

PAY-FOR-PERFORMANCE: The Future of Incentivized Care

By Ross Swanson and Karen Hartman

What is Pay-for-Performance?

Called “the provider payment methodology of the future,” Pay-for-Performance (also referred to as P4P) has become the latest “catch-phrase” for both healthcare administrators and clinical providers. The global strategy of all P4P methods is to raise the quality of healthcare, which in turn, should control costs while maximizing reimbursement. In today’s fee-for-service payment methodology, healthcare institutions and providers are reimbursed according to the level of service provided, which has been shown to decrease the length-of-stay (LOS) for inpatient episodes due to the case rates that are assigned by the Centers for Medicare & Medicaid (CMS) to the Diagnostic-Related-Groups (DRGs). Outpatient procedural costs have also changed with Ambulatory Payment Classifications (APCs), in an attempt to correct reimbursements based on actual procedural expenses.

Even with positive findings in the existing fee-for-service methodology, overall health expenditures have continued to increase, which is directly related to the demand for better technology and experienced personnel. There is also very little data that the increased expenditures related to medical technology advancement have positively impacted the quality of care being delivered.

In a P4P model, reimbursements for clinical services will be adjusted according to the quality of care that has been rendered. Currently, P4P programs offer incentives to physicians and hospitals to practice evidence-based standards, linking reimbursement bonuses to performance on a variety of measures. Most health plan administrators feel that these financial incentives should be non-punitive and reward only for positive outcomes. The total financial incentive is usually less than 5% of the total reimbursement¹. The healthcare community is in the infancy stages of moving to a unified (or standard) P4P model. Many private health insurers have created a “patchwork” approach that applies reimbursement levels that are directly linked to outcomes in clinical quality. Managed care providers are far ahead of CMS when it comes to the utilization of Pay-for-Performance incentives².

There are over 100 different P4P models or demonstration projects used among the private insurers attempting to utilize a performance system in the United States today,³ Pay-for-Performance initiatives are not quite ready for standard implementation. First, P4P incentives must draw from a standard set of measures so that providers are not competing for revenue from the same source(s) using different metrics.

Second, healthcare providers must develop an infrastructure that will allow the rapid and accurate capture of data so that reporting to regulatory bodies and payers is seamless.

Third, financial incentives that are based on clinical outcomes could have implications for patient access, as those patients likely to produce the best outcomes could be selected for care while others are denied access entirely. As providers (both hospital and physicians) search for increased quality and financial opportunities, those navigating the healthcare system will need to become very familiar with the strategies employed in Pay-for-Performance models.

Defining Pay-for-Performance Metrics

Currently, there are performance measures (or metrics) in healthcare that have become widely-adopted, though they are not standardized across all organizations. Hospital administrators and clinicians may recall several practice changes that were adopted in 2002. These changes were necessary to remain compliant with the newly-formed Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Oryx initiative, more commonly referred to as the JCAHO Core Measures. The Oryx performance measures mirror many of the indicators that are being used today to determine quality performance of P4P programs.

Standardization of one set of performance measures is viewed as an essential next step in advancing P4P philosophies. In December, the Institute of Medicine (IOM) released a 300-page report that called for the adoption of a universal set of performance measures. Many believe that the healthcare industry across the board must be using the same tools and procedures, including a universal set of performance measures, in order for pay-for-performance to gain broad success⁴. There is a valid argument that having different performance metrics across institutions or health plans will increase costs.

The IOM has suggested the collection of 22 measures in acute coronary syndrome, heart failure, pneumonia, smoking cessation, and surgical infection prevention. It is not surprising that these recommended areas of measurement are similar to the metric categories that have been established for the JCAHO Core Measure initiative. Any standardized measures would need to be validated before CMS and the medical and insurance communities can formally adopt them.

There have been concerns raised that a standard set of performance metrics for the majority of hospital services would inundate

the National Quality Forum with requests to validate performance measures for each of the clinical specialties⁵.

With Corazon niched in cardiovascular services, our firm has worked with many clients in the evaluation of performance improvement initiatives related to acute coronary syndrome and heart failure. Corazon believes that if the IOM’s recommendations for performance measurement are adopted, then hospitals demonstrating compliance with the JCAHO Core Measures will have less difficulty demonstrating quality results in any future P4P program. Even with the most meticulous data collection methodologies in place, findings from several demonstration projects convey that P4P is complicated to implement. The foundation for effective P4P models is to ensure that standard measurements are used that are easily retrieved from data sources thus allowing providers to be following a constant direction.

Information Technology Investment - Accurate and Efficient Data Capture

Providers must plan on participating in P4P especially given the increased popularity of this concept. Therefore, hospitals and physicians must be implementing clinical outcomes tracking systems now. Providers should be able to access their data using “just-in-time” reporting mechanisms so that decision making is streamlined in lieu of potential negative outcomes. How do hospitals accomplish this monumental task of instantaneous data (or metric) reporting? Simple – by having a well-developed Information Technology (IT) infrastructure that interfaces with clinical systems, as well as an electronic medical record. Hospitals with functional service lines in place will find that IT integration is a necessity for outcomes tracking. In fact, the movement to a service line (or product line) structure forces many institutions to generate service line Quality Dashboard reports that continuously aggregate data. In Corazon’s experience, hospitals and physician practices that do not have a structured Dashboard reporting system usually have difficulty reporting both operational and clinical outcomes.

The United States government has placed a goal on the healthcare system to develop and utilize an integrated electronic medical network for patients. Many hospitals have been slow in the movement to an Electronic Medical Record (EMR) due to the associated costs inherent to purchasing and implementing this new technology. Other hospitals have implemented EMRs with many staff members, particularly physicians, reluctant to use the new systems. Several of the P4P demonstration projects have shown that the

additional financial incentives have prompted physicians and physician groups to embrace information technology and electronic medical records at a faster pace⁵. The message is simple – accurate and comprehensive data must be collected for the providers to be eligible for additional bonus payments. Only with an integrated use of electronic records can physicians and hospitals guarantee that their data is present for reporting.

P4P Potential to Limit Patient Access

The success of Pay-for-Performance initiatives is clearly dependent upon a provider's ability to deliver quality care with positive patient outcomes. A successful P4P model can bolster better patient care, as well as increase revenue for both hospitals and physicians. It is evident that clinical outcomes are not always directly related to the skill and training of the front-line clinicians. Quality patient care comes with a price, though the necessary capital to deliver quality may not be available at all facilities. Therefore, quality at hospitals that typically care for the poor or underinsured may be far behind that of institutions with greater resources because they care for a population with a better payor mix.

Adequate space, functional equipment, modern technology and supplies, standardized processes, and skilled personnel are the key ingredients for the delivery of quality healthcare. People typically associate quality care with the proficiency of the providers; however, poor performance can be just as much a reflection of a poorly-designed hospital space and inefficient patient flow processes. Redesigning or optimizing physical space or operating processes require a significant capital investment that a facility with a poor historic payor mix may not be able to meet upfront. Second, the IT infrastructure that is necessary to aggregate and evaluate outcomes data [as has been previously discussed] may not be possible for hospitals in less affluent markets. Taking both of these factors into account reveals that providers may opt to care for patients, or practice in an environment that has already demonstrated positive outcomes.

In the current P4P models, there is no adjustment in any financial bonus incentives received to adjust for socioeconomic status of the target patient population⁶. Socioeconomic status of the market is probably the most visible indicator of patient access to care. All hospitals are NOT equal. Hesitancy exists to widely adopt P4P because a hospital's demographic attributes may determine where bonus incentives are allocated.

As increasing numbers of P4P models are implemented in programs across the country, payors will have to scrutinize financial incentives in order to ensure that bonuses are fair and equitable across specialties. For instance, it has been argued that greater numbers of incentives offered to physician specialists could make P4P more expensive for the payors. Furthermore, in some service lines, access to care may become limited as proposed physician payment cuts incentivize physicians to drop out of the Medicare system. In cardiovascular services, this is unlikely due to the large number of Medicare beneficiaries with CV disease.

Clinicians could further limit access to care as patients are "cherry-picked" for those that will produce the best outcomes. Those patients with the greatest co-morbid conditions could be denied treatment in lieu of a reimbursement system that provides incentives based solely on positive clinical outcomes. This only adds to the fear that the best performing hospitals/providers will be able to maintain and grow key service lines while other organizations may have to eliminate those services entirely.

Transparency of Outcomes Data – Program Tracking

An attempt to know a hospital's clinical outcomes has never been simpler with patient and physician consumer's ability to access almost any hospital's clinical performance through internet. Public accessible websites, such as HealthGrades[®] and the Department of Health and Human Service's "Hospital Compare," offer a first hand look at the ease with which hospital data can be obtained. This public disclosure of data has permitted all potential customers (and competitors) to view a hospital's outcomes against key performance metrics.

The US healthcare market has clearly entered an age of information and data transparency, which has caused a paradigm shift in the way data is collected and reported. Hospital quality rankings used to be derived solely from financial records because patient billing statistics were easily accessible. But, over the last several years, quality measures have been directly extracted from clinical data. Much of the same information is collected, though through different means. Reporting agencies have traditionally pulled quality data from hospitals' financial information such as MedPar and UB92 patient bills; but, recent trends show that hospitals more readily push their data to outside agencies for review.

There are now 24 states that require hospitals to report quality data and seven have passed legislation to require public disclosure; transparency is on nearly everyone's agenda.⁷ This ability to view hospital data was once thought to serve as a marketing tool and driver of internal performance improvement initiatives. It is now clear that this same data will likely be used to drive different levels of reimbursement. Even as early as 10 years ago, P4P initiatives would not have been likely in many regions due to a lack of quality data disclosure on any level.

In Corazon's home state of Pennsylvania, public disclosure of hospital data is mandatory for Open Heart Surgery. Hospitals in the state report charge information to the Pennsylvania Health Care Cost Containment Council (PHC4). The PHC4 was the first state council to publish reports that displayed hospitals' mortality rates, lengths-of-stay, costs, and readmission rates. This reporting has not been without its "growing pains". The measurable differences in internal clinical hospital data and the billing data have been surprising. For example, the citizens of Pennsylvania were faced with a report that showed alarmingly high inpatient infection rates. Hospitals have contended that the reports are flawed because the data, which had been abstracted primarily

from billing reports, could not account for where the infections were acquired or any type of risk adjustment⁷. Program such as PHC4, other state initiatives, and several demonstration projects are the primary drivers of the P4P movement.

CMS/Premier Pay-For-Performance Demonstration Project

Private payers will typically base a large percentage of their reimbursement methodologies on practices that have been formally adopted by the CMS. Experts believe that Congress will push for a pay-for-performance methodology as part of Medicare reform. They will have to consider how much funding to allocate or just reallocate the same budgeted dollars to such a program under the prospective payment system⁸. At present, Medicare has various initiatives to encourage improved quality of care in all settings where Medicare beneficiaries receive services. Medicare quality initiatives include projects that have been designed for hospitals, physician practices, and disease management programs.

Supporters of the Pay-for-Performance initiative felt a major victory when CMS partnered with Premier, Inc. to develop a \$21 million demonstration project related to a P4P reimbursement model. The CMS/Premier demonstration model is perhaps the largest organized demonstration project to test pilot the P4P concept. Hospitals that are participating in the demonstration must have been participants in the Premier Perspective system as of March 31, 2003. Participation in the demonstration project is voluntary with 278 hospitals currently enrolled. CMS is collecting data on 34 quality measures relating to five clinical conditions¹.

P4P payments will be based on rankings within the defined quality measures, and payouts will be tiered to correspond to achievement of a target threshold within those measures. Hospitals scoring in the top 10% for a given set of quality measures will receive the standard DRG payment with an additional 2% incentive. Those facilities scoring in the next 10% will receive a 1% bonus payment. According to CMS, hospitals that have lower performance among the selected measures (those performing in the lowest 10%) will be subject to reductions in payment if they do not meet target thresholds for quality⁹. Controversy exists regarding punitive incentives for poor performance...Should programs that do NOT reach minimum quality measures receive lower reimbursement?

Initial results from the CMS/Premier demonstration project are yielding mostly positive results. Those hospitals that have participated have a noted increase in physician and staff behavior change. The demonstration facilities have also seen a positive trend in terms of clinical outcomes related to the measures. CMS formally announced that hospitals participating in the project yielded indicators that rose by approximately 7% after the implementation of the demonstration. Corazon has a particular interest with participating facilities as three of the five clinical conditions under measurement are related to cardiac services (AMI, CABG, and

CHF). In actuality there are nine metrics being collected to measure a hospital's performance related to the treatment of AMI (See Figure 1).

Figure 1

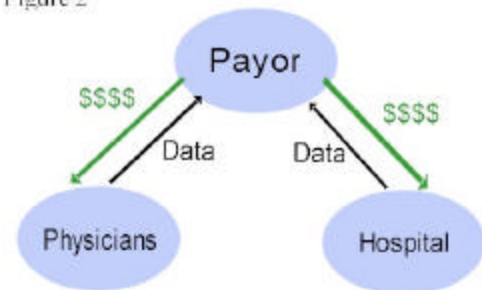
CMS/Premier Demonstration Measures for Acute Myocardial Infarction (AMI):	
1.	Aspirin at arrival
2.	Aspirin prescribed at Discharge
3.	ACE-Inhibitor for Left Ventricular Systolic Dysfunction
4.	Smoking cessation advice/counseling
5.	Beta-blocker prescribed at discharge
6.	Beta-blocker upon arrival
7.	Thrombolytic received within 30 minutes of hospital arrival
8.	Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival
9.	Inpatient mortality rate

Further data is needed to determine if hospitals participating in the Premier project have yielded a cost savings. Many physicians and hospitals believe that the current fee-for-service system is deeply flawed. Pay-for-performance benefits could prove insufficient to offset the losses sustained under this payment formula that does not adequately track physician practice costs¹⁰.

Physician Performance Incentives (PPI) – A P4P Model for the Future

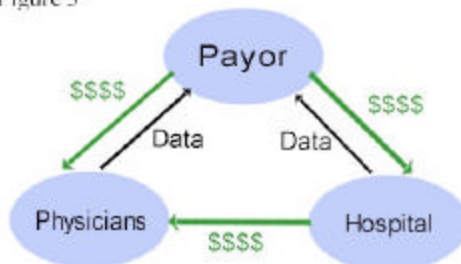
Existing P4P models distribute financial incentives (or cash flow) in two primary directions; from payer-to-hospital or payer-to-physician (See Figure 2). Corazon believes that programs that are early adopters of "leading edge" payment models will experience the greatest benefits in patient outcomes and revenue. The future is unclear; however, there is a greater opportunity to utilize more adaptations of P4P models as hospitals wish to partner with physicians.

Figure 2



Corazon has evaluated a new model of P4P that provides financial incentives directly from the hospital-to-physician (See Figure 3). This model would use a standard set of quality measures across the hospital to benchmark physician and/or physician groups. Corazon refers to this type of partnering arrangement as Physician Performance Incentive (PPI) approach.

Figure 3



The unique feature of PPI arrangements is that hospitals would have the ability to reward physicians for positive outcomes using evidence based clinical indicators. An example of PPI would be for a Cardiovascular Surgeon under a PPI arrangement with the hospital to have five or six indicators defined and benchmarked internally and externally. The CV Surgeon may use clinical indicators such as Aspirin prescribed at discharge, CABG using internal mammary artery, inpatient mortality rate and post-operative hemorrhage or hematoma. Internal data would be used to benchmark the Surgeon on his current statistics and then by using a stepping matrix would reward the physician as he meets the established goals.

For example, \$20,000 may be defined as the total bonus opportunity with each individual goal at \$4,000. The five goals would be specifically defined so that for each goal met, the surgeon would receive a payout no greater than the maximum of \$20,000. Adding flexibility to the PPI arrangement may allow the parties to define their financial rewards based on individual or group practice outcomes.

This partnering model, an incentive-based reimbursement model for healthcare outcomes, must be reviewed for any legal issues present when implementing. Payments must be "commercially reasonable" and consistent with "fair market value." When structuring any type of bonus incentive, it may not conflict with anti-kickback statutes, CMP laws, or anti-kickback statutes. In Corazon's discussions with a few healthcare lawyers, this type of partnership model had occurred years past and should if structured properly be able to be implemented. Again, hospitals rewarding for positive outcomes for the community served.

As consumers (patients and families) and the government continue to focus on the need to have physicians and hospitals provide high-quality patient care, P4P models will continue to grow and be enhanced.

The direction of paying for services that does not include quality has eroded for not only healthcare but in other industries as well. For example, would you continue to use the same airline if you heard reports of continual maintenance issues when compared to their competitors? This simple example shows how quality must be a part of a new generation of healthcare. The question remains: should quality be expected or be rewarded or both? As P4P gains acceptance, this question will continue to be examined from varied perspectives industry-wide with the goal of achieving fiscally-sound, high-quality care.



Ross is a Manager of Consulting Services at Corazon.



Karen is COO and President of Consulting.

Corazon is a national leader in specialized consulting services for CV program development from strategic business planning through clinical implementation. Corazon combines business planning, market and financial analysis, feasibility studies, clinical operations, Heart Hospital design, best practice benchmarking, and staff education for newly established or existing programs. Corazon is a 2003 Ernst & Young Entrepreneur of the Year Company. Call 412-364-8200 or visit www.corazoninc.com

REFERENCES:

- Dilulio, R. (September 2005). P4P Primer; The 10 things you should know about pay-for-performance reimbursement programs, *Medical Imaging*, pp.18-19.
- www.aishealth.com/ManagedCare/GenBus/MCW/P4P_payers.html - access on 1/9/2006. "Private Payers Proceed on P4P programs, While watching CMS's Progress on demos". Reprinted from Managed Care Week (May 2, 2005)
- DoBias, M. (December 2005). Needed: One set of Standards. IOM calls for universal pay-for-performance criteria. *Modern Healthcare*, pp. 8-9.
- www.aasld.org/eweb/DyanmicPage.aspx?webcode=pay_forperformance - accessed 1/9/2006 "Pay for Performance and Why You Should Care"
- Lammie, N.(ed.) (December 2005). Pay for Performance Improving Health Care Quality and Changing Provider Behavior, But Challenges Persist. *Western Pennsylvania Hospital News*, pp. 4.
- Mantone, J. (December 2005). Incentives linked to access woes. *Modern Healthcare*, pp. 10.
- Scalise, D. (November 2005). Two States, Two Stories: Pennsylvania and Tennessee take very different routes to reporting quality data. *Hospitals & Health Networks*, pp. 40-44
- Cardiovascular Roundtable. Care Quality: Pay-for-performance gains clout as payment methodology of the future. 7/27/2004.
- www.cms.hhs.gov/apps/media/press/release.asp?Counter=1343 - Accessed 1/11/2006. "Medicare "Pay for Performance (P4P)" Initiatives
- Glendinning, D. (February 2005). Medicare tests pay-for-performance. *American Medical News*, pp. 1-2.