (2)[a] shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1). (*see Appendix 1 for full Sec 1311(g) text)*

Thus the Exchange is not explicitly required to design its own quality improvement and incentive strategy, but is required to receive reports about those strategies. In addition, the Exchange is tasked with evaluating a QHP's quality improvement strategies per the final rulemaking on Exchange functions.[b] As part of this evaluative function, the Exchange should have wide latitude to develop its own template for QHP reporting on quality and incentive strategies.

The ACA is quite specific about preferred areas for quality improvement: health outcomes, preventing hospital readmissions, improving patient safety and reducing medication errors, implementing wellness and health promotion activities, and reducing disparities. However, additional specific guidance in this area is still pending. The final rule restates the earlier proposed rule's language that HHS "intend(s) to address the content and manner of quality reporting under this section in future rulemaking."[c]

---

[a] ACA Sec 1311(g)(2) GUIDELINES.-The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

[b] 45 CFR Part 155.200(f). "The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction survey, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting pursuant to sections 1311(c)(1), 131(c)(3), and 1311(c)(4) of the Affordable Care Act." March 27, 2012, p. 41915.

[c] 45 CFR 155-157 (preamble section), Fed. Reg., March 27, 2012, p. 18325.

Vermont requirements for quality improvement go beyond the ACA requirements. First, both Act 48 and Rule 9-03 require plans to engage in "joint quality improvement activities" with other plans.[d] In fact, joint QI activities are already underway as part of Rule 9-03. This emphasis on joint quality improvement by plans is a significant innovation that clearly fits with the longer-term goal of an integrated, universal health system under Green Mountain Care. Second, both Act 48 and Rule 9-03 stipulate that plans must actively participate in the Blueprint for Health, Vermont's state-led delivery system transformation program. Opportunities for coordinating plan-level quality improvement activities with the Blueprint goals will be discussed in this report.

The Vermont Exchange is well-placed to meet the ACA requirements for quality improvement strategies. Accreditation by both NCQA and URAC require health plans to undertake quality improvement projects, so the leading insurers in the Vermont market will already have projects underway. In addition, plans are currently complying with the extensive quality improvement requirements contained in Rule 9-03. These requirements include submission of QI work plans and project reports (including joint projects) on an annual basis.

In advance of final rulemaking on quality reporting, this report addresses the following questions:

1. What are the policy levers available to the Exchange for rewarding high performing health plans, and to health plans for rewarding high performing providers?

2. How should the Exchange evaluate the quality improvement and incentive strategies of QHPs?

The UMass contract requirement (quoted above) stresses incenting *of* QHPs *by* the Exchange. In the absence of detailed regulations in this area, though, it is not yet clear whether Exchanges will in fact be allowed to apply financial incentives to QHPs. But, given the emphasis on state flexibility within the ACA, this report assumes that the Exchange will be able to directly incentivize QHPs at some point in the future. In addition, this report will include two critical topics not listed in the contract requirement text: provider-level incentives (i.e., incenting *of* providers *by* health plans), and ways the Exchange might evaluate the strength of quality strategies developed by plans and submitted to the Exchange for review.

This report includes the following: a presentation of different types of incentives (both financial and non-financial), a description of our methods for reviewing the evidence base regarding incentives, a discussion of what is known through the evidence-based

[d] Act 48, Section 1806(c)(2).; Vermont Rule H-2009-03, part 6.3 (D), pp. 65-66.

literature about the most effective incentives, and a brief concluding section with general recommendations for linking incentives to the Exchange's quality reporting requirements.

2. Types of Incentives

The types of levers available to incentivize the provision of quality care fall into two large buckets: financial and non-financial. In 2002, Bailit Health Purchasing prepared a brief on incentive models for the National Health Care Purchasing Institute.[1] Relevant models from the brief are summarized below. All incentive types may be applied to either providers or plans, except where noted.

2.1 Financial incentives

Financial incentives fall into at least five different categories and are administered through contractual relationships.

Bonuses: A bonus is extra compensation that is paid over and above the usual payment. Providers or plans that exceed quality targets are eligible to receive payment. Typically the bonus is paid from a pool of funding that has been set aside at the beginning of the bonus period. The size of the bonus depends on the number of providers or plans who qualify for the funding.

Withholds[e]: Under a withhold system, a portion of regular compensation is withheld and is paid contingent on meeting certain quality targets. Providers or plans who meet all targets receive all the withheld funding; those who meet some of the targets receive a portion of the withheld funding.

Enhanced fee schedules (provider only)**:** This model may be implemented in one of two ways: either by designing an enhanced fee for single, specific, desirable services (e.g. well adolescent visits) or by bumping up a provider's compensation for all services by a specific percentage (e.g. 115% of the regular fee schedule for high performing providers).

Quality grants: This model requires eligible participants to apply for grant funding under a Request for Proposals issued by the Exchange. Grants are awarded depending on the topic, soundness and feasibility of the proposal and available funding. Providers or plans typically receive funding as deliverables are met.

Shared savings[2]: The shared savings model (not included in the 2002 Bailit brief) offers providers or plans a portion of any net savings that accrue from their efforts to reduce health care spending. The Medicare Shared Savings Program

[e] Labeled "Compensation at Risk" in the Bailit brief.

for ACOs is pioneering this methodology. Some medical home demonstrations also share savings with participating providers. This model could also be administered by a payer contracting with a health plan.

2.2 Non-financial incentives

There are a number of non-financial levers for rewarding quality as well.

Publicizing performance (plan level only): Since the Exchange will be required to report quality measures to consumers this option, as an incentive, goes beyond web-based reporting. For this option to serve as an incentive, the Exchange would need to move beyond passive reporting and perhaps establish a "Plan of the Year" award to recognize outstanding QHPs. The Department of Financial Regulation's proposed, but not implemented, Annual Quality Improvement Project Excellence Award could serve as a model. Under this option, the Exchange might establish an award to be given to a QHP that conducts a quality improvement project of importance, scope and with significant results. The reward would consist of publicity and the ability to use the award in plan marketing materials.

Alternatively, the Exchange could flag plans that meet certain standards (e.g. generous wellness benefits, or current and accurate network information) with a "Seal of Approval" on the pages displaying plan information to consumers.[3]

Technical assistance for quality improvement: Under this model, the Exchange would offer technical assistance to health plans and provider groups to design, implement and track quality improvement initiatives. A key philosophy of this approach is the sharing of best practices among health plans and providers. Vermont's Act 48 and Rule 9-03 both mandate that plans to engage in joint quality improvement projects, so QI staff at the major health plans will already be acclimated to working together to share knowledge. Implementing a TA incentive could be an extension of the existing mandate. Larger provider entities, such as hospitals or group practices, could also be incented to undertake joint QI activities.

Plan or Provider sanctions: This model sets a minimum floor for quality performance. If a plan or provider falls below the threshold, the contract with that plan/provider is terminated. At the plan level, the Exchange would have leverage to sanction a poorly-performing QHP by de-certifying it, either at the time of regular re-certification, or at any time the Exchange felt appropriate. QHPs in turn could sanction low-quality providers by removing them from the QHP network.

Reducing administrative requirements (plan level only): As a reward for high performing plans, the Exchange could "deem" selected requirements. For example, the Exchange might choose to waive audit criteria for data submitted to

the Exchange for reporting. Or the Exchange may waive certain recertification requirements, based on the plan's accreditation by federally approved entities.

3. Evaluating Quality Improvement and Incentive Strategies

To inform the discussion of incentives, we conducted a search of the evidence-based literature related to incentives and the effectiveness of incentives in changing behavior. Although almost all the literature describes incentives at the individual provider level, some studies discuss larger organizational groups such as hospitals or large group practices. The newest reform initiatives involving shared savings between payer and health plans have limited evidence regarding results.

The specific questions addressed by the review included:

1. What is the evidence that financial incentives actually improve health care quality?

2. What is the evidence that non-financial incentives improve quality?

We searched three databases (PubMed, Medline, and OVID) looking for terms such as "*provider incentives," "financial incentives," "quality incentives," "health plan incentives,"* and *"performance incentives."*

Several criteria were used for study selection: 1) relevance to provider incentives; 2) free full text available; 3) published in the last 10 years; 4) English language; 5) published in the U.S.; 6) original research with a preference for Randomized Controlled Trials (RCTs) or study with a comparison group or meta-analysis; 7) sample size >50.

In addition to peer-reviewed literature, we also reviewed reports from several national organizations. The organizations included AHRQ, Kaiser Family Foundation (KFF), Commonwealth Fund (CWF), Robert Wood Johnson Foundation (RWJ), Mathematica Policy Research (MPR) and the Urban Institute.

We explicitly excluded studies that researched incentives to consumers, and studies that lacked a well-defined intervention and outcome. We also excluded studies that required payment and/or a subscription to access the complete, full-text article. (Most, but not all, research journals were available to us through the UMass Medical School library website.)

3.1 Evidence for the impact of incentives on quality

3.1.1 Financial Incentives

The evidence for the impact of incentives on quality of care is decidedly mixed. On the one hand, what gets measured gets improved (sometimes). On the other, what is not measured may actually decline in performance, possibly because attention has been diverted from non-measured activities to those that are linked to payment.

In the primary care practice setting, evidence from randomized trials of incentives has shown partially positive results of providing monetary rewards tied to selected indicators. Several studies document increases in immunization rates tied to the provision of an incentive, although authors do note that it may be the documentation of the immunization that increased.[4] [5] Roski et al. show that incentives can increase referral rates to smoking cessation programs.[6]

More recent studies using cost-benefit analysis methods or cross-sectional designs have shown partial effects. Rosenthal used cost-benefit analysis techniques to evaluate the effect of incentives on three measures in approximately 300 physician groups in California: HbA1c testing, cervical cancer screening and mammography screening. Only cervical cancer screening rates appeared to be affected by the incentives.[7]

Unfortunately, removing incentives or not incenting an indicator at all does seem to be associated with a decline in performance on those measures. In an analysis of Kaiser Permanente data for 2.5 million members, Lester et al. showed that removing incentives from previously incented activities resulted in an absolute decline in performance.[8] Similarly, Doran et al., conducting a longitudinal analysis of British National Health Service (NHS) data on primary care practices from 2000-2007, documented that non-incentivized items declined in performance relative to incentivized items. The NHS primary care incentive system included a large basket of incentive targets (146 indicators) in hopes that attention to quality would become widespread. But instead, the authors found that the program had negative effects on non-incentivized areas, possibly because the program led physicians to focus their efforts on patients to whom incentives applied.[9]

Turning from physician practices to hospitals, incentives appear to have little or no impact on performance. Studies have looked at hospital pay-for-performance (P4P) programs at the federal and state levels. A number of researchers have examined CMS's Premier Hospital Quality Incentive Demonstration (PHQID), which began in 2003. This voluntary program offered financial incentives to hospitals for improved care of Medicare patients. A study of data from the first three years of the program (2003-2006) found that participating hospitals did not experience significantly higher rates of performance improvement on incentivized measures than did non-participating hospitals. (All hospitals improved to some degree during the period, on all measures, including those not incentivized in the program).[10]

In 2006, CMS changed the incentive methodology, making it easier for more hospitals to qualify for payments; hospitals could receive payment for improvement on baseline levels, rather than having to meet an absolute attainment threshold. However, this change failed to increase the effect of incentives. In fact, participating hospitals saw their rate of quality improvement decline relative to non-participating hospitals.[11]

Hospital incentives have not proven effective at the state level either. Massachusetts Medicaid (MassHealth) has made hospitals eligible for very substantial incentive payments since 2008. A recent evaluation found no improvements in the incentivized areas in Massachusetts hospitals, as compared with hospitals in other states (hospitals that were not participating in any Medicaid P4P programs during the study period.)[12]

The results of Medicare's Physician Group Practice Demonstration (PGPD) show that organizations which become accountable for all the care received by members can achieve quality targets. The incentives in the PGP Demonstrative took the form of shared savings.[13]

3.1.2 Non-financial incentives

Public reporting as a non-financial incentive has been well studied. In 1994 and 1995, Hannon et al. published two seminal articles regarding the impact of public reporting on provider quality. In both cases the authors studied the effect of New York State publishing mortality rates after coronary bypass surgery (CABG) by physician. The studies found dramatic improvements (decreases) in mortality rates following public reporting. One key factor in this improvement was that many poor-performing surgeons either left the field or were barred by hospitals from performing CABG surgeries, in response to the publication of data.[14] [15] More recently, Fung et al. completed a comprehensive review of the literature on the impact of public reporting in 2008 and concluded, among other things, that public reporting does stimulate quality improvement activities among the affected providers.[16]

The unintended consequences of public reporting have also been studied. As early as 1996, Schneider and Epstein reported that Pennsylvania cardiac surgeons were increasingly unwilling to accept severely ill or complex cases after that state instituted a public reporting program similar to New York State's.[17] Critics of the Schneider study pointed to its weak methodology (a survey of cardiologists and cardiac surgeons) and suggested that perhaps the very sickest patients presented the riskiest surgical candidates and should not be receiving CABG. But more recently, Werner's 2005 study demonstrated racial and ethnic disparities in access to cardiac procedures attributable to the New York State public reporting system.[18]

3.2 Exchange's role in incentivizing quality

The Exchange cannot offer financial incentives to individual providers to maintain or improve quality; only the Qualified Health Plans themselves may do this. However, the Exchange can play an active role in incenting quality in several ways: through its process of recertifying (and potentially decertifying) QHPs, its public reporting role, and

its oversight of the quality incentive programs put in place by QHPs. Moreover, Vermont has other state-level incentive programs underway, through the Blueprint and its associated payment reform efforts.

As our brief review of the literature regarding the impact of public reporting on provider behavior shows, what gets measured gets improved, at least some of the time. Therefore, the choices the Exchange makes with respect to metrics for reporting, and benchmarks for performance, will have a critical role in influencing quality of care in Vermont.

4. Recommendations

We recommend that Vermont continue in the direction it has already established through Act 48, the Blueprint for Health, and other initiatives. The emphasis on payment reform for primary care practices as the primary driver of improvement, which we see in Vermont through the state's incenting of Advanced Primary Care Practices (APCPs), and at the federal level with Accountable Care Organizations (ACOs), is well supported by the evidence base. As the literature review above demonstrates, incentives are most effective when pushed downward to point of first contact between provider and patient. Provider practices are more likely, and better able, to respond to incentives (even if sometimes this response has unintended, potentially negative consequences) than are large institutions like hospitals or health plans. More generally, Vermont's (and the nation's) emphasis on preventive care as the key to improving population health and health care point to the desirability of a primary care-focused incentive strategy.

Until clear federal guidance is issued, we do not know if the Vermont Exchange can directly provide financial incentives to QHPs. QHPs obviously can and are expected to use incentives in their relationships with providers. In its early stages, the Exchange's role with respect to incentives will be to support existing efforts, though its roles in public reporting and oversight. The Exchange can also facilitate joint quality improvement efforts between QHPs, furthering the goals of Rule 9-03. As the implementation of Green Mountain Care moves forward, the Exchange may need to take a more active role in developing new performance incentive programs. These next steps must be addressed during the upcoming waiver negotiations between Vermont and CMS. In the single-payer environment to which Vermont intends to move, a direct role for the Exchange in creating incentive programs at the QHP level would make sense. State Exchanges that function purely as neutral marketplaces may not be well-placed to actively incentivize quality, but Vermont's Exchange will play a much larger role in guiding the state's health care system.

As Vermont moves toward integration of its health system under Green Mountain Care, some general suggestions about incentive design should be kept in mind. A recent article by Van Herck et al.[19] presents six core principles that policymakers should follow when designing an incentive program, whether directed at health plans or providers. We

conclude this report by sharing these principles (language slightly adapted from the original):

1. Select and define incentive targets based on baseline room for improvement.
2. Make use of process and (intermediate) outcome indicators as target measures.
3. Involve stakeholders and communicate the program thoroughly and directly throughout the development, implementation, and evaluation phases.
4. Implement a uniform incentive design.
5. Focus on both quality improvement and achievement (i.e., threshold attainment).
6. Distribute provider incentives at the individual (physician) level and/or at the practice (medical group) level.

While specific questions about incentive design must await the release of federal guidance and the outcome of waiver negotiations, Vermont policymakers should begin to envision a quality incentive system that embodies these principles.

Appendix 1: ACA Section on Incentives

1311(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.—

(1) STRATEGY DESCRIBED.—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) the implementation of wellness and health promotion activities; and

(E) *As added by section 10104(g)*. the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1). [emphasis added]

References

[1] Bailit Health Purchasing. Provider incentive models for improving quality of care. Princeton, NJ: Robert Wood Johnson Foundation. March 2002.

[2] Bailit M and Hughes C. Key design elements of shared-savings payment arrangements. Commonwealth Fund publication 1539: 2011.

[3] Kleinman Communications Group and Consumers Union. Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices. Rockville, MD and Washington, D.C. July 9, 2012.

[4] Fairbrother G, Siegel MJ, Friedman S, et al. Impact of Financial Incentives on Documented Immunization Rates in the Inner City: Results of a Randomized Controlled Trial. *Ambulatory Pediatrics* 2001;1:206-212

[5] Kouides RW, Bennett NM, et al. Performance-Based Physician Reimbursement and Influenza Immunization Rates in the Elderly. Am J Prev Med 1998;14: 89-95

[6] Roski J, Jeddeloh R, An, L, et al. The impact of financial incentives and a patient registry on preventive care quality: increasing provider adherence to evidence-based smoking cessation practice guidelines. Medicine 2003; 36: 291–299

[7] Rosenthal MB, Frank R, et al. Early Experience With Pay-for-Performance From Concept to Practice JAMA 2005; 294 (14): 1788-1793.

[8] Lester H, Schmittdiel J, Selby J, et al. The impact of removing financial incentives from clinical quality indicators: longitudinal analysis of four Kaiser Permanente indicators. BMJ 2010; 340: 1-5

[9] Doran, T, Valderas, J, Campbell, S, et al. Effect of financial incentives on incentivised and non-incentivised clinical activities: longitudinal analysis of data from the UK Quality and Outcomes Framework. BMJ 2011; 342: 1-12

[10] Glickman SW, Ou FS, DeLong ER et al. Pay for Performance, Quality of Care, and Outcomes in Acute Myocardial Infarction. JAMA. 2007: 297: 2373-2380.

[11] Ryan AM, Blustein J, Casalino LP. Medicare's flagship test of pay-for-performancedid not spur more rapid quality improvement among low-performing hospitals. Health Aff 2012; 31:797-805.

[12] Ryan AM, Blustein J. The Effect of the MassHealth Hospital Pay-for-Performance Program on Quality. Health Serv Res 2011; 46: 712-28.

[13] Iglehart JK, Assessing an ACO prototype – Medicare's Physician Group Practice Demonstration. NEJM 2011 364(3): 198-200.

[14] Hannan EL, Kilburn H Jr, Racz M, Shields E, Chassin MR. Improving the outcomes of coronary artery bypass surgery in New York State. JAMA. 1994;271: 761-6.

[15] Hannan EL, Siu AL, Kumar D, Kilburn H Jr, Chassin MR. The decline in coronary artery bypass graft surgery mortality in New York State. The role of surgeon volume. JAMA. 1995;

[16] Fung C, Lim YW, et al. Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care Ann Intern Med. 2008;148:111-123.

[17] Schneider EC, Epstein AM. Influence of cardiac-surgery performance reports on referral practices and access to care. A survey of cardiovascular specialists. N Engl J Med. 1996;335:251-6.

[18] Werner RM, Asch DA, Polsky D. Racial profiling: the unintended consequences of coronary artery bypass graft report cards. Circulation. 2005;111:1257- 63.

[19] Van Herck P, De Smedt D, Annemans L et al. Systematic review: Effects, design choices, and context of pay-for-performance in health care. BMC Health Services Research 2010; 10:247.