Pay-for-Performance: The train has left the station, but where is it going?

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Agency for Healthcare Research and Quality
The National Pay-for-Performance Summit
Los Angeles, California
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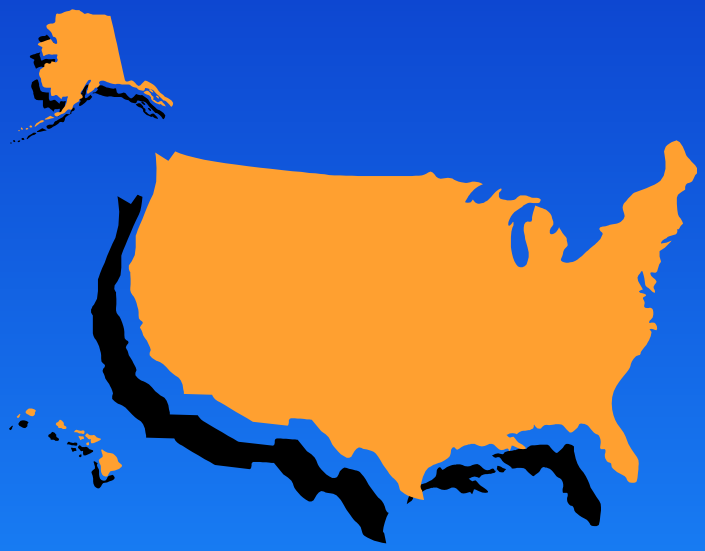
Overview

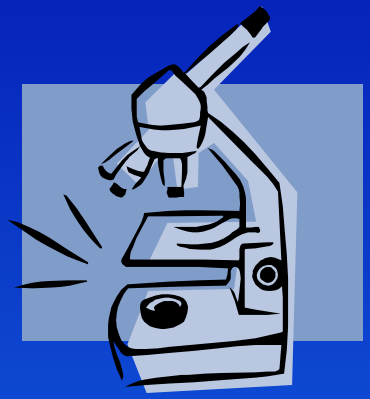
- **AHRQ's role**
- As P4P gains traction
- The evidence base
- The enabling role of Health IT
- Challenges ahead
- Strategic questions
- Q & A

AHRQ's Mission

Improve the quality, safety, efficiency and effectiveness of health care for all Americans



HHS Organizational Focus



NIH

Biomedical research to prevent, diagnose and treat diseases

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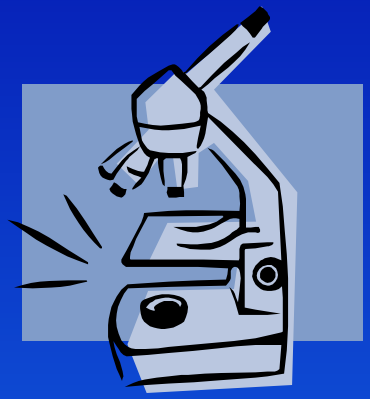

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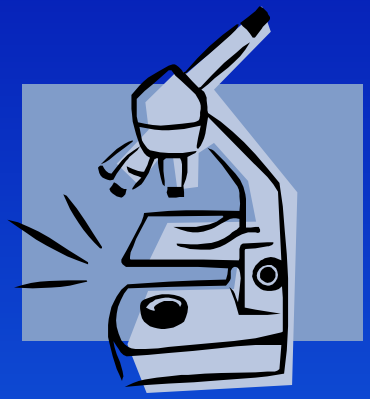

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AHRQ

Long-term and system-wide improvement of health care quality and effectiveness

AHRQ's Role in P4P

- AHRQ's authorizing legislation identifies research role in payment and finance
- IOM Chasm report asks AHRQ and CMS to "develop a research agenda to identify, pilot test and evaluate various opinions for better aligning current payment methods with quality improvement goals"
- MMA Sec. 646 describes AHRQ as "learning laboratory" to evaluate, monitor, and disseminate information about CMS demonstrations
- Private sector payers and providers see AHRQ as a neutral source of evidence

P4P and CAHPS Reporting

- AHRQ's has been reporting Consumer Assessment of Health Care Providers and Systems (CAHPS) for 10 years
- Provides standardized survey instrument to measure patient perspectives on care
- CAHPS care settings include ambulatory, health plans, nursing homes, hemodialysis centers and hospitals in 2006 (with CMS)
- P4P programs use CAHPS data to set quality/cost performance benchmarks

New MCRR Supplement

- AHRQ-sponsored P4P supplement in Feb. ‘06 issue of Medical Care Research and Review
- Features new wave of findings from five research teams to inform pay-for-performance discussion and decision-making
- Includes commentaries by Robert Galvin, Mark Chassin and Glenn Hackbarth providing employer, provider and policymaker perspectives on pay-for-performance initiatives

Key Collaborations

Rewarding Results

Aligning Incentives with High-Quality Health Care

- Joint initiative between the Robert Wood Johnson Foundation, California HealthCare Foundation and the Commonwealth Fund
- Provides grants to health care payers to develop, evaluate and diffuse innovative financial and non-financial incentives for providers to promote high quality care
- Joint evaluation by RWJF and AHRQ

Key Collaborations

THE LEAPFROG GROUP
Informing Choices. Rewarding Excellence.
Getting Health Care Right.

3rd year of pilots testing effectiveness of incentive and reward programs that motivate providers to speed implementation of Leapfrog's recommended quality and safety practices

- GE, Verizon, Hannaford Bros., NY
- Boeing nationwide
- Healthcare 21, TN
- Blue Shield of California
- Buyers Health Care Action Group, MN
- Maine Health Management Coalition

AHRQ P4P Research

EXAMPLES OF SEVERAL CURRENT STUDIES:

- Quality-based Physician Incentive Programs
- Evaluation of “Rewarding Results” Program
- Managed Care, Financial Incentive and Physician Practice
- The Patterns and Impact of Value Based Purchasing

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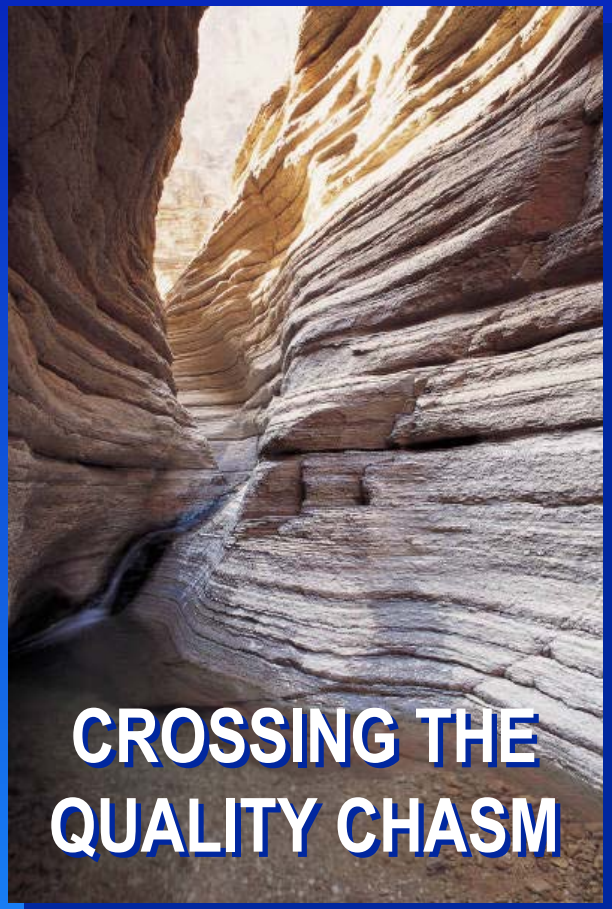
A Call to Action



- 2001 IOM Report: there is a chasm between the health care we have and the care we could have
- Poor systems, not bad people
- Chasm is result of how we organize, structure and pay for care

Drivers Behind P4P

- Large gaps in quality and safety
- Rapid rise of health care costs
- Perverse incentives in payment systems
- Huge budget problems in private and public sector
- Payers want to use market forces to move the needle on quality, cost or both

P4P Is Here to Stay

- Over 100 pay-for-performance programs active programs nationwide -- and the number is growing
- Sponsored by payers who see P4P as a way to accelerate the pace of quality improvement
- Not a question of incentives vs. no incentives but “How do we develop incentives aligned with what we want from health care?”

Strong CMS interest in P4P

- 24 demonstrations implemented
- 12 demonstrations under development
- 16 more demonstrations required by Medicare Modernization Act of 2003
- Billions of dollars in payments to demonstration entities
- U.S. Government is source of 46% of all health care spending

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CMS Premier Demo

- CMS Premier Hospital Quality Incentive demo – first time Medicare has awarded monetary bonuses to providers in a P4P demo
- $8.85 million awarded to hospitals that showed measurable improvement
- "We are seeing that pay-for-performance works" - Mark McClellan

11/14/05 CMS news release

CMS Premier Demo

COMPOSITE QUALITY SCORE IMPROVEMENTS (1st YEAR)

- From 87% to 91% for heart attack patients
- From 64% to 74% for patients with heart failure
- From 69% to 79% for patients with pneumonia
- From 85% to 90% for patients w/coronary artery bypass graft
- From 85% to 90% for patients with hip and knee replacements

11/14/05 CMS news release

P4P and PacifiCare

- $3.4 million in bonus payments made to 200 physician groups in two PacifiCare networks 2001-04
- Pap-smear quality in P4P improved 5.3% compared with 1.7% in control group
- Mammography and hemoglobin tests improved in both P4P and control sites
- 75% rewards went to top performers
- Most improvement came from low performers

Rosenthal et al, *JAMA*, 10/12/2005

Rewarding Results Study

KEY QUESTIONS:

- Size of financial rewards needed to effect change
- How to engage physicians continuously in QI activities
- Whether returns on investment and quality gains outweigh the financial effort
- How to sustain improvement with health IT
- Can P4P work in all settings

11/15/05 RWJF news release

What Does the Evidence Show?

- Incentives can improve quality
- Factors that seem to matter
  - Revenue potential (and certainty of gain)
  - Cost and difficulty of achieving gain
  - Enabling factors at the patient level
- Most research omitted key variables
- Structured evaluations for the future are important

Dudley et all Evidence Review, 2004

Pay for Performance Research

- Rationale for P4P comes mostly from other industries' experience
- Only 9 RCTs of pay-for-performance have been published to date
- Most studies focus on one aspect -- most P4P initiatives use multiple indicators
- Most studies don't note market share

Forthcoming Dudley study

Pay for Performance Research

- Researchers must carefully consider study design to assure results are applicable across networks
- The selection of theories about how incentives work is crucial to success
- Research findings must be reported in ways that can help policymakers and providers make informed decisions

Forthcoming Dudley study

P4P Evidence Acceleration

Deploy current P4P evidence

Decision Guide for Quality Based Purchasing *(Dudley, Rosenthal)*

MCRR P4P issue

BCBS conferences

Pilot Learning Networks

P4P Evidence Acceleration

Deploy current P4P evidence	Develop new P4P evidence
Decision Guide for Quality Based Purchasing *(Dudley, Rosenthal)*	Rigorous studies
MCRR P4P issue	Fast turnaround
BCBS conferences	Linked
Pilot Learning Networks	Co-funded
	Practical focus

P4P Evidence Acceleration

Deploy current P4P evidence	Develop new P4P evidence	Disseminate new P4P evidence
Decision Guide for Quality Based Purchasing *(Dudley, Rosenthal)*	Rigorous studies	Quick, efficient
MCRR P4P issue	Fast turnaround	Use English and limit need for "translation"
BCBS conferences	Linked	Build on current evidence foundation
Pilot Learning Networks	Co-funded	Learn by doing
	Practical focus	

Did We Say Practical?

Goal

- "Will the information resulting from this investigation be operational in the day-to-day delivery system, i.e., will payers and providers be able to change their practices based on the results? Payers and providers are interested in (1) whether an intervention works (2) compared to other options (3) and including both benefits and costs. *(Galvin)*

Focus on Practicality

CONCEPT AND DESIGN

- When and how should providers be engaged in decision about P4P?
- Should we use bonuses, withholds, or a combination?
- How should the bonus be structured?
- Should we reward improvement or performance?
- How much money do we put into performance pay?
- What characteristics of potential indicators make them attractive candidates for inclusion?
- How much market share does it take to affect performance?

Adapted from Adams and Rosenthal, forthcoming

Focus on Practicality

IMPLEMENTATION

- If we have a “report card” now, will P4P offer more of an incentive?
- If considering both P4P and a report card, which should we do first?
- How should we think about P4P and its relationship to benefit design, including tiered networks?
- What organizational characteristics are associated with greater likelihood of success?
- How can we tell if the program is working?
- What unintended consequences should we look for?

Adapted from Adams and Rosenthal, forthcoming

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Health IT and P4P

- Health information technology will enable pay-for-performance initiatives
- Health IT will facilitate the transparent reporting of performance to payers, providers and consumers
- Low HIT adoption rate by physician groups -- especially small groups – is a limiting factor. More incentives for HIT adoption may be necessary

How AHRQ is Helping

- **We fund grants and contracts** to promote Health IT investment, especially in rural and underserved areas
- **We evaluate** what works best, where barriers exist, and how Health IT can be successfully implemented
- **We offer technical assistance** through our National Resource Center on Health Information Technology to help clinicians make the leap from pencils to PDAs

Health IT Grants

Promote access to Health IT

- **$166 million** investment to date
- **Over 100 grants** to communities, hospitals, providers, and health care systems to help in all phases of the development and use of Health IT
- The grants spread across **40 states**
- Special focus on **small and rural** hospitals and communities

Health IT Opportunities

Remove barriers

- Build interoperable systems
- Standardize medical nomenclature
- Examine privacy issues
- Prepare the health care sector and clinicians to use full potential of health IT
- Learn and share best practices through the AHRQ National Resource Center for Health IT and other channels

Key Collaborations

- Quality coalition between NCQA, GE, Verizon, Ford, Humana, P&G, UPS, BCBS of KY, OH and IL, and Tufts, United and Aetna health plans
- Diabetes and Cardiac Care Link Programs reward top performing physicians
- Physician Office Link Program rewards physicians for investing in IT and creating chronic care improvement programs

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Challenges Ahead

Performance Measurement: Accelerating Improvement

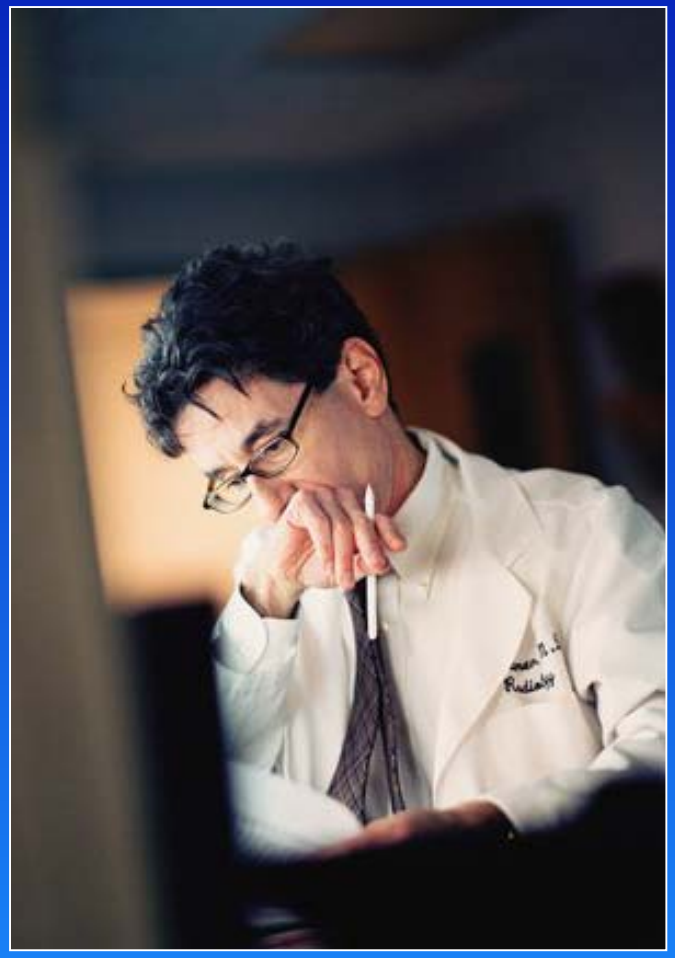
Institute of Medicine

One set of standards

- New report from IOM says a single playbook is needed to make P4P work
- Compares P4P fragmentation to health IT
- Calls for Congress to authorize National Quality Coordination Board

Institute of Medicine, December, 2005

Challenges Ahead



Rewarded or railroaded?

- AMA, AAFP and other physician groups have legitimate concerns about:
- Payers influencing medical decisions
- Faulty performance measures
- Too much record keeping
- Too much emphasis on cost cutting
- Fair and equitable program incentives

P4P Success Factors

PROVIDERS NEED TO:

- Understand the incentives and what must be done to qualify for them
- Perceive the value of the incentives to be worth their time and efforts
- Believe the incentives will be good for their patients
- Have sufficient control over the clinical activities required to achieve the targets
- Be assured incentives are administered fairly

Challenges Ahead

P4P not reaching small practices

- Site visits to 12 nationally representative communities discovered only two had significant pay-for-performance programs

Center for Studying Health System Change, 2005

Challenges Ahead

Unintended consequences

- Can be as strong as intended ones – will pursuing quality related initiatives distract providers from other important clinical activities for their patients?

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Strategic Questions

- When and how should providers be involved in P4P decisions?
- Should we use bonuses, withholds or a combination of financial incentives?
- How should bonuses be structured?
- Should improvement or performance be rewarded?
- How much market share does it take to affect performance?

Adapted from Dudley and Rosenthal (forthcoming)

Strategic Questions

- Does P4P primarily reward providers who are already doing well – can it also stimulate quality improvements for lower performers?
- Where should incentives be directed – to individuals, groups, hospitals, or a mix?
- How much should incentives be for physicians? Is the current average of 5% enough to drive meaningful quality improvement?
- How much should incentives be for hospitals? Is the current average of 1-2% too small to achieve significant quality improvement?

Strategic Questions

- How do we integrate efficiency measures with quality measures?
- What is the role of incentives in areas such as chronic disease management, and prevention and wellness programs?
- How can P4P programs work in small group practices, the settings where the majority of Americans receive care?

As P4P picks up steam…

Have you ever noticed....anybody going slower than you is an idiot, and anyone going faster than you is a maniac?

George Carlin

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