The Allen Consulting Group

Making hospitals work (while not stuffing up the rest)

Mary Ann O'Loughlin
Director

2008 Economic and Social Outlook Conference

Outline

- Pay for performance (P4P) in United States
  - What can we learn from the experience of P4P
  - Next steps on P4P agenda
- The hope – and limitations – of P4P.

What is pay for performance?

- P4P programs align financial reward with improved outcomes
  - providers receive differentiated payment based on performance on quality and efficiency measures.

What do we know about P4P programs?

- More than 100 P4P programs
- Characteristics
  - primary physicians more likely to be focus – but programs increasingly targeting specialists and hospitals
  - average of 5 performance measures – clinical processes most common, although more advanced P4P include outcome and cost-efficiency measures
  - maximum bonus 5-10% for physicians, 1-2% for hospitals
  - rewards for reaching fixed threshold dominate – only 23% reward improvement
- Some are part of integrated strategy for improvement of health care – technical assistance, use of IT, public reporting.

Effectiveness of P4P programs

- Most have not been fully evaluated with control comparisons
- Evaluations have yielded mixed conclusions
- Cost effectiveness studies are few in number
- 'Early adopters' motivated by:
  - belief that they will eventually formulate an effective program
  - belief that paying more for higher quality is fairer than paying solely for the quantity of services provided
  - using P4P as a step toward other goals, such as making performance transparent, or developing a tiered payment system.

Crossing the Quality Chasm

- Landmark Institute of Medicine report
  - quality of health care low relative to accepted standards
  - treatment patters extremely variable across regions and providers — suggesting that improvement is possible
- The report strongly recommended that the federal government identify, test and evaluate various payment options that more closely align compensation methods and quality improvement goals.

Hospital Quality Incentive Demonstration

- HQID rewards hospitals for performance on 34 process and outcome measures for inpatients with acute myocardial infarction (AMI), heart failure, pneumonia, coronary artery bypass graft surgery, and hip and knee replacement
- Incentives/penalties
  - hospitals in the top 20% of performers received bonus payments of 1-2%
  - hospitals in bottom 10% received 1-2% reduction in Medicare payments
- Incentive payments ranged from $744,000 to $2,829 – to 115 hospitals
  - cost of bonuses about US$9 million.

HQID top line results

- The average composite quality scores improved significantly between the beginning of the program and end of Year 2 in all five clinical focus areas:
  - 88% to 94% for patients with AMI
  - 85% to 94% for patients with coronary artery bypass graft
  - 65% to 82% for patients with heart failure
  - 69% to 86% for patients with pneumonia
  - 85% to 93% for patients with hip and knee replacement
- Overall improvement of 12%.
- Range of variance among participating hospitals also smaller
  - hospitals in the lower quality range improved their quality scores and narrowed the gap between themselves and the top performers.

HQID matched study

- 2 year results, comparing changes in process-of-care measures between 207 P4P hospitals and 406 matched control institutions (already engaged in public reporting)
- P4P was associated with improvements of:
  - 2.6% for AMI
  - 4.1% for heart failure
  - 3.4% for pneumonia
- Performance greater in hospitals with lowest quintile of baseline performance
  - 16.1% improvement compared to 1.9% in highest quintile.

Next steps for Medicare P4P

- *Rewarding Provider Performance: Aligning Incentives in Medicare* – Institute of Medicine 2007 study
- Basis of payment
  - improvement vs excellence
  - coordinated care

Institute of Medicine 2007 study

- *Rewarding Provider Performance: Aligning Incentives in Medicare*
  - Report by IOM in response to US Congress request to conduct a study that would identify options for aligning performance with payment in the Medicare program to accelerate pace of quality improvement
- Recommended implementation of P4P in Medicare using a phased approach.

Improvement or excellence?

- Most P4P programs reward excellence — physicians/hospitals whose performance exceeds an absolute threshold
- Thus, *quality improvement* is not explicitly required for the receipt of a bonus
- The incentives to improve will vary with baseline performance
  - physicians/hospitals whose baseline performance is high need only maintain the status quo to receive payment
  - for physicians/hospitals with the lowest performance, the award may not be sufficient to balance the cost of making the required dramatic improvement.

Institute of Medicine: Recommendation 5

- Design a P4P program that initially rewards both providers who improve performance significantly and those who achieve high-performance.
- The fraction of rewards allocated to improve on a given measure set should be reduced over time to only reward care that is truly of high-performance.
- As providers make significant improvements on basic measures, the allocation of rewards for those measures should shift in favour of higher payments for more complex indices of perform.
- Rewards should also shift to reflect progress in development of new measure sets and changes in priorities.
- Even when measure sets or priorities are stable, focus of rewards should be altered to ensure providers do not focus performance improvement efforts too narrowly.

Changes to HQID payment methodology

- Attainment Award
  - Hospitals that attain or exceed median level composite quality score performance receive an incentive payment.
- Top Performer Award
  - Hospitals in the top 20% of hospitals in each clinical area will receive an additional incentive payment.
- Top Improvement Award
  - Hospitals that attain median level performance and are among the top 20% of hospitals with the largest percentage quality improvements in each clinical area will receive an additional incentive payment.

Coordinated care

- P4P that focuses on individual doctors or hospitals — targeting discrete diagnoses and care at only one point in time — risks reinforcing fragmentation and lack of coordination.
- IOM: transformational changes in the health care delivery will depend upon the adoption of more comprehensive, longitudinal set of measures of costs and quality that cut across settings and providers
  - longitudinal measures will need to be developed that can capture the performance of multiple providers caring for a patient; examine how well care is provided across transitions to different settings; and evaluate patient outcomes over time.

Institute of Medicine: Recommendation 8

- CMS should design Medicare P4P program to include components that promote, recognize, and reward improved coordination of care across providers and through entire episodes of illness.
- Thus, CMS should:

  (1) encourage beneficiaries and providers to identify providers who would be considered their principal responsible source of care; and

  (2) reward successful care coordination that meets specified standards for providers who take on that role.

Extending the P4P Medicare agenda

1. The federal government should fund a research program to rapidly build the scientific basis for managing chronic illness.
2. The CMS should offer a partnership with providers to coordinate the care of chronically ill patients and participate in a shared savings program to redesign delivery systems to correspond to the benchmarks of relatively efficient providers.
3. Building on 1 and 2, the CMS should adopt prospective payment for chronically ill patients based on validated clinical pathways and an actuarially fair, risk-adjusted price.
4. To encourage participation, the CMS could impose a nonparticipation penalty on providers not willing to join, and eventually only cover providers capable of such evidence-based care.

The hope of P4P

‘The hope is that payment incentives can offer a stimulus to move health care practices overall from the status quo toward new organizational and individual behaviours that will result in better quality of care.’

Institute of Medicine

Capacity

‘Lack of capacity is the Achilles heel of accountability. Without substantial investment in capacity building, all that performance-based accountability systems will demonstrate is that some schools are better prepared than others to respond to accountability and performance-based incentives, namely the ones that had the highest capacity to begin with. This is not exactly what the advocates of performance-based accountability had in mind.’

R. Elmore 2002, *Bridging the gap between standards and achievement*, p. 23

P4P should...

- Have clear objectives, and be consistent with objectives for broader health care system
- Promote better outcomes of care, especially through coordination of care
- Encourage most rapid, feasible performance improvement by all providers
- Reward significant provider improvement as well as achievement of excellence
- Be part of a payment approach that *supports* improvement and innovative change throughout health care system.

P4P cannot...

- Significantly improve quality in isolation from other changes in health care system
  - and could hinder changes required to significantly improve care if implemented in ways that reinforce the current fragmentation of service delivery.