Pay for Performance

In November of 2005 a workgroup was convened by VPQHC, to review current national and international best practice for pay for performance and to report our findings and recommendations to the Health Care Administration. Members of the workgroup include:

- *Kathryn S. Callaghan, Director, Employee Benefits and Wellness*
- *Peter Cobb, Executive Director, Vermont Assembly of Home Health Agencies*
- *Candace Collins, Office Manager, Cold Hollow Family Practice*
- *Susan Fitzpatrick, Assistant Vice President, Quality Management, CIGNA*
- *Cliff Frank, Vermont Managed Care*
- *Mark Hage, Director of Member Benefits, Vermont NEA*
- *Paul Harrington, Executive Vice President, Vermont Medical Society*
- *James Hester, PhD, Vice President, Vermont, MVP Health Care*
- *Pat Jones, Director of Quality Assurance & Consumer Protection, Health Care Administration*
- *Cy Jordan, MD, Medical Director, VPQHC*
- *Frank J. Landry, MD*
- *Patricia A. Launer, RN, Quality Improvement Advisor, VPQHC*
- *Stephen J. LeBlanc, Dartmouth Hitchcock Medical Center*
- *Richard Magnuson, Chief Financial Officer, Fletcher Allen Health Care*
- *Lou McLaren, Regional Director of Provider Networks, MVP Health Care*
- *Jill Olson, Vice President, Vermont Association of Hospitals and Health Systems*
- *Stephen Perkins, MD, Medical Director, Blue Cross–Blue Shield*
- *Larry Ramunno, MD, Clinical Coordinator, Northeast Health Care Quality Foundation*
- *Helen Riehle, Executive Director, VPQHC*
- *Mary Shriver, Executive Director, Vermont Health Care Association*
- *J. Scott Strenio, MD, Medical Director, Office of Vermont Health Access*
- *Beverly Tessier, RN, Quality Management Coordinator II, CIGNA*
- *Robert Tortolani, MD*
- *Lisa Ventriss, President, Vermont Business Roundtable*
- *Barbara Walters, DO, Senior Medical Director, Dartmouth Hitchcock Medical Center*

Each member of the workgroup received a notebook containing a literature review, pertinent articles, and websites. In January VPQHC set forth draft recommendations for the implementation of pay for performance programs in Vermont. These recommendations laid the groundwork for future discussions at workgroup meetings, and via e-mail communications. What follows is a compilation of recommendations developed by VPQHC with input from the workgroup.

A. Guiding Principles. These key principles are offered to serve as a guide for the design and implementation of pay for performance initiatives throughout the state of Vermont.

Consensus Statements

1. The primary goal of pay-for-performance programs must be improving health care quality and patient safety.

2. Providers, purchasers, and patients must be involved in the design of pay-for-performance programs.

3. Clinical measures used in pay-for-performance programs must be evidence based, broadly accepted, clinically relevant, and regularly updated.

4. Performance data must be adjusted where appropriate for sample size and case-mix composition, including factors of age/sex distribution, severity of illness and number of comorbid conditions.

5. Providers must have the ability to review and correct performance data.

6. The administrative burden and costs of implementation must be kept to a minimum for both payers and providers.

7. Definitions of measures must be uniform across all Pay for Performance programs.

8. Pay for Performance programs will be externally evaluated to assure compliance with the **Guiding Principles**.

9. Pay-for-performance programs must facilitate provider implementation of infrastructure, such as: use of electronic health records, decision-support tools, self-management support, and case management.[1]

Areas of non-consensus (these were principles with which one or more members had issues)

1. Initial implementation and provider participation in pay-for-performance programs must be voluntary.

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[1] Adapted from: Medical Group Management Association Position Paper. *Principles for Pay-for-Performance Programs and Recommendations for Medical Group Practices.* February 2005. www.mgma.com/about/MGMApos-payforperformance.cfm (See Appendix A)

Discussion:
Members of the work group were unable to agree on this principle. Most members of the group, especially those representing providers and provider practices, felt that voluntary participation was absolutely essential to the acceptance of pay for performance by the provider community, particularly if additional demands would be placed on the provider practices.

The program design of pay for performance programs influences commercial payers' abilities to support several of the non-consensus statements listed here. Program design limited one commercial payer from supporting voluntary participation.

2. Pay-for-performance programs must not be budget neutral within the payment system.

Discussion:
This suggested principle led to a lengthy discussion of the need for practices to be financially rewarded for their participation in pay for performance initiatives. The majority of the workgroup members recognized that many primary care practices are experiencing major financial stress. In the worst case scenario, additional expenses could result in some small practices going out of business.

Workgroup members also expressed the need for the evaluation and payment process to be transparent in order to instill a sense of trust that would result in higher participation rates by providers.

Here again, program design limited one plan from supporting this statement. Nationally their pay-for-performance design is based on budget neutrality.

3. Pay-for-performance must reimburse providers for any administrative burden for collecting and reporting data to payers.[2]

Discussion:
While several of the commercial insurers felt strongly that this was not a statement that they could accept, others on the workgroup expressed concerns that the additional costs associated with gathering data would prove to be too costly for primary care practices. Therefore, many in the workgroup agreed that this is a necessary principle, closely linked with budget neutrality and voluntary participation.

This principle asks the question: will P4P programs generate administrative tasks that are more costly and, therefore, cause economic hardship to doctors' practices? If primary care providers are on the edge financially, additional costs arising from new or expanded administrative demands must be covered to some extent. Proposed rewording of this principle was:

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[2] Adapted from: Medical Group Management Association Position Paper. *Principles for Pay-for-Performance Programs and Recommendations for Medical Group Practices.* February 2005. www.mgma.com/about/MGMApos-payforperformance.cfm

Pay-for-performance programs must reimburse providers for additional costs that are linked directly to the collection and reporting of data to payers.

Hospitals stated that they were not so much interested in reimbursement for expenses, but rather the alignment of data collection needs. A statement that the P4P data collection burden for hospitals would not extend beyond that which is already required as part of the Act 53 report cards or what is already available to the plans through public data sets or their own claims data, would meet the needs of Vermont hospitals. (See appendix B)

> This is consistent with guiding principle numbers 6: *The administrative burden and costs of implementation must be kept to a minimum for both payers and providers,"* and 7: "*Definitions of measures must be uniform across all Pay for Performance programs*."

The preceding three principles are interrelated, and are ultimately connected to how P4P programs will define the term facilitate as used in Guiding Principle 9: *pay-for-performance programs must facilitate provider implementation of infrastructure, such as: use of electronic health records, decision-support tools, self-management support, and case management*. *Facilitate* replaces the word *reward* used in the initial draft, and use of this term was necessary to allow consensus support. It is clear that a large number of the providers felt that whether the word was facilitate or reward, ultimately the incentive for change needed to be financial. Other members of the workgroup were not in agreement as to whether this reward should be financial or professional.

B. Recommended Starter Set of Performance Measures

As stated in Guiding Principle 3 and 7, the workgroup believes that: *Clinical measures used in pay-for-performance programs must be evidence based, broadly accepted, clinically relevant, and regularly updated*, and that *Definitions of measures must be uniform across all Pay for Performance programs*.

Several groups, including the Institute of Medicine (IOM), the Center for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), and Physician Consortium for Performance Improvement, have identified or are in the process of identifying potential P4P measures. (See appendix C)

Recognizing that the P4P process is ongoing, the measures presented in this report serve as a starting point for P4P measurement. Measures can and should be added or removed as the process continues.

The workgroup determined that individual subgroups should be implemented for the purpose of identifying a set of recommended starter measures for the areas of hospital care and ambulatory care. The recommendation was that each subgroup should consist of a broad spectrum of experts including clinical experts, policy experts, payers, and consumers.

Hospital Care:

The Hospital subgroup met in May to begin work on a recommended set of starter measures for use with P4P in the hospital community. Many if not all members of the hospital subgroup were already part of the Act 53 committee and felt strongly that the work of the subgroup needed to be consistent with the work already being done. The hospital subgroup was therefore incorporated into the larger committee.

The subgroup agreed that most of the CMS measures (heart attack, heart failure, and pneumonia) could be used as a recommended set of starter measures in the hospital setting. Additionally, the CMS measures related to surgical infection prevention, the Leapfrog survey and the Hospital CAHPS survey have P4P potential and could be looked at for addition at a later time.

Hospital subgroup members do not believe that the AHRQ volume and mortality measures should be used in P4P.

Ambulatory Care (Primary Care):

The Consortium for Physician Quality Improvement is working on 140 standard measures of performance for physicians covering 34 clinical areas. These recommendations should be available by the end of 2006. Believing that it is essential for Vermont's recommended starter set of measures to be consistent with what is happening nationally, the Ambulatory Care subgroup will convene following publication of these measures.

Nursing Home Care and Home Health Care:

Nursing homes (see Appendix D) and Home Health Care (see Appendix E) currently do not have any P4P measures in place. They do however have quality measures through the Center for Medicaid and Medicare Services (CMS).

The Nursing Homes also have quality measures through the Quality Improvement Organizations. These quality measures look at pain management, late loss ADLs, restraints, and pressure ulcers. The measures being used for Home Health are part of OASIS and are currently being used by CMS. Nationally future implementation of P4P in the Home Health setting would probably use a subset of these measures, possibly using re-hospitalizations as a key indicator.

Institution of P4P programs within the Nursing Home or Home Health communities should be consistent with the quality measures already in place.

Discussion and Evidence for the Guiding Principles

Pay for performance must reward and support necessary elements to improve patient safety. In an article published in August 2005, Donald Berwick and

Lucian Leape reported on the progress made in building a safer health system since the publication of "To Err is Human" in 2000. In the article they discuss several elements necessary for improving patient safety including implementation of electronic medical records, diffusion of proven safe practices, full disclosure of mistakes to patients, and the spread of teamwork, training and safety.[3]

Ideally, financial incentives connected with pay for performance will be large enough to reward and motivate structural and systems change, including the implementation of electronic medical records. It is also hoped that alignment of payment will encourage proactive, preventative care not only increasing care quality but also increasing efficiency and decreasing costs.[4]

The Hospital Quality Improvement Demonstration (HQID) currently underway through the Centers for Medicare and Medicaid Services (CMS), and coordinated by the hospital alliance Premier, seeks not only to pay for performance but to encourage transparency. The outcomes for those hospitals performing in the top five deciles of each measurement category will be published. While those hospitals that fall into the lower five deciles will not be publicly revealed, they are a matter of public record. Participating hospitals see pay for performance and public reporting as not only inevitable but also as a means of focusing their quality improvement efforts. [5]

In the United Kingdom experiment it was found that the financial incentives were effective motivation for change, especially if they were aligned with professional values and were focused on areas of clinical importance.[6] Health Partners, a healthcare organization covering nearly 25% of all people living in the Minneapolis- St. Paul area, found that it needed to pick target areas for quality improvement that were under the control of physicians and hospitals, they needed to set targets that were high but achievable, negotiate individual quality improvement goals with providers and practices, and provide financial incentives that made participation in the process more than a zero-sum game (i.e. all eligible medical groups meeting targets were rewarded).[7]

In January 2004, Epstein, Lee, and Hamel concluded that for pay-for-performance to be successful it is necessary that:

- the financial incentives be increased (from the current level),
- large insurers participate,

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[3] Leape, Lucian L., Berwick, Donald M. *Five Years After to Err is Human: What Have We Learned?* The Journal of the American Medical Association 293: 19 May 18, 2005:2384-2390.
[4] Epstein, Arnold M., Lee, Thomas H., and Hamel, Mary Beth. *Paying Physicians for High-Quality Care.* New England Journal of Medicine 350:4 January 22, 2004:406-410.
[5] Becker, Cinda. *Right on the money.* Modern Healthcare November 14, 2005:8-9.
[6] Roland, Martin. *Linking Physician's Pay to the Quality of Care – A Major Experiment in the United Kingdom.* New England Journal of Medicine 351:14 September 30, 2004: 1448-1454.
[7] Apland, Babette A., Amundson, Gail M. *Financial Incentives: An Indispensable Element for Quality Improvement.* Patient Safety and Quality Healthcare September/October 2005:14-20.

- clinical performance indicators be rotated and expanded upon over time, and
- affordable mechanisms for measuring and tracking quality be invested in.

Ultimately, they conclude, an investment in information infrastructure and office redesign is the most realistic hope for improving quality of care.[8]

Pay-for-performance initiatives may choose to develop their own measures to meet unique needs, or use existing measures. Measures can fall into three categories: structural (i.e. staffing levels, implementation of EMR's), process (i.e. % of eligible patients receiving flu vaccinations) and outcomes (% of patients with diabetes who have A1c less than 7).[9]

When setting expectations for performance, measures should be "unambiguous, easily understood, efficient to collect as part of a process of care, risk-adjusted where appropriate, and applicable to a wide variety of practitioners."[10]

There are several important issues to consider when selecting measures to use for pay for performance.

- outcomes measures often require risk-adjustment;
- disease specific measures may not be a true indicator of the overall quality of a provider;
- statistical issues may arise when developing measures applicable to small providers or low volume programs;
- variation exists among both high and low volume providers;
- difficulty exists in separating system performance (i.e. the hospital) from individual provider performance; and
- much of what consumers view as high quality care cannot be easily quantified.[11]

Recognition of and response to these concerns is essential for provider buy-in.

Linking pay for performance with disease specific clinical practice guidelines (CPGs) brings its own set of issues. Individuals with complex co-morbidities require a balance of clinical judgment and attention to individual preferences in order to effectively treat the whole patient. Pay for performance based on disease specific CPG's may fail to recognize the complexity of treatment of these patients, while at the same time providing a disincentive for providers to work

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[8] Epstein, Arnold M., Lee, Thomas H., and Hamel, Mary Beth. *Paying Physicians for High-Quality Care.* New England Journal of Medicine 350:4 January 22, 2004: 406-410.

[9] American Hospital Association. *Paying for Performance: Creating Incentives for Quality Improvement.* Trendwatch 5:3 September 2003:1-8.

[10] American Hospital Association. *Paying for Performance: Creating Incentives for Quality Improvement.* Trendwatch 5:3 September 2003: 1-8.

[11] ibid

with older, more complex populations (and an incentive for providers to focus on individual diseases and younger, healthier populations).[12]

Consequences: Intended and Unintended

Nationally and internationally the implementation of pay-for-performance initiatives come with the possibility of a myriad of consequences, some positive and some that will highlight limitations. Each of these potential consequences needs to be viewed in the context of issues facing Vermont healthcare, including nursing shortages, a rural delivery system, and resource limitations, issues being faced by states across the nation.

As implementation of pay for performance begins, questions arise around payment as a motivator for change.

Will the hospitals and providers who are at or above the target level be motivated to work towards improvement when they have only to maintain the status quo to receive their bonus? Will hospitals and providers below the target see little reason to change if success seems infeasible? [13] Will the rewards, both financially and in terms of healthcare improvement, be sufficient to justify the cost? Will financial incentives support the implementation of structural changes?[14] Will the consumer ultimately carry the cost through increased premiums?[15] What will happen if the cost of premiums rises to the point that small businesses are no longer able to offer insurance? Will pay-for-performance lead to patients with complicated conditions and high resource needs being isolated by this payment system with some providers' cherry picking the "healthy sick" to improve their outcome scores? Should special consideration be given to those providers who care for patients with a broad spectrum of illness and acuity?

Potential positive consequences:

- rapid expansion of clinical computing systems;
- increase in clinics that specialize in the management of specific chronic diseases; and
- improved health outcomes.

Potential negative consequences:

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[12] Boyd, Cynthia M., et al. *Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Disease: Implications for Pay for Performance.* The Journal of the American Medical Association 294:6 August 10, 2005:716-724.

[13] Rosenthal, Meredith B. *Early Experience with Pay-for-Performance from Concept to Practice*. The Journal of the American Medical Association 294:14 October 12, 2005:1788-1793.

[14] Epstein, Arnold M., Lee, Thomas H., and Hamel, Mary Beth. *Paying Physicians for High-Quality Care.* New England Journal of Medicine 350:4 January 22, 2004:406-410.

[15] American Hospital Association. *Paying for Performance: Creating Incentives for Quality Improvement.* Trendwatch 5:3 September 2003:1-8.

- increased specialization in primary care;
- increased biomedical orientation and a less holistic approach;
- fragmentation and poor coordination of care for patients with multiple conditions;
- reduction in the quality of care for conditions not included in the incentive system; and
- increased administrative costs. [16]

Please contact Patty Launer at PattyL@vpqhc.org or Linda Schlott Lindas@vpqhc.org if you wish the links to the appendices and measure sets referenced in the report.

[16] Roland, Martin. *Linking Physician's Pay to the Quality of Care – A Major Experiment in the United Kingdom.* New England Journal of Medicine 351:14 September 30, 2004:1448-1454.