Boom, Boost or Boon? ePrescribing & Pay-For-Performance

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TEPR Annual Conference

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Agenda

- State of ePrescribing
- Managed Care Environment
- Pay-for-Performance Primer
- ePrescribing and Pay-for-Performance

State of ePrescribing

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What *is* ePrescribing?

Decision Support

- EMR
- Connected
- Medication Mgmt
- Prescription Writer w/Data
- Stand-alone Prescription Writer
- Electronic Reference

Source: eHealth Initiative

Data Flow of Interoperable ePrescribing

Physician Practice

EMR or eRx System

A — Formulary Database

Rx

A Request Eligibility, Formulary, Drug History

RxHub

Response

PBM or Plan

Claims Processing System - benefit plan rules, formulary, history

B New Rx

SureScripts, Proxymed, NDC, WebMD

Retail or Mail Pharmacy

Pharmacy Dispensing System

C Refill Request
Refill Auth/Denial
Change Request

ePrescribing by the numbers…

5-18% MDs prescribing electronically
(eHealth Initiative, 2004)

85% pharmacies enabled for ePrescribing
(SureScripts, ProxyMed, NDC, WebMD)

5% US hospitals using CPOE
(KLAS, 2005)

14-39% Outpatient EMR use
(California Healthcare Foundation, David Brailer, MD, 2004)

150 million Lives for whom formulary & benefits are available through Rx Hub

$29 billion potential annual ePrescribing savings
(Center for Information Technology Leadership)

“The Stars Are Aligning…”

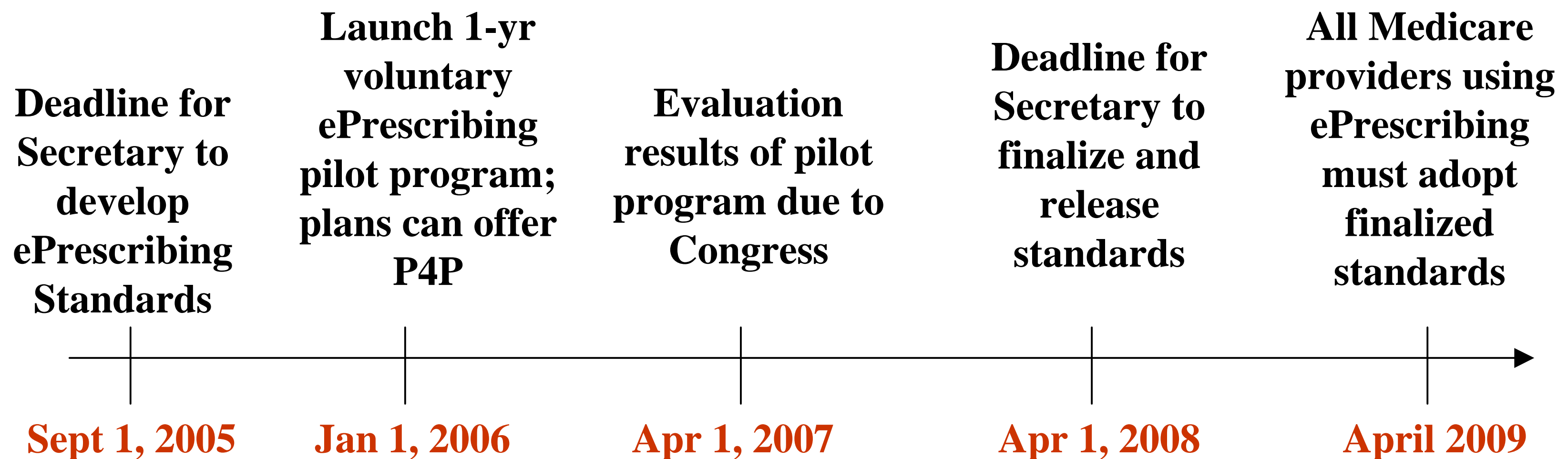
- President Bush mentioned HIT and EHR in '05 and '04 state of the union addresses
- Establishment of office of Healthcare Information Technology and appointment of David Brailer, MD, PhD
- FDA and IOM and are calling for eRx for safety
- Grants from the US Department of Health and Human Services and Agency for Healthcare Research and Quality
  - Recent award of $139 million for grants, HIT demonstration projects
- Politicians want to be seen as “doing something” about medication errors
- Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)

Medicare Prescription Drug Improvement and Modernization Act of 2003

- Directs HHS to conduct a voluntary electronic prescription pilot project in 2006, unless there is already adequate experience.
- Establishes a real-time ePrescribing program to be used by prescribers, pharmacies and pharmacists who serve Medicare patients
  - No mandate, but if used, standards must be followed
  - Standards via National Committee on Vital and Health Stats
- Information provided electronically includes:
  - Eligibility and benefits, formularies and tiering, coverage limitations
  - Information on drug being prescribed, patient's history, DUR
  - Information on therapeutic alternatives

Medicare Prescription Drug Improvement and Modernization Act of 2003 (cont.)

- Other components:
  - Discretionary grants to be made available to prescribers
  - Plans, hospitals, groups may purchase hardware for MDs
  - Plans may pay additional fees for reduced medication errors, improved formulary compliance & fewer adverse drug events



Barriers to Widespread Adoption Still Exist

- Who pays? There are still outstanding questions about the business model for ePrescribing
- Which vendors will succeed? No one wants to repeat the dot.bomb experience.
- Standards development takes time
  - Stakeholder objectives often at odds
  - Development and approval process is painstaking
- Adoption/utilization still lagging. Critical mass exists in only a few regions
- ePrescribing is not yet an expected standard of care

Managed Care Environment

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Managed Care: Growing but with a Different Future

- Plans face unprecedented challenges
  - Severe managed care backlash
  - Growing numbers of plan closures
  - Loss of clout with providers
  - Rising Rx and other medical costs
- Continued mergers and acquisitions
- Growth of specialty Rx
- Growth in premiums and profitability

Evolution of Managed Care

Consumerism

Pay for Performance

Managed Care

- Cost-containment driven
- Medical and Rx silos
- Pressure on MDs to conform

Medical Management

- Clinical outcomes driven
- Rx integrated into UM, DSM and Care mgmt
- Emphasizes quality and safety
- Partners with providers

Evidence-Based Medicine

Government

- MMA, Pending Bills
- ONCHIT

Employers

Value-based Purchasing

Pay-for-Performance

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Principles of Pay-for-Performance

- Provides providers with financial rewards for progress via quality metrics
- Establishes a common set of metrics on which physicians′ performance can be measured
- Agent for behavior change. Goal is to influence, change or re-engineer into a desirable direction
- Current emphasis on "enabling" vs traditional on "rewarding" behavior
- Complementary to "consumerism" trend, as metrics are made available to patients.

Pay-for-Performance Programs

- Are real and a good thing
  - 35 health plans, covering 30-million patients have some kind of program
- May be our biggest change in reimbursements since DRGs
  - According to CMS Administrator, Mark McClellan, MD, PhD, in the next 5 to 10 years, P4P programs could account for 20% to 30% of CMS MD pay
- Is tied directly to pt safety & quality improvement
- Is the "market forces" responding to the new quest for value in health care (highest quality for lowest care)

Source: First Consulting

Pay-for-Performance Criticisms

- Performance measures are arbitrarily applied and don't take into account risks
- Measuring what MDs do doesn't measure what's important – outcomes
- Accountability an issue as some MDs receive payments regardless of how the patient fares
- No consistent agreement on the P4P metrics to use across all populations, which is confusing to providers to know exactly how they are being measured

Pay-for-Performance Criticisms (cont)

- Possibility of harm, as physicians could learn to "game" the system
- Incentives may not be large enough. Surveys: 5% to 10% of physicians' pay would make it worthwhile
- Physicians say they don't have technology to track follow-up care

Source: *Wall Street Journal*

Lingering Questions

- Are pay-for-performance programs sustainable?
- Can pay-for-performance programs improve quality care?
- Is there evidence that better care will reduce costs, unnecessary follow-up care?
- How do P4P results translate into meaningful information for consumers?

Bottom line: Can P4P Programs work in the fragmented US healthcare system?

ePrescribing and Pay-for-Performance

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Incentives and HIT

- Misaligned incentives and payment policies have long been considered a barrier to widespread adoption of HIT
- Those who pay for HIT are often not the ones who benefit directly from the investment
- IOM Report *Crossing the Quality Chasm* calls for:
  - Purchasers to examine payment methods
  - CMS and AHRQ to develop a research agenda to determine how to align current payment methods with quality improvement goals

Incentive Models for HIT

- **Cost Differentials** – co-payments and/or deductibles for provider visits
- **Direct Reimbursement** – primarily focused on the virtual provider-patient visit
- **Shared Withholds** – withholds or delays provider payment rate increases and release fees contingent on providers' technology implementation
- **Payment Differentials** (pay-for-performance) – bonuses or add-on payments

Source: Health Strategies Consultancy

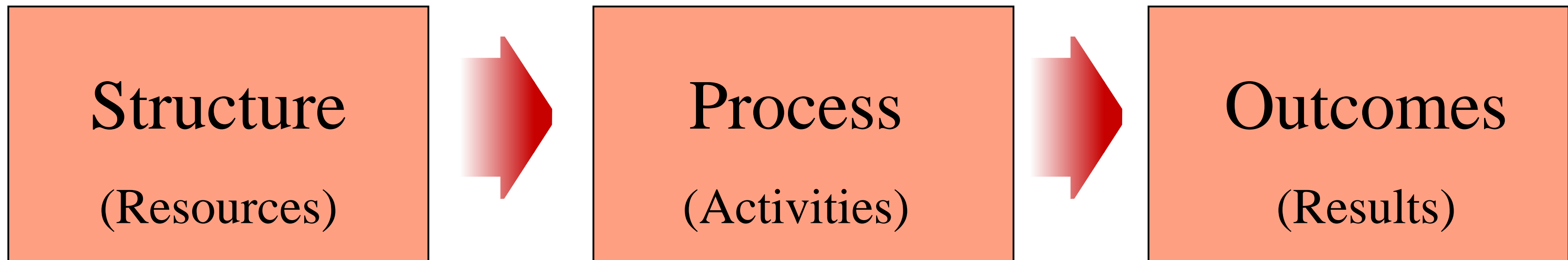
Payment Differentials
(Pay-for-Performance)

Health Plan ➔	Physician Groups
Health Plan ➔	Hospitals
Employer ➔	Physician

- Bonuses or add-on payments that reward for adoption and use of HIT
- Models vary:
  - Per Member Per Year
  - Total Claims
  - Tiered Approach

Source: Health Strategies Consultancy

ePrescribing-related Pay-for-Performance Programs



Donabedian, 1980

- Plans, employers, consortiums and others are experimenting with pay-for-performance.
- In the “innovator” and “early adopter” phase of Everett Rogers bell-curve model of technology adoption.
- Programs are in various phases along a classic health care continuum: structure -> process -> outcomes.

ePrescribing P4P Programs

- Bridges to Excellence
- Integrated Healthcare Association
- Wellpoint - Anthem Quality Insights (AQI)
- Southeast Michigan ePrescribing Initiative
- Blue Cross Blue Shield of Massachusetts

Bridges to Excellence

- Multi-stakeholder approach to quality incentives
  - Employers, plans, consumers, physicians & groups
- Mission:
  - Improve quality of care through rewards and incentives
- Focus on ambulatory environment
- Rollout in selected markets: (1) Cincinnati/ Louisville, (2) Massachusetts, (3) Albany/Schenectady
- Program costs paid by employers
- Plans can license program

Bridges to Excellence

Physician Office Link

- Redesign Process of care close to the Quality Chasm
- Reduce "defects" that cost money and harm patients
- Target all physicians and patients

Diabetes Care Link

- Improve outcomes for patients with diabetes
- Reduce overuse and underuse of services
- Target PCPs and Endocrinologists

Cardiac Care Link

- Improve outcomes for patients with CVDs
- Reduce overuse and underuse of services
- Target PCPs and Cardiologists, and patients with cardiac disease

Bridges to Excellence

(POL: Performance Assessment Metrics)

Clinical Information Systems/Evidence-based Medicine	Patient Education and Support	Care Management
Use of patient registration	Use of educational resources	Care of chronic conditions (disease management)
Electronic Rx and test ordering system	Assessment & referrals for risk factors, chronic conditions	Addressing preventable admissions
Electronic Medical Records	Quality measurement and improvement	Care of high risk medical condition

Source: Bridges to Excellence

Bridges to Excellence
(Physician Office Link)

- Enables practice sites to qualify for bonuses
  - Earn up to $50 annually per covered patient
    - Includes adoption of EMR/eRX
    - Tied to Care Management process
- Report card created for each practice site
  - Reports performance on program measures
  - Reports made available to public
- Participating physicians highlighted in provider directories

Current rewards are for <u>infrastructure</u>, not use.

Integrated Healthcare Association

- Coalition of six California HMOs covering 8 million members, 45,000 doctors
- Awards 40% for clinical quality measures, 40% for patient satisfaction and **20% for clinical IT**
- Provided 215 CA medical groups with information on their performance, and made available to the public in fall 2004
- 2004 bonuses were $50 million for P4P programs; an estimated $100 million for quality performance
- Of 100 groups reporting, 67 received full credit for IT, 7 partial and 26 no credit

Wellpoint – Anthem Quality Insights (AQI)

- Anthem Northeast P4P Platform
  - Primary Care quality incentive program
    - 100-point program with up to a 6% increase above existing reimbursement levels
    - ePrescribing (15 of 25 technology points)
    - Generic prescribing (25 points)

AQI Physician Program Framework

P4P Component	Measure	Points
I. Outcomes		10
Diabetes	HbA1C & LDL outcomes levels	
II. Process		40
Diabetes	Appropriate Screenings	
Asthma	Appropriate Medications	
CAD	One LDL screening	
Immunizations	HEDIS/Combo 2 Standard	
Adolescent Well-Care	Annual Visit	
III. Pharmacy	% of Generic Prescription	25
IV. Technology Infrastructure	In production and in use w/Anthem	25
E-Prescribing		
EMR		
Chronic Disease Registry		

Southeast Michigan ePrescribing Initiative (SEMI)

- For Blue Preferred Plus (BCBS Michigan)
- $500 incentive
  - $250 up-front at installation
  - $250 if "use" for 6 months
    - Must remain active user
- In process of developing a more sophisticated program
  - Criteria, Reporting, Metrics, How Articulate

Blue Cross Blue Shield of Mass

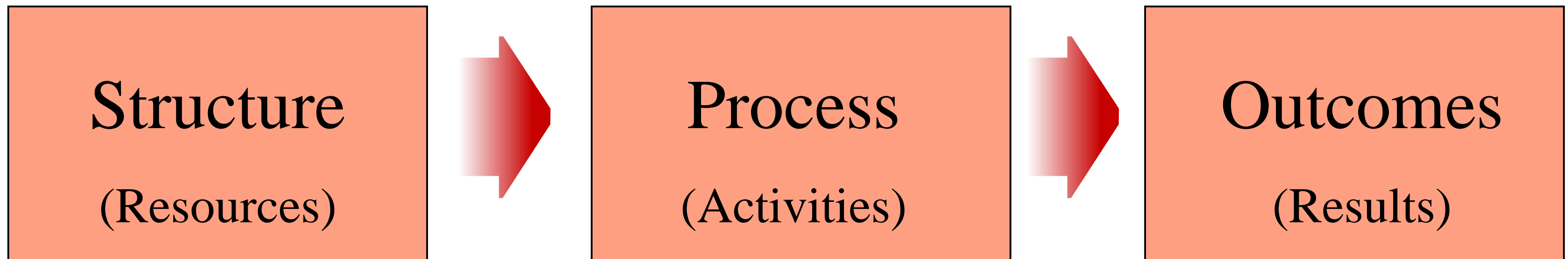
- 1,800 physicians are eligible for program
- Paying physicians participating in ePrescribing program $1 PMPM who:
  - Successfully implement ePrescribing solution (ZixCorp)
  - Continue to write more than 50% of prescriptions electronically – measured over a 2-month period
  - Only for BCBS MA patients
- Average monthly payment: >$200

Robert Mandel, MD, Vice President, eHealth, BCBSMA, May 25, 2004Testimony to NCVHS

CMS ePrescribing Demonstration Projects

- MMA encourages prescription drug plans to provide differential payments for:
  - Reduction in medication errors
  - Formulary compliance
  - Reduction in adverse drug events
- RFP Promised by “End of Summer 2005”

Summary of ePrescribing-related Pay-for-Performance Programs



Donabedian, 1980

Structure	Process	Outcomes
Bridges to Excellence	BCBS Mass	CMS
IHA	Bridges to Excellence (version 2.0 in 2005)	Wellpoint AQI
SEMI	SEMI	
Wellpoint AQI		

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