



Pay-for-Performance Landscape Assessment: “Value-based purchasing: Reimbursement & Recognition Based on Processes and Outcomes”

P. Kenyon Crowley, Graduate Research Fellow, MBA/MS Candidate 2008, Robert H. Smith School of Business

The United States is facing a number of problems with its health system, including the poor utilization of healthcare dollars, the poor management of chronic conditions, and the poor use of best practices or evidence-based medicine in the delivery of care.

→“The United States spends the most money on medical care of all advanced industrialized countries, but it performs more poorly than most on many measures of health care quality” (2004, Health Affairs)

→“Recent studies show that only a little more one-half (54.9 percent) of adult patients receive recommended care. The level of performance is similar whether it is for chronic, acute, or preventive care and across all spectrums of

Pay-for-performance (“P4P”) is viewed by many as a solution. By changing incentive systems there is the promise of a change in physician and patient behaviors leading to an improvement in outcomes, better coordination of care, greater efficiency, less costs and greater access to care. However, there are many issues to be resolved in order for P4P to proliferate, from poorly designed incentives, concerns over risk-stratification, to lack of IT systems to accurately capture data and the administrative burden of the programs. Yet, there are practical solutions to resolve impediments to adoption such as early involvement of physicians, harmonization of measures, pushing the programs from the C-Suite, and financially supporting IT system implementation and use.

The purpose of this research briefing is to describe the current P4P landscape and provide insight into the key trends and issues shaping the P4P agenda. Several leading stakeholders are profiled and recommendations for promoting P4P adoption are provided.

Background

P4P is also called “Value-based purchasing” and “Pay for quality”. The concept refers to the use of incentives to physicians, hospitals, medical groups, and other healthcare

providers for meeting certain performance measures for quality and efficiency. Pay-for-performance programs generally base a portion of physician payment on quantitative measures. These may include patient care process measures, outcomes measures, use of technology or patient satisfaction scores.

CMS defines P4P as the use of payment methods and other incentives to encourage quality improvement and patient-focused high value care. The Association of Health Insurance Plans (AHIP) has a similar general definition, but expands the concept to include consumers: “Offering physicians financial rewards, such as increased per-member-per-month payments or other non-financial rewards, including public recognition, preferential marketing, or a reduction in administrative requirements; and presenting consumers with reduced co-payments, deductibles, and/or premiums for using providers deemed to be of higher quality (based performance measures).”

P4P Stakeholders

A number of health industry stakeholders are involved in the proliferation of P4P, including: government & commercial payers; providers; hospitals; and employers. There are also organizations, typically broad coalitions, who develop measures and who endorse measures, respectively.

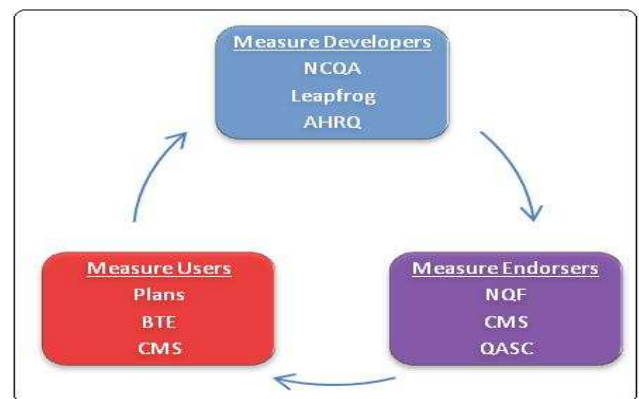


FIGURE 1. P4P MEASURES CYCLE

Payers

The payers are the lynchpin in the P4P debate, as they drive payment mechanisms and reimbursement decisions. Many of the first programs were launched by payers. The commercial payers P4P agenda includes the following principals: incentive programs should

designed to give providers the opportunity to receive rewards for achieving agreed-upon quality goals; the involvement of physicians, hospitals, and other health care professionals in the design and implementation of programs that reward quality performance is essential to their feasibility and sustainability; incentives must be sufficient enough in size to attract participation and alter provider behavior; and stakeholders should collaborate to develop standardized measures to ease the administrative burden of data collection and reporting.

All the major health plans (Blues, Aetna, WellPoint, Cigna, etc.) have pay-for-performance operational or in pilot programs. The size and structure in programs exhibits a high degree of heterogeneity, however pay mechanisms are typically a mix of bonuses, enhanced fee schedule – typically 1% - 8%, public recognition and /or premium network designation – resulting in higher patient volume.

Hospitals

Hospitals' beliefs include that incentive approaches should be developed collaboratively, involving all stakeholders; that P4P approaches must align hospital, physician and other providers' incentives, encouraging all to work together toward the same goals of improving quality and patient safety; measures should accurately recognize differences among hospitals and differences among the patients they serve and that measures should be selected to ensure that all hospitals have an opportunity to participate and succeed without bias or disadvantage. Measures with built-in biases (e.g., Medicare spending/payment measures) should not be used. Efforts should be taken to ensure that the measures used do not institutionalize existing care disparities, with appropriate representation of the increasingly diverse populations hospitals serve.

Physicians & Group Practices

Physicians' interests in P4P focus on improved quality of care, as opposed to minimizing expenses or procedures as certain payer-based programs advocate. Physicians believe they should be involved in the design of the programs and that any data used for measurement is reliable, accurate and scientifically valid. There is a concern among physicians that some programs will hamper the physician/patient relationship, such as a program that requires certain treatments may not fit with the individual needs of certain patients. Physicians believe program participation should be voluntary and that incentives should be positive rather than punitive. Another chief concern of physicians is the administrative burden of complying with P4P program requirements; many systems in use were not developed to facilitate P4P reporting so they believe P4P reimbursement should

include payments for any administrative burden for collecting and reporting data to payers. Physicians further believe that physician performance data must be fully adjusted for sample size and case-mix composition, including factors of age/sex distribution, severity of illness, number of comorbid conditions and other features of physician practice and patient population that may influence the results.

Employers

Employers are one of the largest payers of healthcare and have a vested interest in the functioning of the health system not only for cost containment, but also for the quality & quantity of work provided by employees. Private sector employers have already begun aligning their efforts through health care quality improvement coalitions such as the Leapfrog Group, Bridges to Excellence, and others, which offer standardized programs of performance measurement, reporting, and reward.

Bridges to Excellence

Founded 2002 by a coalition of large employers (Ford, General Electric, Proctor & Gamble, United Postal Service...) in association with physicians, health care services, researchers, and other industry experts to reward health care providers who demonstrate that they meet BTE care standards. BTE covers 9,642 participating physicians from 1,838 practices, receiving a total of \$10.7 million in rewards. AETNA recently announced that it will begin using BTE standards of care.

The Leapfrog Group

The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing. The Leapfrog Group's growing consortium of major companies and other large private and public healthcare purchasers provide health benefits to more than 37 million Americans in all 50 states; Leapfrog members and their employees spend tens of billions of dollars on health care annually.

Other Business Interest Groups

Groups such as the National Business Group on Health (NBGH) and the National Business Coalition of Health (NBCH) advocate for employer interests related to improved health policy. The NBGH, is a member organization of over 270 primarily large employers who provide coverage for 55 million Americans and The NBCH, is a national non-profit association of nearly 80 business and health coalitions with a network of 7,000 employers and 30 million covered lives. Both groups are strong advocates for P4P and urge Congress, Employers, and Health plans to implement pay-for-performance on a widespread basis for hospitals, physicians, and other health care facilities and professionals.

Measure Developers

Measure developers work to build scientifically valid, evidence-based guidelines for implementation in P4P programs. There are several organizations working under this title, including NCQA, Leapfrog, JCAHO, as well as medical boards, principally the American Medical Association Physician Consortium.

National Committee for Quality Assurance (NCQA)

NCQA's principal P4P activity is the development and maintenance of the Health Employer Data Information Set (HEDIS). HEDIS is a performance measurement tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.

American Medical Association Physician Consortium (Consortium)

The Consortium is comprised of over 100 national medical specialty and state medical societies; the Council of Medical Specialty Societies; American Board of Medical Specialties and its member-boards; experts in methodology and data collection; the Agency for Healthcare Research and Quality; and Centers for Medicare & Medicaid Services.

Measure Endorsers

Measure endorsers are typically broad-based coalitions with a specific mission to scientifically vet the measures that are developed by the other organizations. The principal endorser is the National Quality Forum (NQF); other endorsers include the Ambulatory Quality Alliance (AQA), as well as CMS.

National Quality Forum (NQF)

NQF is one of the principal endorsers of P4P measures. The NQF is a voluntary consensus standards-setting organization as defined by the National Technology Transfer and Advancement Act of 1995 and Office of Management and Budget (OMB) Circular A-119. As such, the NQF has a formal process by which it achieves consensus on standards that it endorses. NQF has broad participation from all parts of the health care system. Through 2006 NQF has endorsed more than 300 measures, indicators, events, practices, and other products to help assess quality across the healthcare continuum.

Ambulatory Quality Alliance (AQA)

Formed in 2004, AQA is a broad based national coalition of more than 125 organizations (AAFP, ACP, AHRQ...) that joined together to lead an effort for determining how to most effectively and efficiently improve performance measurement, data aggregation, and reporting in the ambulatory care setting.

Centers for Medicare and Medicaid Services (CMS)

CMS is the largest single payer of healthcare services has a major impact on industry trends. CMS is an

endorser and user of P4P measures. CMS has two major hospital P4P programs under way, the CMS Hospital Quality Initiative and the Premier Hospital Quality Demonstration Project, as well as several smaller programs. Many experts believe system change must be driven in large part by CMS.

With system-wide adoption of P4P programs similar to that used in the Premier demonstration, Hospitals would have nearly 70,000 fewer deaths annually and reduce hospital costs by \$4.5B annually (2008, Hospitals & Health Networks)

Other stakeholders of note**Integrated Healthcare Association (IHA)**

IHA is the largest pay for performance program in the US, representing 228 medical groups and 40,000 physicians and providing care for 12 million HMO members. IHA uses a quality scorecard that covers three broad categories: clinical quality, 50% of total score; patient satisfaction, 30% of total score; information technology investment, 20% of total score. IHA paid bonuses of \$65M in 2007 to CA hospitals, a \$10M increase over previous year.

Key Trends**Commonalities in Stakeholder Agenda "Top 5"**

1. Focus on quality first;
2. The collection of such data should not be overly time-consuming, resource-intensive, expensive, duplicative or otherwise burdensome so as to discourage provider participation;
3. Evidence-based, scientifically rigorous measures should be used;
4. Measures should be taken in program design to avoid patient discrimination and properly risk stratify;
5. Broad-based coalitions should be used.

Examination of current programs reveals four key trends: (1) Health plan activities are heterogeneous, as in an exploratory phase to find best ways to reward quality; (2) CMS, the largest single payer, has embraced the concept of P4P and is experimenting with different ways to reward quality; (3) Employers have taken a prominent role; and (4) Collaboration among different stakeholders is widespread.

Other noteworthy trends include the following. While the predominant emphasis on pay-for-performance has been primary care providers, specialists are increasingly being targeted for programs. Payers have increased both the size of financial incentives and the amount of measures.

Principal Issues

The development of P4P programs and widespread adoption is hampered by several issues. There is a lack of consensus about the scope of these programs. There are concerns about programs inability to properly risk-stratify patients or account for treatment non-compliance. Some plans it is argued neglect the complexity of patient care, especially for elderly patients and those with many chronic conditions. Hence, physicians may be unfairly penalized. There is wide margin of heterogeneity in the programs. Early and subsequent adopters of P4P have developed their own structures and methodologies, creating a confusing, potentially dizzying array of programs and dealing with that program variation and the individual reporting requirements is proving burdensome to many practices, especially in primary care.

Some programs not necessarily focused on improving care quality, but rather on increasing efficiency, decreasing services utilization, and boosting profit margins through lower costs. For example, some programs include target measures for inpatient stays or advanced-imaging studies ordered, or for the use of generic drugs. Compounding issues is the fact that current clinical information systems are not designed to collect clinical quality indicators, do a poor job of collection, and consequently will need significant upgrading and enhancements. Also working against progress is the slow march toward universal adoption of electronic health records.

There may be several possible unintended consequences of some pay-for-performance programs, such as an incentive to drop difficult patients whose outcome measures do not meet the quality standards or who cannot comply with treatment plans, or to not accept new patients who clearly will not meet existing measures. The American College of Physicians Ethics has expressed concern that Pay-for-performance initiatives that provide incentives for good performance on a few specific elements of a single disease or condition may lead to neglect of other, potentially more important elements of care for that condition or a comorbid condition. For example, an elderly patient with multiple chronic conditions is especially vulnerable to this unwanted effect of powerful incentives.

Recommendations

(1) CMS should continue to be a leader, and continue funding of its programs; (2) For employers, Value Based Purchasing must be led by the C-Suite, not only HR; (3) Promoting provider involvement is critical as a way to reduce opposition to programs; (4) There is a need to use only a single or few nationally accredited measures such as those provided by the NQF, in order to overcome conflicting and confusing overlapping programs, and to

permit better coordination with other programs. (5) Programs must provide adequate incentives to make program participation worthwhile; (6) The Case for ROI of P4P must continue to be developed, with appropriate alignment of benefits to investment

Conclusion

The US Health care system is in need of many fundamental changes, not least of which being a method to appropriately reward care. P4P programs are demonstrating that appropriately structured reward systems are yielding improved outcomes. However, several issues from variability in programs, lack of standardization, and complexity in risk stratification create an unsure path forward. Through leadership from CMS, employer groups, payers and other broad-based coalitions combined with measurement harmonization and appropriately rewarding measures in addition to supporting the use of IT systems to ease reporting requirements, we can achieve a more effective health system, where the high quality of services, use of evidence-based medicine, efficient processes, capable coordination of care and management of chronic conditions are the standard, resulting in real benefits to real people and society as a whole.

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Please contact the Center for the complete working paper.

CHIDS Contact Information

Director – Dr. Ritu Agarwal, Professor and Robert H. Smith Dean's Chair of Information Systems

Center for Health Information and Decision Systems

Robert H. Smith School of Business, University of Maryland
College Park, Maryland 20742
Ph: 301.405.0702
chids@rhsmith.umd.edu
www.rhsmith.umd.edu/chids

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