

# A Primer on Pay for Performance

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Including a Review of the  
Key IT Requirements and  
Challenges

January 13, 2005



# Topics

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- ◆ Pay for Performance – the Basics
  - What is It?
  - How it Works
  - Current Status
  - What to Expect
- ◆ IT Implications
  - Data Capture
  - Identifying the Patients
  - At the Point of Care
- ◆ Incorporating P4P in IT Decisions
- ◆ The Organizational Backdrop

# What is Pay for Performance?

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*Pay for performance ties payment to the quality of care delivered.*

**“...The lack of financial incentives and the presence of disincentives to improve quality allow the quality gap to persist.” (MedPAC, Modern Healthcare, June 23, 2003)**

**“Think of it as a bonus system for hospitals. Just as individuals earn bonuses for high-quality work on the job, we are going to reward hospitals that excel.” (HHS Secretary Tommy Thompson, Associated Press, July 11, 2003)**

- ◆ **Pay for performance is increasingly viewed as an important tool for transforming the U.S. healthcare system.**

# What Incentives?

*Financial incentives in pay-for-performance programs fall into three common models.*

<b><i>Bonus</i></b>	<ul style="list-style-type: none"><li>◆ Bonus payment when quality measures are met or for implementing certain safety practices such as implementing information technology.</li></ul>
<b><i>Fee Differential</i></b>	<ul style="list-style-type: none"><li>◆ Percentage increase in reimbursement when a threshold percentage of patients in the population meet quality standards or for providers who get the highest scores for performance based on rank ordering of performance.</li></ul>
<b><i>Variable Cost Savings for Patients</i></b>	<ul style="list-style-type: none"><li>◆ Cost-break incentives to choose efficient and effective care.</li></ul>

- ◆ Variation: Pay for reporting

# P4P Trends

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## Started recently...but growing up fast.

- ◆ Started in 2001 as local efforts by individual health plans and employers that were mostly focused on physician practices.
- ◆ CMS introduced a reporting initiative and a demonstration project of performance incentives for hospitals; a similar demonstration program for physician practices will start in April 2005
- ◆ CMS initially started with voluntary programs with the intention that they become mandatory.
- ◆ In the summer of 2004, 3700 hospitals began reporting performance on the 10 dimensions of care for three conditions in order to receive a 0.4 percent Medicare payment adjustment starting in 2005.

## Watch what CMS does:

- ◆ Measures adopted by CMS will likely become the de facto standard for data reporting (although financial incentives will still vary by payer).

# P4P Status

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- ◆ Many non-federal programs are confined to a single state.
- ◆ Regional and national programs are few but increasing.
- ◆ Health plans sponsor most programs, a few in collaboration with employers and other groups such as hospital associations.
- ◆ Early physician programs were focused on primary care/general medicine; now specialties are joining in the mix.
- ◆ The national programs and related demonstration projects are the ones to watch. Medicare will be the tipping point to widespread adoption. (HQA and Premier and PGP demonstrations) ([www.cms.gov](http://www.cms.gov))
- ◆ There is convergence, JCAHO and HQA have harmonized requirements for common measures.
- ◆ The Leapfrog Group recently inventoried P4P programs ([www.leapfroggroup.org](http://www.leapfroggroup.org))

# Early Hospital Programs

*A number of national pay-for-performance programs address quality measures in the acute care hospital.*

Program Name	Participants	Summary
<b>Premier Hospital Quality Incentive Demonstration</b>	<ul style="list-style-type: none"> <li>◆ Sponsored by CMS</li> <li>◆ Hospitals are members of Premier GPO</li> </ul>	<ul style="list-style-type: none"> <li>◆ 278 participating hospitals</li> <li>◆ Anticipate \$21 million in bonus payments over 3 years</li> <li>◆ Tiered program includes up to 2% bonus or 2% reduced reimbursement for highest/lowest performing hospitals in 2006</li> </ul>
<b>Hospital Quality Alliance (HQA) -or- National Voluntary Hospital Reporting Initiative (NVHRI)</b>	<ul style="list-style-type: none"> <li>◆ Sponsored by CMS</li> <li>◆ Initially voluntary for hospitals</li> </ul>	<ul style="list-style-type: none"> <li>◆ 3700 hospitals</li> <li>◆ 10 initial measures, expanding to 22 in 2005</li> <li>◆ All results will be posted</li> <li>◆ Hospitals required to report on first 10 in order to receive 0.4% Medicare payment adjustment starting in 2005.</li> <li>◆ Reporting also mandatory in Connecticut as of April 2004</li> </ul>

# Early Physician Practice Programs

*Three large-scale programs now focus on physician practice*

Program Name	Sponsors	Summary
<b>Bridges to Excellence</b>	<ul style="list-style-type: none"> <li>◆ Ford, General Electric, Humana, Proctor &amp; Gamble, UPS, Verizon</li> <li>◆ Tufts Health Plan, UnitedHealthcare,</li> </ul>	<ul style="list-style-type: none"> <li>◆ Regionally-focused physician incentive program currently rolled out in Cincinnati, Louisville, Massachusetts, and upstate New York</li> <li>◆ Focus on diabetes, cardiac care, and systematic office processes</li> <li>◆ Includes PMPM physician bonuses and public reporting</li> </ul>
<b>Integrated Healthcare Association</b>	<ul style="list-style-type: none"> <li>◆ Major California health plans: Aetna, Blue Cross of California, Blue Shield of California, Cigna, HealthNet, Pacificare</li> </ul>	<ul style="list-style-type: none"> <li>◆ Largest physician incentive program in country</li> <li>◆ Includes 50,000 doctors in 220 medical groups</li> <li>◆ Core performance measures aligned across plans; with a couple exceptions</li> <li>◆ Actual form and level of bonus payments varies by plan</li> </ul>
<b>CMS Physician Group Practice (PGP) Demonstration; (DOQIT)</b>	<ul style="list-style-type: none"> <li>◆ CMS</li> </ul>	<ul style="list-style-type: none"> <li>◆ DOQIT still in early stages of pilot and development</li> <li>◆ PGP</li> <li>◆ 10 large groups in PGP starting 4/2005; three disease conditions plus prevention</li> <li>◆ Measures built from AMA-led Physician Consortium for Performance Improvement</li> <li>◆ Combines FFS payment with bonuses for improved quality against performance targets</li> </ul>

# FCG's Position on the Future of Pay for Performance

**FCG believes pay for performance is a market reality because it is far more defensible and sustainable than efforts to tier providers and steer patients based on cost or quality.**

- ◆ The reality is that pay for performance is here to stay.
  - Pay-for-performance is the biggest change in reimbursement since DRGs
  - It's a much-needed approach for an ailing healthcare system plagued by poor outcomes.
  - Increasing adherence to best practice will lower the overall cost of care.
  - It is common sense that high-quality providers deserve higher payments.
- ◆ FCG recommends that hospitals and other health delivery organizations begin ***now*** to:
  - Ensure that the QI agenda is aligned with national P4P targets
  - Integrate P4P considerations more prominently into clinical system strategy and plans

# IT Implications



## The Basics

# Hospital P4P Targets

*Hospital-based pay for performance is focused on a small set of conditions where gaps in agreed upon care recommendations persist.*

	Premier	HQA*	JCAHO*
<b>Acute Myocardial Infarction (AMI)</b>	✓	✓	✓
<b>Coronary Artery Bypass Graft (CABG)</b>	✓		✓
<b>Heart Failure</b>	✓	✓	✓
<b>Pneumonia</b>	✓	✓	✓
<b>Pregnancy, Childbirth, and Neonatal Conditions</b>			✓
<b>Surgical Infection Prevention</b>	Hip and knee only	Starting summer 2005	✓

- ◆ These are already reflected in quality reporting programs, and many hospitals have QI initiatives in these areas.

# MD Practice P4P: Targets

*Pay-for-performance for adult physician practices focuses on a growing set of conditions where care management has proven to address gaps in recommended care.*

	Bridges	IHA	DOQIT	PGP
<b>Immunizations*</b>			✓	✓
<b>General Preventive*</b>		✓	✓	✓
<b>Diabetes*</b>	✓	✓	✓	✓
<b>High Blood Pressure/HTN*</b>			✓	✓
<b>Beta Blocker Treatment After a Heart Attack, Persistence*</b>				
<b>Asthma*</b>		✓		
<b>Cholesterol Management*</b>	✓	✓		
<b>Cardiovascular Disease/Stroke</b>	✓			
<b>CAD</b>			✓	✓
<b>Heart Failure</b>			✓	✓
<b>Depression*</b>		✓	In Dev.	

\*Many have been included in HEDIS reporting for years.

# P4P: The Data

*The ideal state, in which all needed information is captured electronically, is a long way away.*

<b>The Basic Metrics</b>	<ul style="list-style-type: none"><li>◆ Always include patient demographic and diagnosis/problem list</li><li>◆ Much of the needed info comes from H&amp;P and progress notes</li><li>◆ Vital signs are needed for some measures</li></ul>
<b>Inclusion and Exclusion Criteria</b>	<ul style="list-style-type: none"><li>◆ Inclusion criteria identify target population<ul style="list-style-type: none"><li>■ Age, diagnosis typical</li><li>■ Sometimes also health history or result of prior test/procedure or vital sign value</li></ul></li><li>◆ Exclusion criteria are reasons to exclude patient from measure<ul style="list-style-type: none"><li>■ Medication, allergy intolerance</li><li>■ Clinical contraindication</li><li>■ Patient reason (e.g., economic, religious)</li></ul></li></ul>

# P4P: Data Capture

## *IT Requirements*

<b>In General</b>	<ul style="list-style-type: none"><li>◆ Minimum data sets (needed for measurement)</li><li>◆ Structured fields (quality-metric-based choices)</li><li>◆ Ability to document patient-reported information and care documented elsewhere</li></ul>
<b>Hospital</b>	<ul style="list-style-type: none"><li>◆ Transitional tools to capture data before full electronic notes documentation</li><li>◆ Ability to combine structured and free text in electronic documentation</li><li>◆ Real-time data exception reporting</li></ul>
<b>Physician Practice</b>	<ul style="list-style-type: none"><li>◆ Patient registry</li><li>◆ EHR with registry capabilities</li></ul>

# P4P: Identifying the Patients

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## Considerations

- ◆ Targeted patients are typically identified by diagnosis, sometimes further refined by inclusion criteria (possibly one or more additional diagnoses).
- ◆ Ideally IT should facilitate providing a *consistently* up-to-date diagnosis in *real time*.
- ◆ In both the hospital and ambulatory care, the clinical team will have to pay *much* more attention to updating problem list/diagnosis as this is essential.

# P4P: Identifying the Patients

## *IT Requirements*

<b>In General</b>	<ul style="list-style-type: none"><li>◆ Lists of patients for verification and updating</li><li>◆ Ability to request documentation of inclusion criteria</li></ul>
<b>Hospital</b>	<ul style="list-style-type: none"><li>◆ Prompts to verify diagnosis</li><li>◆ Advanced form; trigger based on new information</li></ul>
<b>Physician Practice</b>	<ul style="list-style-type: none"><li>◆ Distinguish between acute, chronic, historical</li><li>◆ Easy ways to d/c active problems</li><li>◆ Distinguish active from inactive patients</li></ul>

# P4P: At the Point of Care

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## Considerations

- ◆ The ultimate goal of P4P (and quality reporting in general) is improvement, not measurement for measurement's sake. This means assisting front-line clinicians in matching patients with documentation requirements and care recommendations
- ◆ As the organization evolves to more advanced clinical applications, the potential to improve delivery of recommended care expands incrementally, at the same time as the burden of measurement decreases.
- ◆ Along that journey, each new clinical application provides additional capabilities that can be applied.
- ◆ P4P may define the first targets of clinical decision support. Acceptance requires a high "hit rate".

# P4P: At the Point-of-Care

## *IT Requirements*

<b>In General</b>	<ul style="list-style-type: none"><li>◆ Heightens importance of CDS<ul style="list-style-type: none"><li>■ Prompt documentation</li><li>■ Recommend care</li></ul></li><li>◆ Need to incorporate exclusion criteria in CDS management<ul style="list-style-type: none"><li>■ Allergy, underlying conditions, current medication therapy</li><li>■ Religious beliefs, patient refusal</li></ul></li><li>◆ CDR or data warehouse</li></ul>
<b>Hospital</b>	<ul style="list-style-type: none"><li>◆ Rules engine (or flexible application-based toolset)</li><li>◆ Ideal: Ability to prompt in advance of electronic notes and CPOE</li></ul>
<b>Physician Practice</b>	<ul style="list-style-type: none"><li>◆ Condition-specific flow sheets</li><li>◆ Prompting that can be based on specifics beyond age and sex</li></ul>

# P4P: IT Decisions

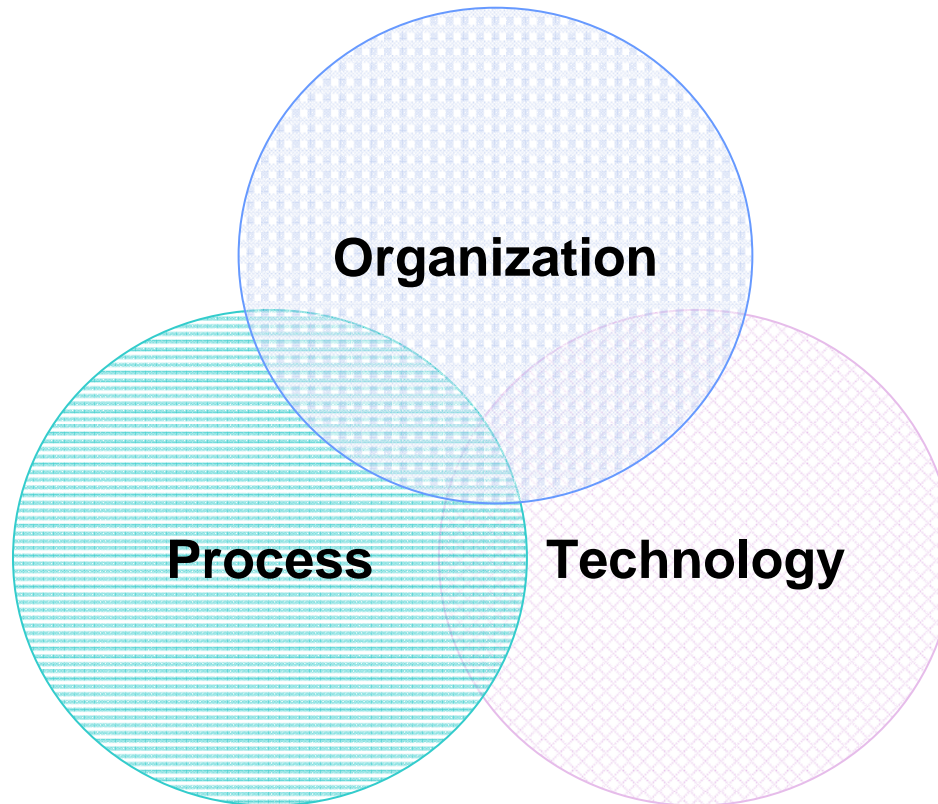
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*Ensure that P4P (and quality reporting in general) is an element of strategy and plans.*

- ◆ Include representatives of CQI and quality reporting in all decision making
- ◆ Develop a P4P/quality reporting strategy for each stage of CIS roll-out
  - Data Capture
  - Clinical Decision Support
  - Analysis and Reporting
- ◆ Consider assigning vital signs capture a high priority in application rollout

# P4P: A Final Thought

*Pay for performance drives organizations to perform well and be able to demonstrate that they perform well.*



*IT is necessary but not sufficient*