

HS&S Strategy OUTLOOK

Summer 2005 Volume Eight, Number Three

P4P – A Viable Approach for Improving Quality and Containing Costs?

Rapidly growing costs are devouring an ever-increasing share of the Gross Domestic Product, while large employers, health plans, consumers, and government agencies are demanding more formalized approaches for addressing uneven health care quality, patient safety concerns, and medical errors. These factors are converging to encourage a payment structure that will directly link health care reimbursement with quality through pay-for-performance systems (P4Ps).

P4P has the potential to have a vast, transformational effect on the health care delivery system. Providers whose incomes have typically depended on locally negotiated rates based on the volume of patients seen and the complexity of services, rather than the quality of the care provided, should brace themselves for the reality that P4P is unlikely to be a passing fad, although it undoubtedly will evolve and mature as incentive-based reimbursement systems are researched and refined. For payors and consumers, P4P is the latest salvo for keeping escalating health care costs in check and ensuring better health care quality, although it is much too early to predict the likelihood that P4P will live up to its promises.

What is P4P?

P4P is a reimbursement approach in which providers are paid financial incentives to achieve defined quality standards. P4P programs are intended to use incentives to encourage the use of evidence-based practices to produce better medical outcomes. Under the current reimbursement system, no direct financial incentives exist to encourage providers to follow clinical guidelines, and the system



fails to reward provision of preventive services and chronic care management.

In 2003, less than 40 P4P programs existed throughout the country. Today, according to a data presented at a recent pay-for-performance seminar sponsored by the Jefferson Medical College Department of Health Policy, there are approximately 85 P4P programs, with projections that more than 150 P4P programs will be in place by 2006. The commercial sector in particular is inundated with P4P programs. Blue Cross Blue Shield has 17 plans in 34 states, with 80 percent of the 93 million Blue Cross Blue Shield members reportedly participating in P4P plans.

Setting the stage for the current development of P4P programs are two notable studies that have focused attention on medical errors and quality gaps. The 2001 Institute of Medicine (IOM) report *Crossing the Quality Chasm* estimated 98,000 preventable deaths due to medical errors annually. A more recent study by HealthGrades doubled the IOM's mortality figures and calculated that the U.S. health care industry spent an extra \$19 million on preventable incidents between 2000 and 2002. These studies, as well as others, have contributed to the prevailing attitude among government agencies, consumers, employers, and payors that the health industry must recognize and reward providers whose health care services are distinguished by high levels of safety, quality, and value.

What Does P4P Look Like in Hospitals?

Most of the early P4P efforts have been targeted at hospitals. In the largest trial of P4P programs, beginning in 2003, Medicare measured hospital compliance with numerous best practices for 34 processes and outcomes for conditions such as pneumonia, heart attacks, coronary bypass operations, and joint replacement surgery. The P4P trial, a three-year demonstration project to determine the effects of P4P on quality of care, has been coordinated by Premier, a consortium of nonprofit hospitals. The program began in October 2003, with 272 hospitals and health care facilities throughout the country. There are risks and rewards for participation in this Medicare P4P experiment. Hospitals scoring in the top 10 percent in quality

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ratings for each condition are reimbursed an extra 2 percent per case. Those in the next 10 percent receive an additional 1 percent. Hospitals that fail to improve from the bottom 20 percent will have payments reduced up to 2 percent during the trial.

For organizations participating in the Premier P4P trial, the impact on quality of care has been remarkable. In the first nine months of the program, the median score for the quality of care for all conditions at all facilities participating in the trial improved by 6 percent, with the most noteworthy improvements in care provided to heart failure and pneumonia patients.

One striking P4P development occurred at Hackensack University Medical Center in New Jersey. The medical center scored highly on Medicare's 100-point quality of care scale in all areas except orthopedics. Further evaluation determined that physicians had neglected to cut off antibiotics within 24 hours of surgery, leaving patients vulnerable to infections and life-threatening diarrhea. Once physicians agreed to new care guidelines, Hackensack was able to pull its orthopedics score into the top 10 percent within a year, after initially failing to rank in the top 30 percent.

P4P for Physicians and Others

In addition to P4P programs for hospitals, Medicare has other P4P initiatives underway in an effort to enhance quality of care and maintain or reduce the overall costs of health care in physician offices, ambulatory care facilities, nursing homes, home health care agencies, and dialysis facilities. Three Medicare P4P initiatives target physician practices: the Physician Group Practice Demonstration, the Medicare Care Management Performance

Demonstration, and the Medicare Health Care Quality Demonstration.

- **The Physician Group Practice Demonstration** represents the first pay-for-performance initiative for physicians under the Medicare program. Ten large physician practices (200+ physicians) are participating in the demonstration in which practices receive performance-based incentive payments if they achieve savings in comparison to a control group.
- **The Medicare Care Management Performance Demonstration** is a three-year demonstration project with physicians in small- and medium-sized practices that focuses on using health information technology to improve the quality of care for chronically ill Medicare patients.
- **The Medicare Health Care Quality Demonstration** is a five-year demonstration program for physician practices or integrated health systems, which will focus on improving patient safety to enhance the quality of care provided.

Are Commercial Payors on Board with P4P?

Most commercial, nongovernment payors are engaged in the P4P discussion. Some commercial payors instituted P4P programs before the Medicare Demonstration Project, with the momentum creating the flood of P4P programs in the private sector today and projected for the future. Empire Blue Cross Blue Shield paid 29 hospitals in Manhattan and eastern New York \$195,000 in 2003 for adopting the quality measures outlined by the Leapfrog Group.

Another example, California's Integrated Health Association (IHA) pay-for-performance system, is notable for its comprehensiveness. The IHA, comprised of health systems, physicians groups, health plans, hospitals and systems, and representatives from academia, the business sector, and the consumer population, developed clinical guidelines to reward physicians for achieving quality targets. Initiated in 2003 in collaboration with California's six largest insurers, IHA's P4P program included seven million commercial HMO members, 215 medical groups, and 45,000 physicians. An estimated \$50 million

was paid to California physician groups as a reward for performance in the program's first year, and substantial improvements in patient care were apparent: 150,000 more cervical cancer screenings, 35,000 more breast cancer screenings, 18,000 more diabetes tests, and an additional 10,000 children received needed immunizations.

The Physician Perspective

The American College of Physicians has commented "For physicians, it is no longer a question of whether they will be asked to participate in such programs, but when and how many." According to the American College of Physicians, the physician community would prefer to take an evidence-based approach to selecting the appropriate P4P programs.

In 2004, a nationwide coalition of large employers, public and private payors, and physician groups formed the Ambulatory Care Quality Alliance (ACQA) to formulate evidence-based guidelines for nationwide ambulatory care measurement and reporting. ACQA hopes to announce a starter set of ambulatory care performance measures shortly, in time for use in January 2006 contracts. But the P4P revolution is well underway. Consumers and payors, have forged ahead with P4P systems and are already using many measures under ACQA consideration; however, ACQA measures that have been reviewed by the medical community are generally seen as a positive approach for getting physicians on board with the P4P programs.

And What Do Consumers Think?

A recent national poll by American Healthways looked at physician pay-for-performance. The survey of 1,223 adults with health insurance found that 70 percent of respondents do not believe physician bonus programs would result in better quality care, although 80 percent of respondents would like to see quality ratings of physicians in their community. The most frequent reason given by consumers for not supporting physician pay incentives was the perception that physician incomes are already substantial. Also, consumers believe that the Hippocratic Oath requires that physicians deliver quality care, and that physicians should not have to be persuaded to do so with bonus pay.

The Challenges Ahead

P4P systems present a host of complex challenges. Getting buy-in from multiple stakeholders and agreement on what



quality is will require considerable effort. Physicians are beginning to realize the inevitability of P4P systems, but some remain cautious and skeptical since evidence-based quality has been difficult to define and measure. In addition, physician leadership may be lacking. IT structures that are unable to provide needed data and make reporting cumbersome present one of the largest obstacles to P4P systems.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently developed some guiding P4P principles for health care providers and payors, including the following:

- Programs should be designed to ensure that metrics upon which incentive payments are based are credible, valid, and reliable.
- Quality-related program goals should be transparent, explicit, and measurable.
- Metrics should be evidence-based or, in the absence of strong science, be based on expert consensus.
- Metrics should also be standardized, risk-adjusted where appropriate, and have broad acceptance in the provider and professional communities.
- Credible and affordable mechanisms to audit data and verify performance must be developed and implemented.
- The measurement set should be constructed to fulfill program objectives with the minimum amount of measurement burden needed.

- Programs must be designed to acknowledge the united approach necessary to effect significant change, and the reality that the provision of safe, high-quality care is a shared responsibility between provider organizations and health care professionals.
- Incentive payments should recognize systemic drivers of quality in units broader than individual provider organizations and practitioner groups and encourage improvement at these aggregate levels.
- Incentive programs should support team approaches to the provision of health care, as well as integration of services, overall management of disease, and continuity of care.
- Incentive programs should encourage strong alignment between practitioner and provider organization goals, while also recognizing and rewarding the respective contributions of each to overall performance.

For providers evaluating the possibility of developing their own P4P program other considerations emerge. Do the metrics represent one-time measures or moving targets? How are payments made to providers by payors? How often are they paid? What is the amount of payment? Are they a percentage of technical or professional fees or absolute amounts? Are they paid to individuals or a group of

providers (e.g., a large physician practice)? And most importantly, how are the effects of P4P monitored and demonstrated? In other words, how is evidence gathered to evaluate efficacy?

Looking Ahead

P4P programs that try to incorporate the JCAHO principles and address the questions noted above face significant obstacles that highlight the nascent state of P4P systems and the long road ahead as these programs evolve and mature. But the forces driving the move toward financial incentives show no signs of abating, and alternative reimbursement systems—health care rationing or draconian reimbursement cuts—are not palatable either. The door to a future with greater accountability and performance tracking for health care providers has been opened, and with or without financial incentives, providers cannot shut the door on the fact that clinical outcomes will be one of the key measures of high-performing health care organizations.

Craig E. Holm, CHE, CHC, is a senior vice president of Health Strategies & Solutions, Inc., and is a leading expert on physician-hospital affiliations. His second book, *Allies or Adversaries: Revitalizing the Medical Staff Organization*, was published in 2004 by Health Administration Press.



On the Dais

Upcoming Presentations

American College of Healthcare Executives

Craig Holm and Rick Afable: "Building Effective Medical Staff Relationships," October 26-December 7

American College of Healthcare Executives

Alan Zuckerman: "Strategic Planning from Formulation to Action," November 14-15 in San Antonio

Carolinas Society for Healthcare Planning and Marketing

Christie Markham: "Impact of Clinical Technology Innovations on Service Line Growth," November 16 in Asheville, NC

Off the Press

Recent Articles

"Profitable Joint Ventures: A Real Life Approach" by Craig Holm and Alan Zuckerman, July issue of *Managing the Margin*

"Strategic Alliances and Joint Ventures: Why Make When You Can Buy?" by Alan Zuckerman, August issue of *Healthcare Financial Management*

"Strategic Planning for Financial Turnaround" by Alan Zuckerman, September/October issue of *Health Progress*

Copies of all HS&S articles are available on our website at <http://www.hss-inc.com/4-3-articles.htm>

Shraddha Patel and Anna Schoenthal Promoted to Consultant Positions

Health Strategies & Solutions is pleased to announce the promotions of two of our staff analysts to consultant positions. Shraddha Patel joined HS&S in 2003. She conducts the quantitative analyses that support strategic planning, service line planning, and medical staff development engagements for HS&S clients, including financial and market analyses, feasibility studies, and environmental assessments. Prior to



Shraddha Patel



Anna Schoenthal

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Promotions continued

joining HS&S, Shraddha held positions with the Chestnut Hill Pediatric Group and the Surgical Center of York. She has a bachelor's degree from Penn State University, and is currently working on a master's degree in health care management and health care financial management at Temple University. Shraddha is a member of the American College of Healthcare Executives.

Anna Schoenthal joined HS&S in 2003. Experienced with both quantitative and qualitative research and survey management, she supports HS&S clients with expert analyses of complex projects, including strategic and clinical program planning, demand forecasting, and master facility planning engagements. Anna previously served as an administrative resident and interim director at AtlantiCare Health System in southern New Jersey. She has an M.B.A./M.S. in health care management and health care financial management from Temple University and a bachelor's degree (cum laude) from Saint Joseph's University. Anna is a member of the American College of Healthcare Executives, Greater Philadelphia Health Assembly, and the Healthcare Planning and Marketing Society of New Jersey.



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