Pay for Performance: Trends in US Health Care

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December 2, 2015, Rio de Janeiro, Brazil

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In the US, Pay for Performance (P4P) evolved from 1990s managed care capitation arrangements

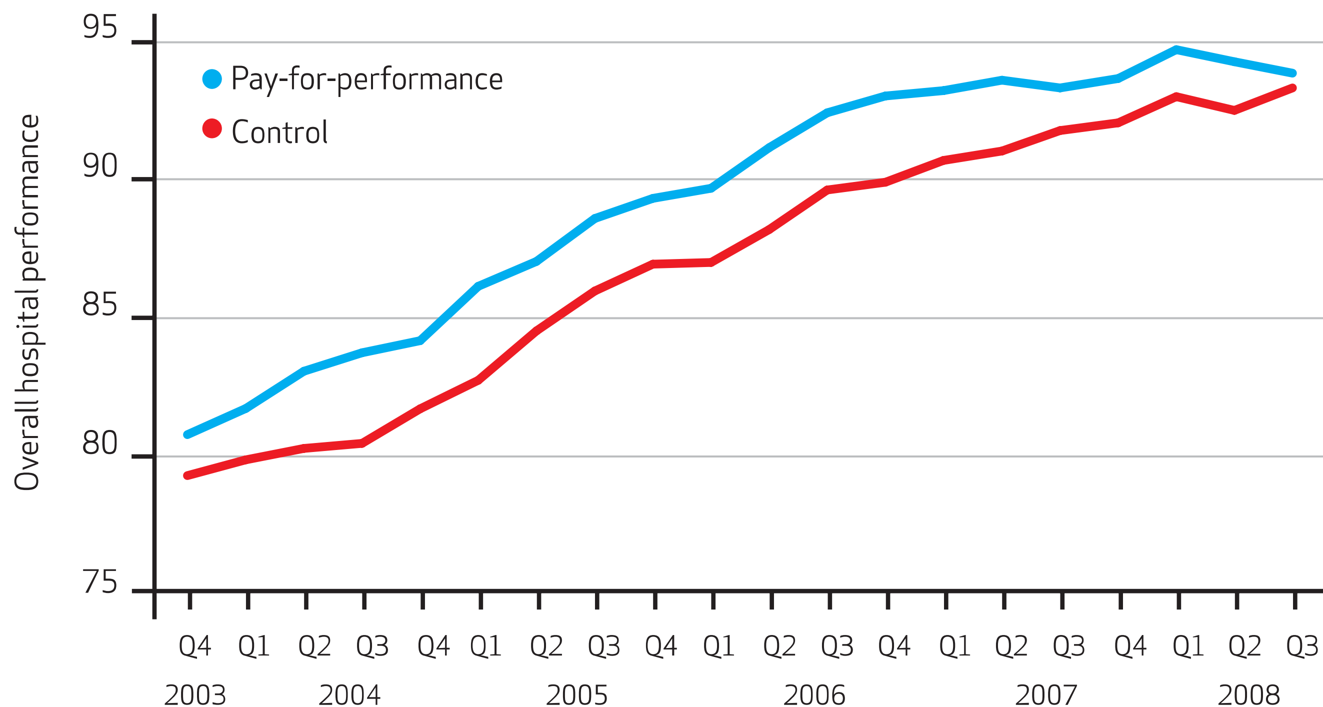
Capitation payments compensated physicians for treating a defined patient population

Capitation controlled costs but did not adjust for quality

New generation of P4P adjusting and experimenting with new approaches

Early trends suggested low P4P returns

Average Performance in P4P and Control Hospitals 2004-08



Patient experience survey results for AMI, heart failure, and pneumonia

Rachel M. Werner, Jonathan T. Kolstad, Elizabeth A. Stuart and Polsky. Effect Of Pay-For-Performance In Hospitals: Lessons For Quality Improvement *Health Affairs*, 30, no.4 (2011):690-698

Early studies showed P4P challenges

- Medicare Premier Quality Incentive showed no difference in mortality rates for AMI, congestive heart failure, pneumonia, and coronary artery bypass surgery from 2004 to 2009
- Massachusetts Medicaid hospital P4P had no improvement in its early years
- Study of Massachusetts physician organizations (POs) found improvement in all POs, regardless of P4P participation 2001-03

New P4P methods adopted in both the public and private sectors -- due to rising costs and faltering quality

US Pay for Performance in 2015

Process Measures	Assess activities that positively impact patient health Performance of steps that improve patient health
Outcome Measures	Effects of specific care on patients Collect and track patient status measures
Structure Measures	Incentives for technology adoption (EMR) Assesses features of delivery organizations and staff
Patient Experience	Patient perceptions of quality of care

Pay for Performance a central component of the 2010 Affordable Care Act (ACA) and its implementation

Health price inflation and low quality are driving interest in P4P

- Two Institute of Medicine studies complement other research showing unacceptable quality of care in the US
- Price inflation outstripping national inflation by a large margin (2% vs. 10%)
- Affordable Care Act (meant to address access, quality and cost containment

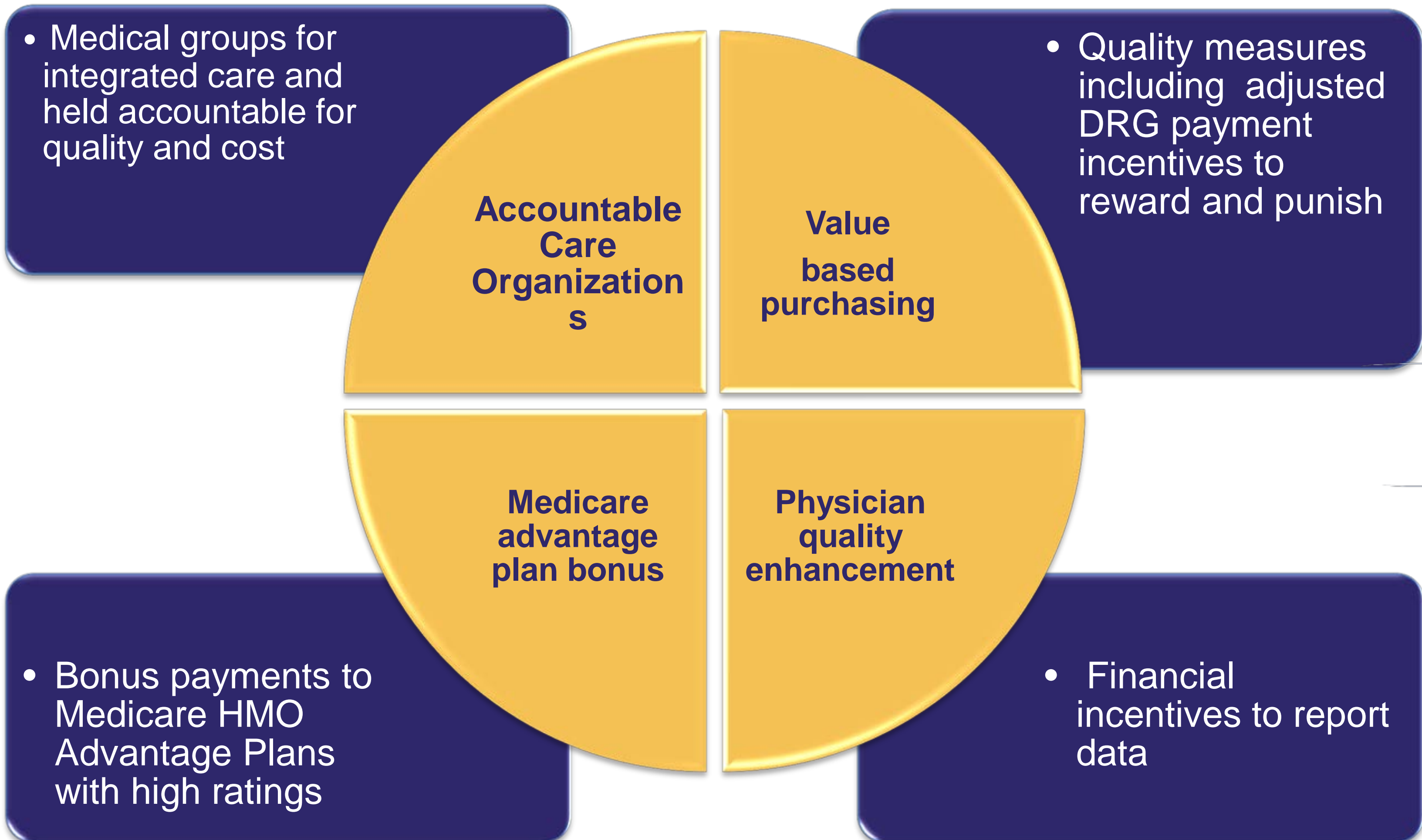
The ACA and public sector financing

- Medicare for the elderly - federal government
- Medicaid for the poor from federal/state funds
- Center for Medicare and Medicaid (CMS) manages both programs - responsible for ACA implementation
- States finance and design incentives
- Federal government and states finance over 50% of all health spending in the US

CMS P4P initiatives

- Affordable care organization (ACO) for integrated care -- accountable for quality and costs
- Value based purchasing rewards hospitals by their performance on set of quality measures and control of costs
- Incentive payments for physician reporting quality data and for adopting electronic medical records (EMR)
- Bonuses for Medicare Advantage Plans (HMOs) for quality

P4P Programs in the Affordable Care Act



CMS payment arrangements under ACA

Alternative Payment Models	**Accountable Care Organizations**
	Medical Homes
	Bundled Payments to include physicians and post-hospital care
	Comprehensive Primary Care and promoting integrated care models
Payment for Quality and Value	**Hospital Value Based Purchasing for quality and value**
	Physician Value Based Modifier for quality and value
	Readmissions/Hospital Acquired Infections penalties

Explicit goals for Medicare payment:

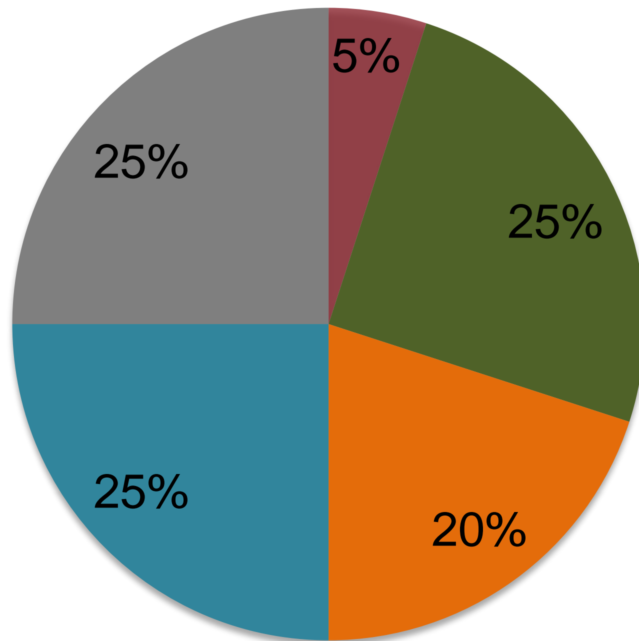
- **Alternative payment models**
  - 2016 - 30% of payments tied to quality or value
  - 2018 - 50% of payments tied to quality or value
- **DRG payments**
  - 2016 - 85% of payments tied to quality or value
  - 2018 - 90% of payments tied to quality or value
- **Physician payment modifier**
  - 2015 penalties begin

Accountable Care Organizations Characteristics

- Pioneer ACOS were designed for organizations with experience in coordinated care and ACO-like contracts
- Are held accountable for quality, costs and integration of care across providers
- 19 ACOs operating in 12 states

CMS hospital value based purchasing

CMS P4P scoring for FY17



- Clinical Care Process
- Clinical Care Outcomes
- Safety (Infection rates)
- Patient Experience
- Efficiency & Cost Reduction

Sample indicators

Flu immunization of patients and health workers

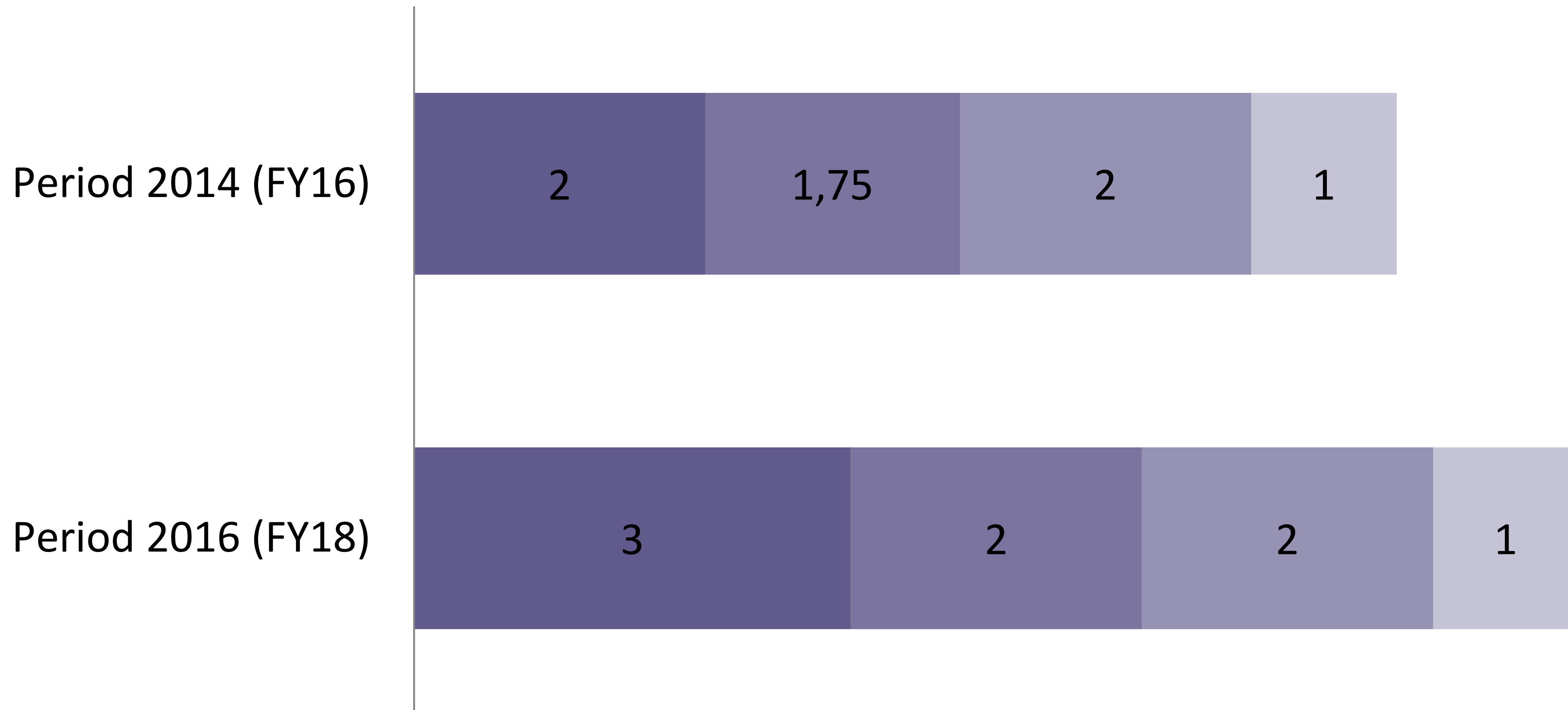
Heart Failure 30-Day Mortality Rate

Catheter Associated Urinary Tract Infection

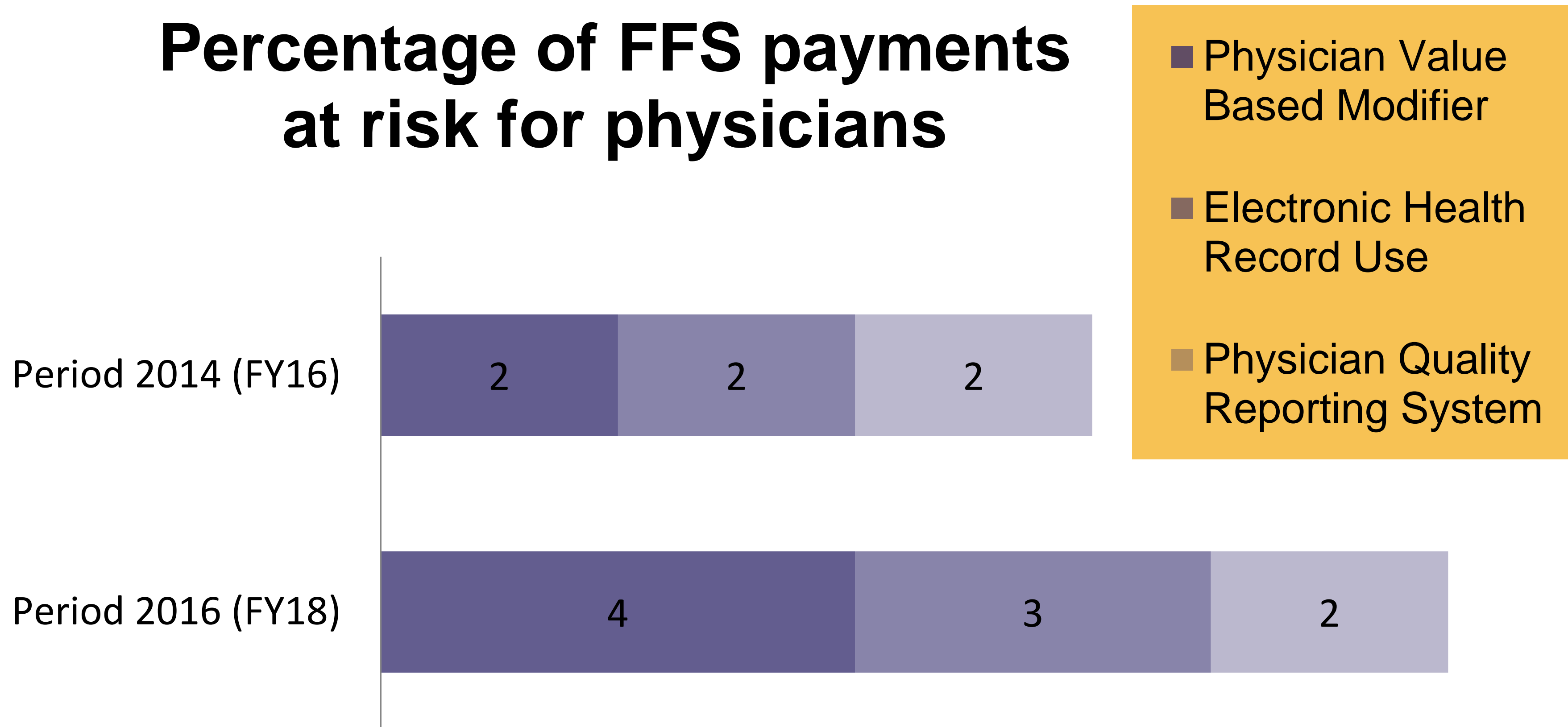
Communication with doctors

Medicare Spending/Beneficiary

CMS: DRG payments at risk (%)



CMS – Physician FFS Payments and Value

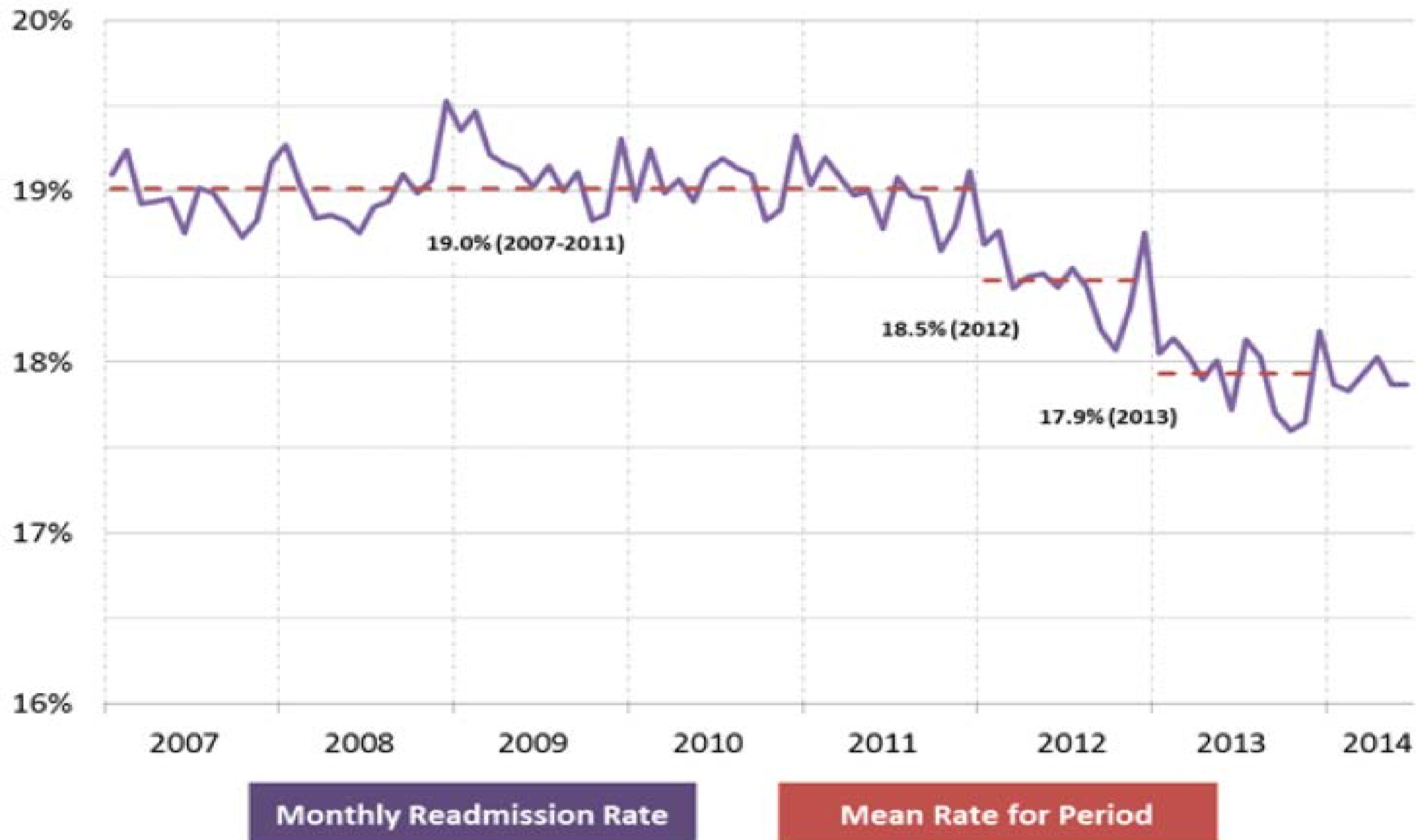


Preliminary impacts of CMS Pay for Performance initiatives

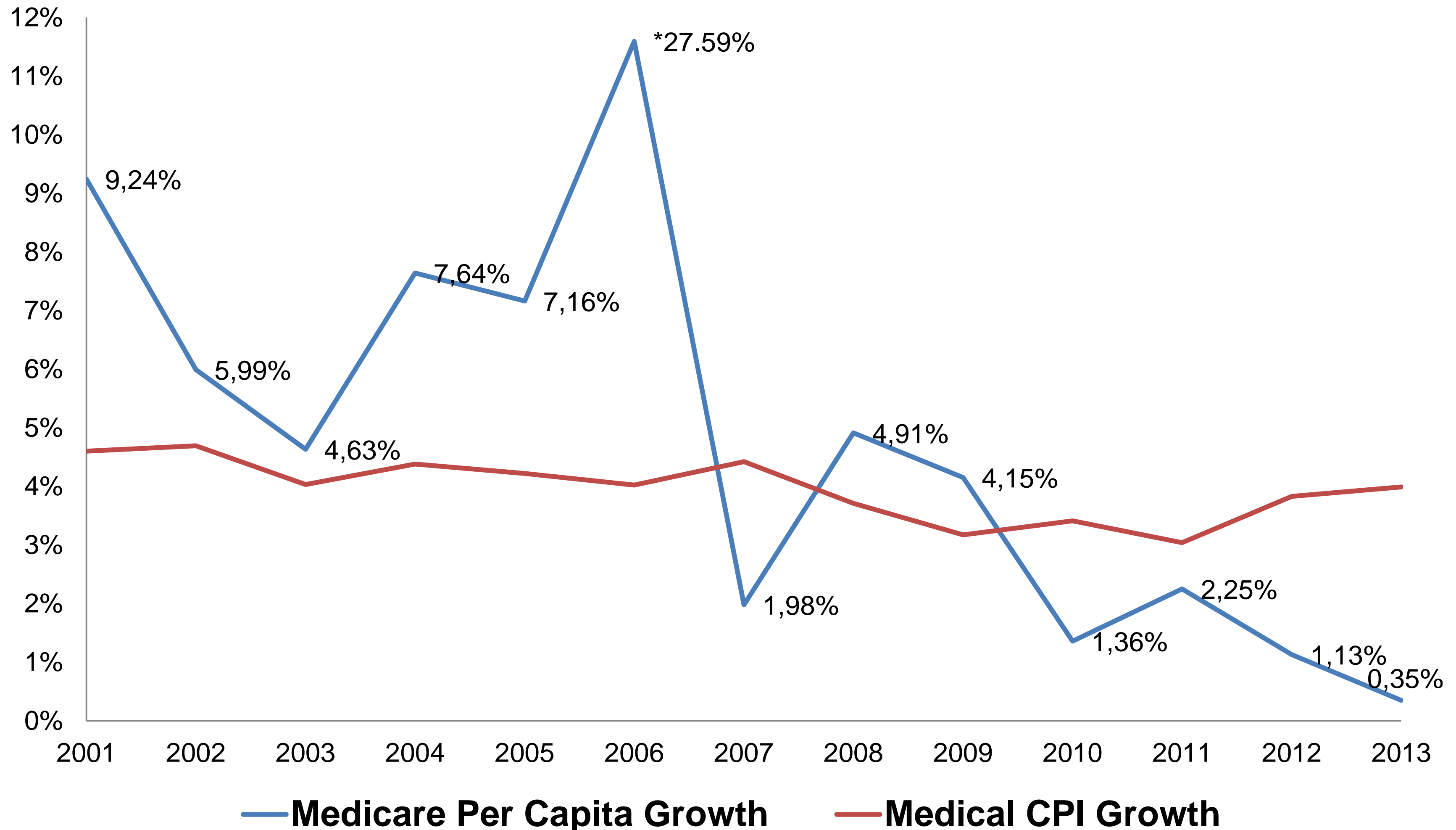
Pioneer ACOs showed big improved outcomes

- Quality outperformed published benchmarks in 15/15 clinical quality measures and 4/4 patient experience measures in year 1 and 2
- Mean quality score increased from 71.8% to 85.2% from 2012 to 2013
- Average performance score improved in 28 of 33 quality measure – or 85%
- $384 million in program savings over two years
- Average savings per ACO increased from $2.7 million to $4.2 million

Positive Medicare readmission trends

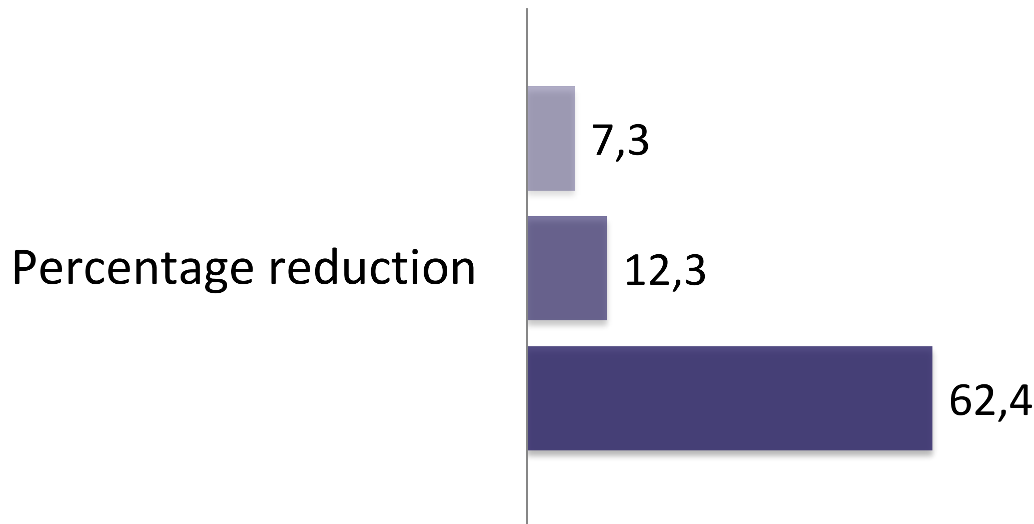


Declining per capita spending growth



Hospital acquired infection percent reduction 2010-2013

- Readmissions
- Central Line-Associated Blood Stream Infections
- Ventilator Associated Pneumonia



- 17% fall in hospital acquired infections
- 50,000 lives saved
- US$12 billion in savings

P4P embraced by the private non-profit sector -- over 40 groups incentivizing quality and cost-based assessments

Private and Non-Profit P4P experiments

California and Massachusetts good examples

California Integrated Healthcare Association – non-profit umbrella group for payers founded 2001, managing 8 private health plans, 200 Physician Organizations

Massachusetts Alternative Quality Contract – non-profit HMO initiative in 2009, 85% of primary care and 90% of specialist network physicians participate

California P4P – value based, cost sharing

- Shared savings model which holds Physician Organizations (POs) accountable for cost, cost trends, resources & quality of care
- Initially funded by California Healthcare Foundation in 2001

Quality Measures	Used to Build Quality Composite Score
	Clinical Quality, Utilizing Information Technology, Patient Experience
Cost Measures	Appropriate Resource Use – Example: Inpatient utilization/readmissions
	Total Cost of Care

California value based P4P

Determining PO Eligibility for Value based P4P → **Calculating Shared Savings**

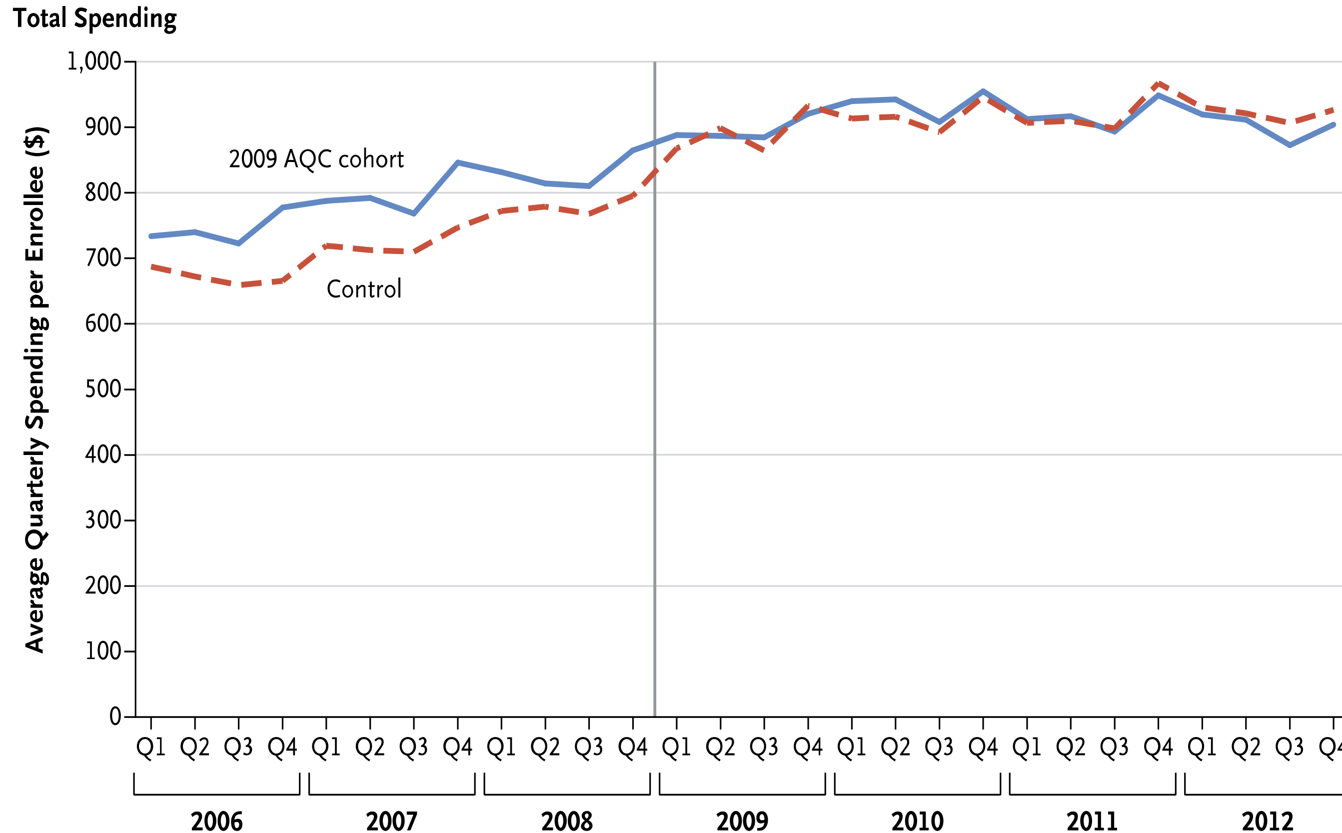
1. The PO's Quality Composite Score is either at the 75th percentile or improved by 10%
2. The POs Total Cost of Care trend is below Consumer Price Index (CPI) +3%
3. Calculate shared savings based on Appropriate Resources Use (ARU) measures
4. Calculate shared savings based on Quality Composite Score
5. Sum shared savings across ARU measures to determine incentive amount

- Blue Cross, non profit quality and cost control P4P - finances large physician groups, HMOs
- 700,000 patients
- Spending and clinical performance data shared with providers – payer supports provider planning and testing of alternative delivery
- Budgets based on historical provider spending
- Payer should participate in redesign and support
- Payers and providers share risk and rewards

Massachusetts Alternative Quality Contract

Global Budget	Defined annual budget for all physician groups. All medical expenses covered for enrollees
Performance	Incentives based on quality measures; performance determines share of profits or losses
Clinical Support	Physician groups have dedicated team from Blue Cross to generate performance data share, best practices across groups and drive innovation

AQC reduces average spending/enrollee



Massachusetts AQC costs fell relative to costs in eight Northeastern US states for commercially insured enrollees

Song Z, Rose S et al. Changes in Health Care Spending and Quality 4 Years into Global Payment, N Engl J Med 2014; 371:1704-1714 October 30, 2014

AQC improves outcomes, 2007-2012

Year	2009 AQC cohort	HEDIS national average	HEDIS New England area

Population Meeting Quality Performance (%)

100
90
80
70
60
50
40
30
20
10
0

2007
2008
2009
2010
2011
2012

2009 AQC cohort
HEDIS national average
HEDIS New England area

AQC enrollees had better outcomes on 5 measures of the Healthcare effectiveness data information (HEDIS)

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P4P shows promise but challenges remain – an ongoing learning process

Challenges in P4P

- Public reporting of hospital performance means non-P4P hospitals improve on their own – competition and reputation matter
- ACOs built on best performers. What of replication?
- Value Based Purchasing programs alter some payments by 1% - insufficient incentive to change behavior of many facilities/physicians
- P4Ps do not work for low income households or where staff outreach capacity is limited

Critical Issues

- Data essential and continuous
- Stakeholders must influence design and monitoring of P4P arrangements (AMA, Kaiser Permanente)
- Cost a new factor - reporting costs high, need technical & administrative skills
- P4P penalties may adversely impact care for low income groups: for hospitals with high readmissions and low scores losing 1% of funding could be catastrophic

Lessons

- Data essential and continuous
- Incentive design and measurement need to align with objectives and be meaningful measures
- Public reporting important
- Performance measures need to be measurable, fair and consistent
- “Pay” needs to reflect groups not just individuals

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Resources for P4P Measures

- The US Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality (AHRQ) produces healthcare evidence.

- AHRQ site - http://www.qualitymeasures.ahrq.gov/index.aspx publishes:

- ***Measures Inventory*** - Current, Past, and In Development Quality measures

- ***National Quality Measures Clearinghouse*** – Center for evidence based quality measure sets - clearinghouse smaller than the measures inventory

P4P Process Measures

- Performance of steps that improve patient health
- Well specified
- Easy, less costly than outcome measures
- Useful when sample sets are small
- Quality improvement easier to guide with process measures

P4P Outcome Measures

- Collect data on patient health status
  - Sample measures: mortality, blood pressure, lab results
- Best in programs with large number of patients
- Less controversial when outcomes guide investigation or how to change delivery
- Controversy - inferences from health status to quality are difficult

P4P Structure Measures

- Assess features of delivery organizations, capabilities of professionals and staff
- Policy environment in which health care is delivered
- Adoption and use of electronic medical records (EMRs)

P4P Patient Experience

- Comparable data on patient perspectives – allows comparisons between hospitals
- Publishing patient perceptions provides incentives for hospitals to raise quality as perceived by patients
- Involves patients in improving their health status