Pharmacy Management Approach:
How Do We Align All the Incentives?

Jeffrey D. Dunn, PharmD, MBA

ABSTRACT

BACKGROUND: While health care costs continue to rise and shift toward employers, a parallel improvement in health care quality has not been evident. As a means to repair this apparent disconnect, pay for performance (P4P) initiatives are being implemented across the country.

OBJECTIVE: To explore the need for P4P in the current state of health care delivery and review the design, components, and results of P4P programs.

SUMMARY: In P4P, clinical evidence is used by managed care organizations (MCOs) to drive financial incentives and align physicians' and MCO goals, thereby improving delivery of care. At the center of all P4P programs are specific metrics, employed to measure the quality of care by which incentives are provided. These metrics fall into 4 main categories: clinical, patient satisfaction, efficiency, and technology. After metrics are employed and a provider is determined to be deserving of an incentive according to the P4P program in place, several different options exist and vary by plan in terms of incentive type. Primarily, these types of incentives include bonuses, adjustable fee schedules, and withholds. SelectHealth, a nonprofit health insurance company serving members in Utah and Idaho, implemented a primary care incentive program in 2002 for several different conditions and for pharmacy utilization that has been successful to date.

CONCLUSIONS: While P4P programs are becoming increasingly common in managed care, challenges still remain, and data on whether these initiatives improve outcomes and manage costs is still limited.

KEYWORDS: P4P, Measures, Metrics, Incentives, Patient satisfaction, Efficiency, Technology, Pharmacy utilization

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BUSINESS health costs are currently on the rise. These costs are being shifted to employers, and managed care stakeholders are left looking for a means to repair the disconnect between rapidly rising expenditures without correspondingly rapid improvements in care.¹

Pay for performance (P4P) initiatives are one such means in which clinical evidence is being used by managed care organizations (MCOs) to drive financial incentives and align physicians' and MCO goals, thereby improving delivery of care. This daunting task is ultimately achieved by 1 or more of the following: (1) reducing medical errors, clinical variation, and acute treatment episodes; (2) publishing quality health cost data; (3) linking provider bonuses to improved performance; and (4) implementing new information technology (IT), improving efficiency in care delivery.

P4P programs employ metrics to incentivize improved care. These metrics typically fall under the categories of clinical, patient satisfaction, efficiency, and IT. Several types of incentives may be offered, including bonuses, adjustable fee schedules, withholds, and nonfinancial incentives. While several challenges exist in creating an effective P4P initiative, such as data-related constraints, market consolidation, and difficulties in creating a collaborative relationship between payers and providers, successful programs have emerged early throughout the United States.

SelectHealth in Salt Lake City, Utah, is an example of one organization that has developed and implemented a P4P program, which has been met with initial success. SelectHealth's program employs quality improvement measures as well as efficiency measures that, on the pharmacy side, are focused on encouraging generic and formulary drug utilization. The P4P program at SelectHealth has been successful in improving these pharmacy measures, with generic drug utilization improving from 42% to 56% and formulary drug utilization improving from 87% to 88% in family practice between the years 2002 and 2006.

Participation in the P4P movement has been on the rise over the past 4 years, with an increasing number of programs every year. While P4P programs have demonstrated significant improvements in health care delivery, these initiatives typically come at a similarly significant cost to MCOs. Ultimately, only improved outcomes will justify the long-term costs of P4P programs.

Need for P4P Initiatives

Per capita health care expenditure increases were relatively consistent until 1963, at which point a rapid rise in spending occurred.² The introduction of Medicare caused a paradigm shift. Prior to that time, third-party payment was made through a few large industrial corporations. Third-party payers were the vast minority.

Following the advent of Medicare, third-party payers became relatively commonplace, introducing the notion in health care that

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those individuals consuming services were not directly responsible for paying for the services. This transformation had a significant impact on the demand for health products and services. Widespread third-party payment also changed the way physicians thought about prescribing care. Likewise, the growth of third-party payment changed the way that technology vendors thought about development; it became increasingly likely that firms could generate return on investment (ROI) for the development of innovative medical devices, drugs, etc. The expansion of health care financing and investment combined to cause an increase in health care costs that has continued to the present day.

However, while health care costs continue to rise, government payment increases are consistently falling short of professional and facility costs, thereby shifting these costs to employers. In 1980, 28.3% of personal health expenditures were paid by private health insurance; by 2000, national health expenditures per capita had risen to approximately $4,500, 34.6% of which was paid by the private sector. The result has meant an increasing proportion of employer profit is being allocated to employee health costs. Furthermore, a significant disparity currently exists between these rising health care expenditures without a parallel improvement in health care quality.

In 2005, the National Committee for Quality Assurance (NCQA) estimated that thousands of avoidable deaths and billions of dollars in avoidable costs were caused by unexplained variations in care in the previous year (see Table). Although the quality of health care has increased over past levels, these data indicate that there is room for improvement.

Considering this disconnect between increasing expenditures and unsatisfactory care, managed care stakeholders need to find more effective ways to allocate funding and improve the overall quality of health care. P4P initiatives provide one such solution in that they are based on clinical evidence and use incentives to improve the delivery of health care.

### TABLE

<table>
<thead>
<tr>
<th>Measure</th>
<th>Avoidable Deaths</th>
<th>Avoidable Medical Costs ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta-blocker treatment</td>
<td>800-1,200</td>
<td>9.7-23.9 million</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>150-600</td>
<td>41.6-78.3 million</td>
</tr>
<tr>
<td>Controlling blood pressure</td>
<td>12,000-32,000</td>
<td>382 million-1.0 billion</td>
</tr>
<tr>
<td>Diabetes care</td>
<td>5,300-11,700</td>
<td>693 million-1.2 billion</td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>4,100-6,200</td>
<td>188-194 million</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>1,000-1,750</td>
<td>519-524 million</td>
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* Data from 2004.


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### Overview of P4P

The concept of P4P is based on the notion that MCOs and providers must think collectively when it comes to the delivery of care. In these collaborative efforts, incentives motivate providers to apply a best-practice approach to disease treatment, maintenance, and prevention. P4P initiatives seek to reduce errors, clinical variation, and acute treatment episodes; publish quality health cost data; link bonuses to improvement; improve efficiency in care delivery; and implement new IT.

P4P programs share several common features, all of which are driven by evidence-based medicine and the concept that provider incentives are often misaligned for delivering quality health care. P4P programs routinely measure clinical outcomes, compliance with clinical process standards, and cost management. Mechanisms for continuous improvement are also commonly featured in MCO P4P initiative structures, along with specific incentives for the increased use of IT. Often, the incorporation of a consumer satisfaction measure is included, as are mechanisms to shift market share based on quality performance.

At the center of all P4P programs are specific metrics employed to measure the incentives earned. These metrics fall into 4 main categories: clinical, patient satisfaction, efficiency, and technology. Clinical metrics are based on specific evidence-based measures in health care such as childhood immunizations, breast cancer screening, asthma control medications, and glycosylated hemoglobin (AIC) levels and screening for diabetes. Patient satisfaction metrics assess the level of care patients report receiving, such as access to or communication with physicians. Efficiency metrics look toward performance, such as generic substitution rates, utilization of services (episodes of care), and practice patterns with apparent financial implications. Finally, technology metrics recognize the value of employing technology to improve patient registries, emergency medical services, lab systems, or the use of electronic medical claims submission.

Metrics in all 4 categories come from a variety of sources, both internal and external to the MCOs employing them. External sources of P4P metrics include widely recognized national health organizations such as NCQA (e.g., the Health Plan Employer Data and Information Set [HEDIS], Bridges to Excellence, etc.), National Quality Forum, American Medical Association (AMA) Consortium, or the Centers for Medicare & Medicaid Services (CMS). Internal sources of P4P metrics include those clinical and efficiency measures developed by the organizations themselves.

MCO plans offer several different types of incentives when a provider’s performance metric attains thresholds as specified in the MCO’s P4P program. Primarily, the incentives can be categorized as bonuses, adjustable fee schedules, and withholds. Bonuses are the most popular type of incentive and are usually paid out annually. Bonuses are also easy to administer since they can be stratified for different measures. Adjustable fee schedules tend to correspond to specialist incentive programs and are therefore more difficult to administer. These incentives are also typically...
Challenges and Promise in P4P

The design and implementation of an effective P4P initiative must take into consideration several challenges that may hinder the success of the program. Considering the wealth of accurate information necessary in a P4P system, data-related constraints are of primary concern. Specifically, the timeliness of data, accuracy of data, availability of pharmacy and lab data, requirement to use chart data, exchange of data with other physicians, and small or limited amounts of data are all issues that must be addressed in comprehensive P4P programs. IT support systems must be standardized, easy to access, provide real-time data, and produce robust and meaningful data. Other challenges arising in P4P programs include the degree of market consolidation required and the collaborative relationship between payers and providers necessary for short- and long-term program success. Furthermore, the structure of a P4P initiative must be designed to overcome provider resistance, skepticism, and legal challenges.

Considering these apparent challenges to the development and implementation of an effective P4P program, MCOs can employ several measures to increase the program’s chance of success. Collaboration of payers and providers in the P4P development stages allows for multidimensional performance initiatives with long-term benefits for each party. In that manner, these collaborations foster a sound organizational infrastructure, cooperative culture, and enhanced professional resources vital to the long-term success of P4P programs. Clinicians should be involved in program design and implementation, and the use of evidence-based guidelines is imperative. Finally, rigorous follow-up processes should be established with a substantial commitment to IT support for monitoring and maintaining the program’s success.

Despite the apparent challenges in P4P, the movement is thriving in managed health care, with more programs arising each year (see Figure). Currently, one third of all health plans feature some form of P4P initiative, totaling 115 operational programs and encompassing 53 million patient lives.

A wide variety of P4P methodologies are in use although, to date, no universal approach to P4P has emerged. Still, similarities exist among current P4P initiatives, with bonuses being the most commonly employed incentive by health maintenance organizations, and primary care physicians being the stakeholders most commonly receiving incentives.

SelectHealth Primary Care Incentive Program

One example of a P4P initiative that has been successful thus far is that of SelectHealth, a nonprofit health insurance company serving members in Utah and Idaho and an integrated subsidiary of Intermountain Healthcare. Since June 1, 2002, SelectHealth has used quality improvement and efficiency measures to evaluate qualifying providers for the provision of P4P incentives.

Among the P4P quality measures implemented at SelectHealth in 2002 were those for asthma care; otitis media; childhood immunizations; depression care; diabetes care; and preventative care, which covers both breast cancer screening and smoking cessation.

The diabetes care quality measures include the number of patients with a diagnosis of diabetes who had an A1C test in the past twelve months and the number of patients with a diagnosis of diabetes who had an LDL-C test in the past 24 months. Performance prior to the P4P implementation for both of the measures was 76%. Subsequently, the 50% and 100% benchmarks for the 2 measures were set at 78% and 83%, respectively.

Pharmacy efficiency measures in place at SelectHealth include generic and formulary prescribing rates. A third measure, which changes yearly, was incorporated later in the program: in 2005, this measure evaluated antidepressant use and, in 2006, this measure evaluated statin use. Monitoring in the program is provided by pharmacy reports, which include the average cost per prescription, number of prescriptions per patient, and cost per
Conclusions

Continually rising health care expenditures and inadequate government payment increases for professional and facility services are shifting costs to employers. This, coupled with a lack of parallel improvement in care, demonstrates the need for a system in which funding can be more effectively used to ensure quality health care delivery.

P4P initiatives seek to improve the delivery of services in managed care by using evidence-based medicine to drive financial incentives. Clinical, efficiency, patient satisfaction, and IT metrics are commonly employed in these initiatives. Successfully implemented P4P programs are capable of enhancing performance on specific metrics through program design.

While P4P programs are becoming increasingly common in managed care, data on whether these initiatives improve outcomes and manage costs is still limited. Although many current programs have demonstrated short-term success, long-term outcomes are still needed to justify the cost of P4P initiatives in improving the delivery of quality health care.

REFERENCES


DISCLOSURES

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