Quality-based Purchasing in Health Care: Patterns and Perspectives from the Field

Meredith B. Rosenthal, Ph.D.
Sloan Foundation Industry Studies Annual Conference
April 26, 2007
Market Failure and the Role of Health Care Purchasing

- Market failure is central to health care industry studies
- Information problems pervasive: most agree that one consequence is too little quality
- Purchasers of health insurance (i.e., employers, who sponsor coverage for about 2/3 of the non-elderly) and health care (i.e., insurers) have become increasingly aware of the need to improve quality of care
Quality of Care

- Gaps in care persist – national data published in 2003 showed that about half of recommended outpatient care was delivered even among insured.

- Patient safety problems in the hospital abound
  - 7,000 people die every year from medication errors alone
  - 2 million suffer from hospital-acquired infections, many of which are preventable.
Quality-based Purchasing (QBP)

- Explicit efforts by employers and health plans to: improve quality of care delivered to employees/enrollees and foster quality competition
  - Quality measurement, reporting, pay for performance
  - Quality improvement projects
  - Patient-centered interventions (e.g., health coaching, disease management)
Employers’ Use of QBP Strategies

- How concerned are employers about quality?
- Efforts directed at health plans
- Efforts directed at hospitals and physicians
- Views on usefulness of alternative approaches
Study Overview

- Sample of 40 metropolitan areas with at least 100,000 HMO enrollees
- 25 largest employers in market
- All HMOs with commercial product
Employers’ Ratings of Health Plan Characteristics as Moderately/Very Important
QBP Efforts Directed at Health Plans (% using strategy, by size of employer)

<table>
<thead>
<tr>
<th></th>
<th>All employers</th>
<th>&lt;1,000</th>
<th>1,001-5,000</th>
<th>&gt;5,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used quality report cards</td>
<td>12</td>
<td>6</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Bonuses/penalties for quality</td>
<td>8</td>
<td>3</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Employees pay higher premium for low quality plan</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Required quality improvement programs</td>
<td>16</td>
<td>9</td>
<td>12</td>
<td>22</td>
</tr>
</tbody>
</table>
# QBP Efforts Directed at Providers (% using strategy, by size of employer)

<table>
<thead>
<tr>
<th></th>
<th>All employers</th>
<th>&lt;1,000</th>
<th>1,001-5,000</th>
<th>&gt;5,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examined provider performance on quality measures</td>
<td>12</td>
<td>4</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Provided report cards to employees</td>
<td>4</td>
<td>1</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Employees pay more for low quality providers</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
Percent of Employers Reporting QBP Strategies “Very Useful”

<table>
<thead>
<tr>
<th>Strategy</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using quality information in choosing health plans</td>
<td>17</td>
</tr>
<tr>
<td>Sharing health plan quality information with ‘eels</td>
<td>36</td>
</tr>
<tr>
<td>Sharing provider quality information with ‘eels</td>
<td>42</td>
</tr>
<tr>
<td>Financial incentives for ‘eels to choose higher quality plans/providers</td>
<td>36</td>
</tr>
<tr>
<td>Quality bonuses/penalties for health plans</td>
<td>28</td>
</tr>
<tr>
<td>Quality bonuses/penalties for providers</td>
<td>25</td>
</tr>
</tbody>
</table>
Health Plans’ Use of QBP Strategies

- Use of patient- and plan-level data for quality improvement
- Profiling, reporting and paying based on quality of physician services
- Use of claims data to send patient and physician reminders
Evaluation and Use of Patient- or Plan-level Quality Data

- **Analyze data**: 98.8
- **Target Measures**: 97.5
- **Demonstrate Improvement**: 93

Legend:
- Analyze data
- Target Measures
- Demonstrate Improvement
Health Plans’ Use of Data on Quality of Physician Services

- Collect data: 81.4%
- Feed back data: 72.3%
- Pay for quality: 52.1%
- Report quality to enrollees: 25.2%
Use of Patient and Physician Reminders

Any needed care
Breast cancer screening
Diabetes care
What Do We Make of All This?

- Calls for industry reform have raised the profile of QBP, but there is more talk than action
- Employers are still not keenly focused on quality (because they perceive no ROI?)
- Health plans are, however, managing quality internally and $$ rewarding physician quality although the bonuses are often small
- Public reporting of quality information is rare – despite views that this is most useful (and is the centerpiece of the administration’s policy)
What Do We Make of This? (2)

- New collaborative efforts may be supplanting individual employer/health plan efforts so there is more than appears.
- Influential purchasers (jumbo employers) may still move market.
  - The most important predictor of health plan pay for performance (i.e., incentives from plans to providers) was having at least one performance contract with an employer.
The $2 Trillion Questions

- Will any of this improve quality in the health care industry? Value?
- Given spillover effects and fragmented financing, what should be the role of individual employers and health plans?