

# *P4P Contracting: Bold Leaps or Baby Steps?*



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# *Bridges to Excellence Mission Statement*

- *“To create significant leaps in the quality of care by recognizing and rewarding health care providers who demonstrate that they have implemented comprehensive solutions in the management of patients, and deliver, safe, timely, effective efficient, equitable and patient centered care.”*

# Overview

- Evolution of quality concepts
- Snapshot of P4P world
- Relationship to financial incentives
- Disconnects in traditional provider contracts
- Assessment and speculations
- Another way

# *The Woodstock Era of Quality*

- Donabedian: structure, process and outcomes
- 80 years of attempts to operationalize quality concepts
- By 1984, IOM notes 100 definitions of 'quality'

# *The Rise of Toyota and 'Value Purchasing'*

- Rising health care costs
- Shift from post-payment utilization review to 'utilization management'
- Employers developing value in their own products apply similar techniques to health benefits (GE, Xerox, GM)
- Value means offering fewer choices which means more emphasis on performance to select who will provide health care
- Beginning of the 'managed care' era

# *Order Out of Chaos*

- NCQA and HEDIS
- Collapse of Clinton health reform
- CPGs and AHCPR related to physician payment reform
- Unexplained variability and evidence-based medicine emerge as bedrock concepts

# *The New Values Coalesce*

- “As Good As It Gets”: President’s Commission
- National Quality Roundtable
- Misuse, overuse and underuse replace Donabedian
- “To Err Is Human” : patient safety
- “Crossing the Quality Chasm”

# STEEEP

- Safe – avoiding injuries
- Timely – reduce waits and harmful delays
- Effective – based on scientific knowledge avoiding underuse and overuse
- Efficient – avoiding waste of equipment, supplies, ideas and energies
- Equitable – care that does not vary in quality because of gender, ethnicity, location and socio-economic status
- Patient-centered – respectful and responsive to patient preferences, needs and values

# *The Point of P4P*

- Propel change to more science, more safety, more patient-centeredness made known with more transparency
- By paying for results, processes and systems will be compelled to change by the application of purchasing power
- Faster than incremental change would produce

# *Typical Forms of P4P*

- Threshold bonuses: BTE
- Tiering bonuses: IHA, CFHCC
  - ◆ AGG's rule: Tiering always means a speculative return for the effort
- Cost savings against a benchmark with tiering: CMS
- The payment forms:
  - ◆ Physicians: Per patient payment; capitation enhancement; some admin burden reduction
  - ◆ Hospitals: 'Stipend' awards; shared bonus pool  
Administrative burden reduction

# *Additional Potpourri*

- Quality score card bonus – BC of CA
- Increased FFS with withhold based on HEDIS-type measures--Harvard Pilgrim to Partners
- Clinic incentive program to self report for 5 physician specialties 2 measurements per specialty on disease specific results in chronic care – BCBS MN
- Anthem Virginia cardiac care program has language in their contracts with hospitals

# *Existing Financial Incentives to Which These Are Add-Ons*

- FFS – over-utilization
- Aligned incentives: myth or method?
- Capitation; DRGs – under utilization
  - ◆ Withholds
  - ◆ Contact capitation – specialty focused pro rata piece
- Global capitation; percent of premium
- Case rates
- The problem with actuarial rates and quality

# *Existing Contract Provisions that Influence Quality*

- Credentialing and selected networks – “they’re baaack”
- What are they selecting for?
- Network configuration and access
- Record keeping and access to data
- Communication clauses: ‘gag’ clauses (did they ever exist?); anti-defamation league; business confidentiality

# *Medical Management Provisions*

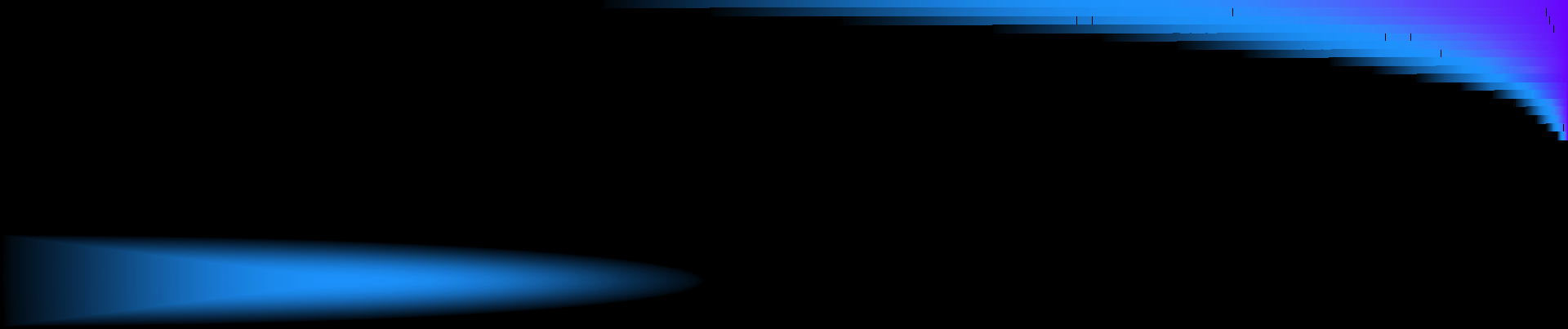
- Gatekeeping to ‘concierge care’
- Quality assurance/improvement: NCQA accreditation
- HEDIS is a bank shot medical management program
- Utilization management: 1-800-nurse-from-hell
- Subscriber grievance programs
- Formularies
- Disease management, demand management

# *P4P Pitfalls*

- You move up to the raised bar – then what?
- Where is the money coming from?
- There is no contractual obligation to pay
- These are add-ons to contracts that are inconsistent -- what about their UM?
- Margins, margins, margins
- Is a disease management program in play?
- Adverse selection
- The data is self-reported; are we getting what we want?

## *Is it so bold?*

- Rolling, piloting
- It can only be transitional at best
- But P4P at least recognizes that not everyone has to be paid the same way



“Every system is perfectly  
designed to achieve the  
results it gets.”

Donald Berwick, M.D.

- “The contemporary moment in health policy is nothing short of a Dionysian rhapsody of regulation, the inhospitality tradition gone riot, the formal and final enshrinement of the doctrine that everything that is not mandatory is prohibited.”

— ---James C. Robinson

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- Is there another way?.....

# *Today's Quality Context: Welcome to Wonderland*

- **Federal regulation of quality**
  - ◆ **PROs/QIOs; EMTALA; Conditions of participation for facilities; QISMC and QAPI in Medicare managed care; HCQIA**
- **Fraud and abuse based in quality: false claims (nursing homes first); exclusions (Tenet); civil money penalties; criminal-United Memorial Hospital**
- **OIG has 9 medical necessity issues and 3 pure quality in the 2004 work plan (see AGG Note)**

# *There is more: particularly for physicians*

- Malpractice crisis: defensive medicine AND cost pressures
- Rampant consumerism in DTC and Olympic caliber web surfing
- Hospital demands to help with their work and challenges if the physicians are businesslike
- Report cards that report on things they can't control

# *The New Values: EBM, CPGs and More*

- Systematic statements of evidence of the science
- Quality of the evidence versus consensus
- Some order is better than no order
- STEEEP values: Evidence-based medicine combined with patient-centeredness made known in transparency (report cards)

# *What are the essentials for quality?*

- Application of the science
- Time and touch with patients
- Engagement of the physicians that speaks to the way they treat and recognizes their central, plenary role (see Journal of Health Law article)

# *Escaping the Rabbit Hole: Five Principles*

- **Standardize**
- **Simplify**
- **Make Clinically Relevant**
- **Engage the Patients**
- **Fix Accountability at the Locus of Control**

# *Gosfield's Unified Field Theory in Practical Steps: Pay the Cost of a CPG*

- **Select a CPG: Better a national one**
- **Translate into applicable ICD-9 and CPT codes**
- **Note documentation standards: templates**
- **Document full pathway (not just physicians)**
- **Accommodate deviations**
- **Engage the patient**
- ***Price the services***
- **Measure compliance**
- **Analyze and refine**

# UFT-A and P4P Compared

	Tiered Q Bonus	Threshold Q Bonus	Lower Cost Bonus	Pay cost of doing CPG
Revenue to MD	↑	↑	?	↑ Underuse ↓ Overuse
Direct time costs	↑	↑	?	
Other direct costs	↑	↑	-	↓ Overuse ↑ Underuse
Margin	?	?	?	↑

- “The only progress we make in health care is the progress we make in medicine. In the daily chaos that is the US health care system there are but three elements that matter: patients, caregivers and medical technologies. Everything else is noise”.

- -- JD Kleinke

# Resources

- Gosfield, “Contracting for Provider Quality: Then, Now and P4P,” HEALTH LAW HANDBOOK, 2004 Ed., [www.gosfield.com/publications/ch3pdf.PDF](http://www.gosfield.com/publications/ch3pdf.PDF)
- Reinertsen, Finucane and Wallace, “Straight Talk from CEOs about Quality”, Ernst and Young White Paper (April, 2004) [www.uft-a.com/publications](http://www.uft-a.com/publications)
- Gosfield and Reinertsen, “Doing Well by Doing Good: Improving the Business Case for Quality”, (March, 2003) [www.uft-a.com](http://www.uft-a.com)

# More Resources

- Reinertsen, “Zen and The Art of Physician Autonomy Maintenance,” *Annals of Int. Med.* (June, 2003)  
<http://www.reinertsenengroup.com/PDF/zen.PDF>
- Gosfield, “The Doctor-Patient Relationship as The Business Case for Quality”, *Journal of Health Law* (forthcoming, spring, 2004)
- Gosfield, “The Quality/Compliance Nexus: Moving Toward Programmatic Integration”, *AGG Note*, (July 2003)  
[www.gosfield.com/notes/index.html](http://www.gosfield.com/notes/index.html)

## *More Resources*

- Gosfield and Reinertsen, “Paying Physicians for High Quality Care,” *New England Journal of Medicine*, (Jan 22, 2004), [www.uft-a.com/publications](http://www.uft-a.com/publications)