

Pay for Performance – What's it All About?

Richard Jacoby, M.D.
Clinical Associate Professor
Department of Health Policy
Thomas Jefferson University

Pay for Performance (P4P)

- What It Is
- Why it Evolved
- How It Works
- Barriers to Adoption
- Its Future

Agency for Healthcare Research and Quality (AHRQ) definition

“Payment or reputational strategies aimed at providers that individual employers, employer coalitions, or government programs could plausibly adopt to stimulate the improvement of quality in healthcare.”

Pay for Performance -What it is

In practice, P4P describes a system of reimbursement whereby insurance payments for medical services (currently structured as bonuses or fee schedule upgrades) are awarded based on success in achieving certain quality measures.

Pay for Performance -What it is

Right now, P4P incentives are small (typically less than 5% of reimbursements from a particular payer), but they likely will grow.

It is possible that, if P4P evolves, a sizable proportion of providers' revenues might be tied to performance, virtually replacing our current "service-based" system with a performance-based one.

The goal of payers who use P4P is to lead to a more balanced focus on "value" for healthcare dollars spent, where "value" is defined as the relationship between quality and cost.

Pay for Performance -What it is

Who is paying? (~150 programs nationwide)

- Insurers
- Employers-Leapfrog group
- Medicare

Medical Group Demonstration Project

Physicians Quality Reporting Initiative (PQRI)

Performance

What is meant by performance?

Quality-Definition

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and the degree to which they are consistent with current professional knowledge.

Institute of Medicine
Crossing the Quality Chasm 2001

Quality

In practice, for the most common type of quality measures, clinical quality scores refer to the percentage of times elements of evidence based medicine (quality measures developed through a consensus approach) are delivered.

Quality Measures

Avedis Donabedian M.D., considered the “Father of Quality”, in 1966 described 3 elements of quality that have come to be known as the “Quality Triad”.

1. Structure
2. Process
3. Outcome

Quality Measures

1. Structure

Personnel-physicians, secretaries, nurses

*Facilities –Hospital, office space
adequate*

*Equipment –instruments, computers,
electronic medical records, etc.*

2. Process

3. Outcome

Quality Measures

1. Structure

2. **Process**

*Refers to the care you delivered
e.g. Were GERD symptoms assessed in
patients receiving ongoing medication
for GERD*

3. Outcome

Quality Measures

1. Structure
2. Process
3. **Outcome**

Refers to the results of the care delivered

e.g. Was the result of the Hemoglobin A1c lab test ordered in a diabetic patient in the last 6 months less than 9%

Quality Measures

In the world of P4P, the measures utilized are predominantly Process measures.

Pay for Performance Why It Evolved

- Concerns about quality
- Concerns about cost
- Concerns about safety

Quality Concerns-Adults

Recommended care that adhered to widely agreed upon evidence-based guidelines was delivered just 54.9% of the time.

Rand Corp. report

McGlynn EA, Asch SM, Adams J, Keeseey J, Hicks J, DeCristofaro A, and Kerr EA, "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine*, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645

Cost Concerns

- National health care costs rising at twice the rate of general inflation.
 - Health care consuming more and more of national gross domestic product (GDP):
 - 1990s = 13.5% of GDP
 - 2002 = 14% of GDP (\$1.6 trillion)
 - 2006 = 16% of GDP (\$2.1 trillion)
 - 2016 = 20% of GDP (\$4.0 trillion)*
- *Projected by CMS economists as reported in the *Washington Post*, 2/21/07.
- U.S. health system spends a higher portion of its gross domestic product than any other country but ranks 37 out of 191 countries (WHO 2000)

Safety Concerns

- 2006 Institute of Medicine
Documented adverse drug events: At least 1.5 million Americans injured each year by errors in prescribing, dispensing and taking medications
- 2000 Institute of Medicine Report “To Err Is Human”: 98,000 deaths annually due to medical errors

Pay for Performance- Does it make sense?

“Healthcare has lagged far behind other industries in using data to evaluate the performance of its primary business, namely delivering health care services to customers.”*

*Winkler, R. “What the PCP Should Know about National Quality Initiatives-For the Hospital and Office.” *Primary Care Reports* 12;8:August, 2006,85-92.

Pay for Performance- Does it make sense?

- “You can’t manage what you don’t measure.”
- The premise of P4P is that higher quality health care will cost less in the long run.

Pay for Performance - How it works

- Decide on measures to track
- Develop system for payers/providers to report on measures (administrative data/CPT 2 codes)
- Analyse data
- Report on provider performance against "Benchmarks of Performance."
- Providers develop and implement "Continuous Quality Improvement" initiatives to increase performance on measures of clinical quality

Medicare Physicians Quality Reporting Initiative (PQRI)

- Started in 2006 as Physicians Voluntary Reporting Program (PVRP) -36 measures
- 2008 – 119 measures including 2 structural measures (electronic health records and electronic prescribing)-
- 10 PQRI measures specifically refer to Gastroenterology

PQRI

PQRI, which is a voluntary program, is not a P4P program at this time, though it likely is a precursor of that.

- Bonus potential
 - 2007-1.5%
 - 2008-1.5%
 - 2009-4% (2% +2% e-prescribing)

P4P- Barriers to Adoption

- Educating and training providers
- Systems to capture and record quality data
- Costs of reporting exceed bonuses?
- No standardization of programs
- Attribution of patients

Pay for Performance Its Future

- Success of large, well designed P4P programs in increasing Quality scores suggests trend will continue
- Favor outcome over process measures
- Widespread public reporting of results
- Appropriateness of care criteria
- Disincentives –not paying for negative outcomes (medical errors)-already here

Pay for Performance Its Future

Question

- What is the focus of the Physician Quality Reporting Initiative (PQRI)?

Answer

- The Physician Quality Reporting Initiative (PQRI) is a first step toward linking Medicare health professionals' payments to quality, which is consistent with Medicare's ongoing transformation from passive payer to active purchaser of high-value health care.

Reference: <http://www.cms.hhs.gov/pqri>

QUESTIONS?

American Gastroenterological Assoc.
2008 PQRI Open Door Forum

Date/Location (conference call)
September 23 2008 — 2-3:30 pm

<http://www.gastro.org/wmspage.cfm?parm1=5725>