

## Module 4: The Quality Enterprise and VBP Principles—Case Studies

Panel: John T. Berthiaume, MD; L. Allen Dobson, Jr, MD;  
George K. Heuser, MD; Peter Salgo, MD; and Jed Weissberg, MD

### COMMUNITY CARE OF NORTH CAROLINA (CCNC)

#### Background

CCNC is a statewide provider organization that has existed for about 10 years. Since its inception, CCNC has concentrated on quality. The CCNC patient roster includes approximately 1.5 million Medicaid recipients.

#### Approach

CCNC takes a population-based approach. Primary care providers belong to community organizations (provider communities or communities). The provider communities partner with hospital specialists and other providers and are accountable for improving quality and lowering costs. The initiative, which began with Medicaid, is progressing to an all-payer model.

The CCNC program offers communities incentives and staff resources for care coordination and the additional primary care resources necessary for medical homes. The program is centered on providing support, enhanced capability, and resources, and does not pay direct financial incentives.

CCNC measures statewide quality/performance on most diseases. Although not required to do so, CCNC bases its measurements on HEDIS.

HEDIS is used by more than 90% of US health plans to measure performance on vital dimensions of care and service. Managed care companies must use HEDIS to report to accrediting agencies.

#### Results

- Providers have become willing participants; the additional resources provided have lowered their operating costs.
- All HEDIS scores are in the top 10%.
- An independent report from Millman in 2011 found that over 4 years, the CCNC initiative saved nearly \$1 billion statewide, representing approximately 10% of CCNC's total program cost, and \$1000 per Medicaid recipient.

- Private payers are recognizing that the CCNC approach is translatable, and have started working with CCNC.

#### Comments From Allen Dobson, MD, President/CEO, CCNC

- “This is not socialized healthcare, it’s privatization. The providers have accountability and responsibility. We’ve established an infrastructure that gives them trusted data, uniformity of effort, and resource support to improve, and confidence that the payer (the state) is willing to partner with them sensibly.”
- “Accountability is key. Even though CCNC is not at risk, we’re accountable to the budget. Ultimately, if we don’t help the state meet its Medicaid budget goals, then the choice is cutting rates or cutting benefits for recipients who will, regardless, still live in the community. It’s the ultimate accountability in a public program.”

### KAISER PERMANENTE

#### Background

Kaiser Permanente is an IDS organized into 8 regions and aligned with a financing arm. Kaiser Permanente has a 70-year history.

#### Approach

As an IDS, Kaiser Permanente’s objective is “to align everyone around providing the best care at the best price to people and employers in the community,” said Jed Weissberg, MD (SVP Hospital, Quality, and Care Delivery Excellence).

Kaiser Permanente collects its own data, and compares them against its own standardized quality, service, and safety measures, as endorsed by Kaiser Permanente’s Board of Directors. In support of its fiduciary obligations, the Board engages third-party experts to assess the results and holds Kaiser Permanente’s management, and the delivery system overall, accountable for consistent improvement.

Over time, Kaiser Permanente has assimilated national standards into its quality measurement protocol, and all 8 Kaiser Permanente regions are now held to national standards.

#### Results

- Metrics demonstrate that quality of member care has

improved. Those metrics are backed by patient testimonials.

- Costs at Kaiser Permanente are increasing at a lower rate than the rest of the industry.

### Comments From Jed Weissberg, MD

- “Because we have a financing arm, we have a built-in efficiency: we don’t have to pass money back and forth.”
- “Introducing third-party, national standards has helped us discern not only who is best among us but who is best in the country, and how good can we actually get.”
- “Kaiser Permanente has been following this basic accountability and quality-improvement approach for a long time. We like to describe ourselves as the mother of all ACOs, and in that sense, we’re already aligned with the current reform movement. We have a great chance to avoid some of the paradigm shifting and scrambling that may befall other HCOs.”

## HAWAII MEDICAL SERVICE ASSOCIATION (HMSA)—BLUE CROSS/BLUE SHIELD OF HAWAII

### Background

HMSA is a nonprofit mutual benefit association that was founded in Hawaii in 1938. HMSA covers more than half (700,000) of the approximately 1.3 million covered lives in Hawaii.

### Approach

HMSA seeks to promote primary care, and follows the patient-centered medical home (PCMH) model. HMSA has adopted the Joint Principles of the Patient-Centered Medical Home, developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association.

HMSA has made appreciable investments in patient management and provider incentives. In 1999, HMSA initiated “Pay for Quality,” a P4P program for primary care physicians (PCPs). During the last 2 years, all lives in HMSA’s PPO and HMO plans were rolled into a single P4P program. PCPs are held accountable based on HEDIS measures.

In its 2011 quality program for commercial members, providers receive patient management fees and incentive payments based on performance, in addition to fee-for-service (FFS) payments. During 2012, the maximum quality payment has increased from \$2 per member, per month to \$4 per member, per month.

In April 2012, and to support its P4P program for PCPs, HMSA rolled out Cozeva, a web-based, system-side platform developed by Applied Research Works for presenting data

and other crucial quality information that allows doctors to track patient care for key quality measures, generate report cards to evaluate their own performance, and communicate securely with their patients and other medical professionals. HMSA provides incentives to PCPs to adopt and use Cozeva.

### Results

- Outcomes trends—data have shown that the vast majority of patients with diabetes show improvement across various measures.
- Costs trends—the rate of cost growth has slowed, freeing up more funds to expand PCMH initiatives.
- Reports from participating physicians reflect that they are more engaged and incented by the 3-pronged approach of (1) requiring adherence to HEDIS measures, (2) Cozeva’s practice management, data delivery, and performance tracking capabilities, and (3) enhanced payments for better performance. Said one PCP: “I’m a better doctor than I used to be.”

### Comments From John T. Berthiaume, MD, VP/Medical Director, Quality Management

- “We made a conscious decision to lead with quality.”
- “Our experience has demonstrated—and we’re fully convinced—that a strong and satisfied corps of PCPs is the best foundation for building a sustainable, affordable, high-quality healthcare system.”
- “Cozeva represents the wave of the future in promoting the quality enterprise. By organizing information and presenting it in easy-to-read reports, our doctors can be proactive in caring for their patients and our members will benefit from more comprehensive and coordinated care.”
- “Our goal is to have 25% of all PCP compensation derived from quality payments. We’ve frozen FFS payments. In 2014, we plan to roll out a risk-adjusted fixed fee per patient.”

## OPTIMA HEALTH

### Background

Optima Health (Optima) is a Virginia-based health insurance plan with more than 430,000 members. Optima is a subsidiary of Sentara Healthcare (Sentara), an integrated healthcare system.

Similar to most employers, the costs for providing healthcare to Sentara’s employees increased steadily during the late 1990s and into the 2000s. To restrain those increases, Optima Health rolled out Mission: Health, a new incentive-based wellness program for its benefits-eligible employees. Participation was voluntary.

## Roundtable

The program began in 2008 and is still in place. Optima published the results of the program in 2010 and again in 2012.

### Approach

Participating employees complete a personal health assessment (PHA), including blood pressure and cholesterol testing, height and weight measurements, and questions about exercise frequency and tobacco use over the prior 3 months. Using the PHA data, the health status and risk factors are determined for each employee.

Employees with 0 to 1 risk(s) receive a premium reduction (currently about \$600). Employees with 2 to 5 risks are required to receive health coaching via telephone in order to receive a similar discount. Employees with certain chronic diseases such as diabetes, coronary artery disease, or congestive heart failure become eligible for additional incentives by participating in a condition management program.

### Results

In 2010, Sentara engaged AonHewitt to independently review the program data. AonHewitt concluded that the reported results were based on an appropriate methodology and could be regarded as an unbiased assessment of outcomes. The following results were reported for the 5-year period 2007 to 2011. For the last 3 years, the results are reported for a study population of 5000 employees who participated in all 5 years of the program.

#### Costs

- 2008—Costs for employee healthcare increased 13.7% and medical claims increased 13%. Increases were attributable to the identification and treatment of previously undiagnosed or untreated (or undertreated) conditions.
- 2009—Costs decreased \$3.4 million over 2008. This included a 37% decrease in costs for employees participating in the condition management program; the decrease was attributed to more employees demonstrating healthy behaviors.
- 2008 to 2009: Costs, projected to increase by at least \$4.2 million, increased only \$1.3 million.
- 2010: Costs remained about \$1 million below the projected increase.
- 2011: The cost trend for Optima's commercial population was 5.8%. Sentara's claims costs increased by only 4.5% percent—23% lower than expected.
- 2008 to 2011: Medical costs were \$4 million lower than projected costs.

#### Clinical Outcomes

Of members continuously enrolled since inception, although that population had aged 5 years, 87% improved or maintained critical health risk measures (blood pressure,

body mass index [BMI], cholesterol, tobacco use, and level of exercise). Improvements were statistically significant for all risks except BMI.

#### Employee Satisfaction

Employees resisted when the program began in 2008. Anecdotal reports now reflect high employee satisfaction overall.

#### Comments From George Heuser, MD, VP/Senior Medical Director

- “We all know where the healthcare costs are going and it's an unsustainable upward spiral. In trying to contain our own costs, we realized that higher copays and premiums across the board wouldn't work, because 20% of our employees were generating 80% of our healthcare costs. We needed to reach down to each employee, and incent them to better manage their diseases and overall health. That's where our savings lived.”
- “These results don't factor in savings from reduced absenteeism and presenteeism. The actual financial results are likely much better than reported.”
- “This program helps bend the cost curve, and we've gotten ROI [return on investment]. But more importantly, on the clinical side, we've made measurable improvements in our employees' health.”
- “We've been touting the success of the Mission: Health program. Now other companies are taking notice and making a similar investment in their organizations and in their people.”

**Author affiliations:** Hawaii Medical Service Association, Honolulu, HI (JTB); Community Care of North Carolina, Raleigh, NC, Engelberg Center for Health Care Reform, Brookings Institution, Washington, DC, and University of North Carolina at Chapel Hill School of Medicine, NC (LAD); Optima Health, Virginia Beach, VA (GKH); Cardiothoracic Intensive Care Unit and Surgical Intensive Care Unit, Columbia University College of Physicians and Surgeons, New York, NY (PS); Kaiser Permanente, Oakland, CA (JW).

**Funding source:** This information contained in this publication was sponsored by GlaxoSmithKline (GSK). GSK reviewed the content of this publication for compliance with its own policies; GSK played no role in the selection or content of the material that appears here.

**Author disclosures:** Dr Heuser reports employment with Sentara Healthcare. Dr Weissberg reports employment with Kaiser Permanente and board membership with Archimedes and Avivia Health. Dr Weissberg has also disclosed ownership of various stocks; information on file at the office of *The American Journal of Managed Care*, Plainsboro, NJ. Dr Berthiaume, Dr Dobson, and Dr Salgo report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this supplement.

## REFERENCE

National Committee for Quality Assurance. The State of Health Care Quality 2007. [http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC\\_07.pdf](http://www.ncqa.org/Portals/0/Publications/Resource%20Library/SOHC/SOHC_07.pdf). Accessed September 19, 2012.