Pay-for-Performance Initiatives

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ABSTRACT

BACKGROUND: Improving the quality of care provided to beneficiaries while reining in costs, is a key goal for Medicare programs. The emerging pay-for-performance (P4P) movement is a reimbursement strategy that provides incentives to improve the overall quality care provided to patients, which can lead to improved clinical outcomes and reduced health care utilization and costs.

OBJECTIVE: To review current P4P initiatives from Medicare as well as the results of select national P4P programs.

SUMMARY: P4P strategies are an attempt to link financial incentives to improve efficiency and quality of care, improve clinical outcomes, and provide disincentives for providing care that does not achieve adequate outcomes. The Centers for Medicare & Medicaid Services (CMS) has developed numerous P4P initiatives to support improvements in the care of Medicare beneficiaries. CMS-sponsored initiatives include hospital demonstration projects that focus on a set of 10 quality measures and link reporting of those measures to payments that hospitals receive. In addition, there are demonstration projects aimed at physician group practices and the use of health information technology (IT). Another aspect of P4P is the movement toward nonpayment for nonperformance, which is intended to provide a negative incentive toward preventable complications resulting from medical errors or improper care.

CONCLUSION: P4P programs represent an attempt to harness the potential of health care payment structures to motivate quality-enhancing and cost-saving changes in the behavior of physicians, pharmacists, and other health care professionals, as well as in the health care systems where they practice.

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Introduction

Like any large health care provider, The Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring that its beneficiaries receive high-quality care. As a result, Medicare has advanced the development and use of quality measures, as well as the standardization of appropriate care guidelines. CMS has developed regulatory standards so that providers are required to have quality improvement systems in place.

In addition to ensuring high-quality care for beneficiaries, CMS is charged with reining in health care costs so that its programs can provide the best care to all eligible beneficiaries. In reality, there continues to be financial disincentives to improving quality of care, which was the basis of traditional Medicare coverage resulting from the fee-for-service payment system. Traditionally, CMS has paid all health care providers without discriminating based on quality of care. As a result, there has been little incentive for providers to improve the quality of care. This has caused an inefficient use of Medicare resources, which perpetuates substandard care for some beneficiaries and does not reward providers who do offer high-quality care. In fact, such an arrangement may even reward poor-quality care by providing additional payments to cover further treatments when patients’ initial therapies fail to resolve their problem.

It is in this context that the movement toward P4P programs has emerged. P4P is a reimbursement strategy that links payment to the quality of care provided by clinicians, offering financial incentives for improvements in care, as well as disincentives for care that does not achieve adequate outcomes. An effective P4P program rewards providers for meeting or exceeding care benchmarks and uses these financial incentives to push for increased efficiency in the delivery of health care services to beneficiaries.

Medicare Pay-for-Performance Initiatives

CMS is developing a set of P4P initiatives to support quality improvement in the care of Medicare beneficiaries. These initiatives include programs for hospitals, physicians, and physician groups. In addition, CMS is exploring potential performance-related programs for nursing home care, as well as for home health care providers. These CMS demonstration projects are intended to assess whether the use of financial incentives can improve the quality of care provided to Medicare beneficiaries.

Hospital Demonstrations

The Hospital Quality Initiative is part of the broader National Quality Initiative that focuses on a set of 10 quality measures and links reporting of those measures to payments that hospitals receive. Nearly all the eligible hospitals are complying with the requirements of this provision. The Premier Hospital Quality Incentive Demonstration provides financial incentives for high-quality care and is aimed at improving the quality of inpatient care for Medicare beneficiaries. CMS is collecting data on 34 specific
clinical measures that relate to 5 clinical conditions, including acute myocardial infarction, coronary artery bypass graft, heart failure, community-acquired pneumonia, and hip and knee replacement. For hospitals that score in the top 10%, this demonstration program will provide a 2% bonus payment on top of the standard diagnostic related group (DRG) payment for relevant discharges.

Physician and Group Practice Demonstrations
The first P4P initiative for physicians under the Medicare program, the Physician Group Practice Demonstration (BIPA 2000) rewarded physicians for improving the quality and efficiency of health care services for Medicare fee-for-service beneficiaries. It involved 10 large group practices (>200 physicians), which earned performance-based payments as a reward for achieved savings compared with a control group.2

The Medicare Care Management Performance Demonstration (Medicare Modernization Act [MMA] section 649) is a 3-year P4P demonstration that will promote the use of health IT to improve the care of chronically ill patients. Bonuses will be paid to doctors who “meet or exceed performance standards … in clinical delivery systems and patient outcomes,” as defined by CMS.2 This program is focused on small- and medium-sized practices in Arkansas, California, Massachusetts, and Utah. A second 5-year demonstration mandated by MMA section 646 (the Medicare Health Quality Demonstration) will examine projects that enhance patient safety and reduce variations in utilization through the use of evidence-based care and best practice guidelines. It will include physician groups and local or regional integrated health systems.2

Disease Management Demonstrations
CMS has also implemented a number of demonstrations to look at the management of patients with chronic complex disease states, such as congestive heart failure, diabetes, end-stage renal disease, or coronary artery disease. The Chronic Care Improvement Program (MMA section 721) is a pilot program to evaluate disease management programs aimed at particular patient populations (i.e., those with congestive heart failure and/or complex diabetes) and will include companies specializing in disease management, as well as larger organizations such as insurance companies. Participating organizations are required to guarantee CMS a savings of at least 5% plus the cost of monthly fees compared with a similar population of beneficiaries. Additional disease management demonstrations include programs aimed at patients with end-stage renal disease, those with severe chronic illnesses, and chronically ill dual beneficiaries.2

Results from National Pay-for-Performance Projects
A number of provider groups across the United States have been reporting results from their P4P initiatives. These results represent the broad applicability of P4P programs as a means of improving the quality of care that beneficiaries receive.

Now in several markets around the United States, Bridges to Excellence (BTE) is the largest employer-sponsored P4P initiative that rewards physicians for meeting specific quality benchmarks. Through its P4P program, BTE has found that physicians who are rewarded for providing high-quality care are able to deliver that care at costs that are 15% to 20% lower than physicians who do not participate in such programs. BTE notes that while financial incentives can influence physician practices, it is necessary for the reward to be large enough to have an effect.3

The Integrated Healthcare Association (IHA) is a California-based coalition of health plans, physicians, health care systems, purchasers, and consumers that has issued a public scorecard that compares the performance of physician groups. These efforts have led to across-the-board improvements in every quality measure they use. In some plans, this has resulted in a 40% increase in patient visits and reduced hospitalizations, with particular improvements among patients with diabetes.3 As with many such initiatives, the innovative use of technology has proven to be a key to the program’s success, demonstrating a direct correlation between the use of tracking technology and improvements in care quality. In fact, physician groups who adopted IT to track outcomes had average clinical scores that were 9 percentage points higher than physician groups that did not (60% vs. 69%).4

<table>
<thead>
<tr>
<th>Condition</th>
<th>No. of Medicare Cases in Fiscal Year 2006</th>
<th>Average Medicare Payment for Admission in Which Condition Was Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Object left in patient during surgery</td>
<td>764</td>
<td>$61,962</td>
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<tr>
<td>Air embolism</td>
<td>45</td>
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<td>Blood incompatibility</td>
<td>33</td>
<td>$46,492</td>
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<tr>
<td>Catheter-associated urinary tract infection</td>
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<tr>
<td>Pressure ulcer</td>
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<tr>
<td>Vascular catheter-associated infectionb</td>
<td>Unknown</td>
<td>Unknown</td>
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<tr>
<td>Mediastinitis after coronary artery bypass grafting</td>
<td>108</td>
<td>$304,747</td>
</tr>
<tr>
<td>Fall from bed</td>
<td>2,591</td>
<td>$24,962</td>
</tr>
</tbody>
</table>

a Data taken from the Federal Register.  
b Data unknown due to a unique code for this condition, which was introduced for fiscal year 2008.  
Nonpayment for Nonperformance

The other side of P4P as an incentive for improvements in quality of care is the movement toward nonpayment for nonperformance. Intended as an antidote to the counterproductive incentives built into health care reimbursement, nonpayment for nonperformance provides a negative incentive against preventable complications that sometimes result from medical errors or improper care.5

As a result of evaluating conditions that are high cost and/or high volume and which have until now resulted in a higher payment as a secondary diagnosis, CMS has identified 8 conditions for which Medicare will no longer pay if they are acquired during an inpatient stay (Table).5

Although the change in payment for these preventable secondary conditions will not result in large amounts of money being withheld from hospitals, the new rule is expected to have a disproportionate effect on hospital behavior, since it is viewed as an indication of things to come as CMS continues to reform provider payment toward an increasingly P4P model.5

An important precursor of other P4P programs, the Asheville Project, was a longitudinal cohort study designed to evaluate the maintenance of outcomes for up to 5 years following the initiation of community-based pharmaceutical care services (PCS) for patients with diabetes. It included an examination of how long-term PCS impacts direct medical costs.6

The study included patients with diabetes who were covered by 1 of 2 employer-funded health care plans. Patients were offered a health care benefit that consisted of consultation with a community-based pharmacist with whom they could meet (at no cost). Pharmacists provided diabetes education, helped establish and track treatment goals, and offered training for in-home blood glucose monitoring, as well as information about adherence.6 They also evaluated patients’ feet, skin, blood pressure, and weight. In addition, an important component of the intervention included the pharmacist’s referral of patients to their physicians or a diabetes education center as needed. Patients were provided with a free home blood glucose monitor and had their copayments for diabetes-specific drugs and supplies waived.6

The investigators evaluated the economic outcomes of the PCS project by monitoring the change in direct medical costs during the study. According to analyses of insurance and prescription claims, the mean total amount paid for all diagnoses decreased with each year of follow-up (Figure). This was accounted for by shifting costs from insurance claims for emergency department, inpatient, and physician visits to prescription claims.6 In fact, mean insurance claim costs decreased by $2,704 per patient per year (PPPY) in the first year and by $6,502 PPPY in the fifth year. Mean prescription costs increased during the same period by $656 in the first year and by $2,188 PPPY in the fifth.6 Overall, the payers saw decreases in total direct medical costs that ranged from $1,622 to $3,356 PPPY.

This demonstration project found that patients with diabetes who received PCS in community pharmacies achieved and maintained clinically significant improvements in hemoglobin A1cs over the length of the study. At the same time, third-party payers benefited from decreases in average total direct medical costs for each year of the study. Based on these results, employers who sponsored the program have adopted it as part of their health plan benefit.
Conclusions

To ensure that its beneficiaries receive high-quality care, CMS has advanced the development and use of quality measures and appropriate care guidelines. In addition to ensuring high-quality care for beneficiaries, Medicare is charged with controlling health care costs so that its programs can provide the necessary care to all eligible beneficiaries. Traditionally, Medicare has reimbursed its health care providers without discriminating based on quality of care. As a result, there has been little incentive for providers to improve the quality of care. This has caused an inefficient use of Medicare resources, which perpetuates substandard care for some beneficiaries and does not reward providers who do offer high quality care.

P4P is a reimbursement strategy that links payment to the quality of care provided by clinicians, offering financial incentives for improvements in care, as well as disincentives for care that does not achieve adequate outcomes. An effective P4P program rewards providers for meeting or exceeding care benchmarks and uses these financial incentives to push for increased efficiency in the delivery of health care services to beneficiaries.

Based on the success of other performance-based programs (e.g., BTE, the IHA, and the Asheville Project), CMS is currently developing a set of P4P initiatives to assess whether the use of financial incentives can improve the quality of care provided to Medicare beneficiaries. These initiatives include programs for hospitals, physicians, and physician groups. CMS is also exploring potential performance-related programs for nursing home care, as well as for home health care providers.

On the other side of P4P is the movement known as nonpayment for nonperformance. This movement serves as an antidote to the counterproductive incentives built into health care reimbursement by providing a negative incentive against preventable complications resulting from medical errors or improper care. In fact, CMS has now identified 8 conditions for which Medicare will no longer pay if they are acquired during an inpatient stay.

P4P programs represent an attempt to harness the potential of health care payment structures to motivate quality-enhancing and cost-saving changes in the behavior of physicians, pharmacists, and other health care professionals, as well as in the health care systems where they practice. As such, they rely on the gathering and analysis of quantifiable quality and cost data. The need for data that can lead to objective assessments of P4P initiatives points to the important role that electronic health records may play in furthering the quality and cost-effectiveness of health care services.

REFERENCES


