The Quadruple Aim: Working Together, Achieving Success
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### Lowering Costs and Improving Quality in Health Care through Incentives

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The Problem

- High and rapidly rising costs in the MHS
- Want to slow cost growth without sacrificing quality
- Question: How can we use incentives to achieve this goal?
Two Types of Incentives Work in Concert

- **Incentives for providers**
  - Reward providers for lowering costs and increasing quality
  - Shared gain/loss for all providers involved in a episode of care
  - But this won’t work unless we can encourage patients to use low cost/high quality providers

- **Incentives for patients**
  - Reward patients for using low cost/high quality providers
  - Reward patients for healthy behaviors
  - Won’t work unless strong incentives for providers to lower cost/raise quality and encourage healthy behaviors
Provider Incentives

- FFS system: the butcher/steak conundrum
- Providers have patients best interests at heart – but financial incentives still play a role
- “Flat of the curve” medical care: why not deliver the extra medical care?
- Strong evidence
  – Introduction of Medicare PPS
  – Area variations
Provider Incentives (II)

- Other extreme: capitation
  - Turn incentives on their head by having the provider bear the spending risk
- But concern that it goes too far – doesn’t reward quality care and could result in poor access
  - “de” capitation!
  - But no evidence so far that this has happened in any quasi-capitated systems
Ideal middle ground: pay for “value” – but what does this mean?
- PMPM capitation payment to providers, with outlier adjustment
- Reward quality metrics
  - Process based (e.g. immunizations)
  - Outcome based (e.g. mortality)
- Commodify services where possible
  - Consider which services can be done equally well at low cost sites
  - Don’t pay a premium where unnecessary
Patient Incentives

- Flat of the curve with respect to patients also
  - why not get extra care?
- And strong evidence as well
- RAND HIE
  - Overall reduction in care with no impact on outcomes
  - But heterogeneity: protection for chronically ill
- Changing health behaviors is harder
  - Financial incentives matter for reducing smoking
  - But less of an effect on weight loss
Patient Incentives (II)

- Overall incentives to use care efficiently
  - Patient cost sharing
  - Value based insurance design
- Particular incentives to shop where services are commodifiable
  - Balance billing
- Experiment with incentives for healthy behavior
  - Financial incentives on smoking/weight gain
  - Employment conditions – training qualification
First step is to establish Patient Centered Medical Homes (PCMH)
  – Coordinate care to lower costs and improve quality

Next step is to Performance Planning Pilot Program (PPPP)
  – Broad system of financial incentives tied to performance

Future steps: go further with patient & provider incentives?
Long-standing view that more effective coordination of care can lower costs, raise quality

Standard model is PCMH

Certain standards proposed by NCQA
  - 3 levels of “recognition”
  - 9 standards ➔ 30 elements ➔ 170 evaluation factors
MHS PCMH Initiative

- MHS is moving towards PCMH for clinics in MTFs
- MHS Goal is 2.5 million enrollees in a Level 2/3 PCMH by end of FY12
- More than 500 clinics expected to seek NCQA recognition
Costs of PCMH

- But PCMH is not free
- AMA finds that coordination of care raises physician costs by 20%
- Are there offsetting cost reductions elsewhere?
- Dozens of studies – many more ongoing
- So far, evidence is unclear on quality & cost impacts
Pilots are much more ambitious: tie financial incentives to achieving key goals – and to reducing cost growth

- Rewards for HEDIS, ORYX, PCM Continuity, Third Available, Beneficiary Satisfaction, ER Utilization, and Overall Management of PMPM
- 7 sites testing incentive design in FY11
Issues with Pilots

- Are we rewarding behavior changes?
  - Need to control for underlying trends that would have happened in absence of pilots

- Are incentives properly aligned?
  - Complicated set of incentives – have we weighted them appropriately?

- Are we setting up perverse incentives
  - Do strong incentives for cost control reduce quality of care? Do strong incentives for quality of care raise costs?
Evaluation is Key

- Given these uncertainties, it is critical for MHS to evaluate the impacts of PCMH and Pilots
  - *Ensure* that they are achieving goals
    - Careful measurement framework to assess impacts
  - *Renovate* if they are not
    - Assess components of interventions so that they can be adjusted in place
  - *Plan* for expansion if they are
    - Motivate further adoption through strong evidence base
Problem with such initiatives: government scorers won’t give them credit

CBO: no solid evidence for cost savings from PCMH or PPPP type interventions

They would be very receptive to carefully designed evaluation

Could lead to scored savings that benefit MHS
First Step: Baseline Data

- Can’t evaluate impacts of change without measuring baseline
- Detailed survey of all MHS sites to gather data on their compliance with NCQA standards
- Key is to gather data on each element so that we can evaluate which elements matter
  - This is an umbrella concept - if only certain elements matter, then want to target
Evaluating PCMH

- Compare MTFs which adopt PCMH standards to those that do not
- Examine broad range of outcomes
  - Medical readiness
  - Patient satisfaction
  - Process measures of health outcomes (readmission rates, screening)
  - Objective measures of health outcomes (lab values, mortality)
  - Staff satisfaction
Evaluating PCMH (II)

- Critical feature of evaluation: assess *which elements* of PCMH are responsible for changes in outcomes
- There is a wide variety of elements to PCMH, but most studies just consider yes/no
- Critical to understand *what works* so we can renovate going forward
  - Particularly since some elements may raise costs while others lower them
Evaluating PPPP

- Careful comparison of outcomes in the 7 PPPP sites to “control” sites where these incentives are not offered
- Examine responses specifically for the rewarded characteristics
- Then look more broadly at other outcomes
Very innovative – as such we have little to guide us on the right incentive structure
- Where should rewards be higher: initial patient access or continuity of care?
- How much of cost savings to share with providers?

We are making initial estimates based on available evidence

But we can use the evaluation to assess where changes are having the largest effect

Adjust incentives based on initial findings
Expanding the PPPP

- If PPPP evaluation is successful, we can plan for evidence-based expansion
  - Use what we learn to craft incentives elsewhere
- Key next step: bringing in patient incentives
  - The majority of medical spending is driven by factors under the patients control
  - What is possible here?