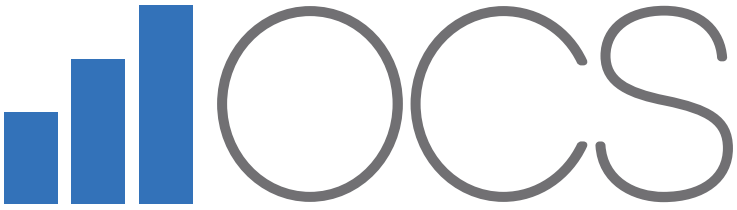
Considerations in Value-based Purchasing

Authors:
Amanda Twiss, President and CEO, OCS, Inc.
Tina Schwien, MN, MPH, OCS, Inc.



ELEVATING HEALTHCARE INTELLIGENCE

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Efforts to Align Payment With Quality

Compared to other industrialized nations, the United States spends a much higher percentage of its GNP (16%) on healthcare expenses without the benefit of experiencing higher overall quality outcomes. In 2006 alone, it is estimated that a total of $2,105 billion was spent on healthcare in the United States. With the growing number of individuals over 65, this figure is expected to balloon to $4,007 billion by 2016.

For over a decade, concern over growing healthcare expenditures has encouraged many healthcare purchasers to look for ways to contain costs - often through the implementation of utilization constraints and encouraging delivery of care in lower-cost settings by less expensive providers. Such measures have failed to have a demonstrable effect on overall health expenditures while raising concern about overall quality.

It is this concern about quality in the face of ballooning healthcare expenses in the U.S. that has prompted researchers and policy-makers alike to question whether our healthcare payment system may be "broken" – that is, whether it rewards utilization regardless of quality outcomes. This concern, in turn, has prompted a growing movement among both private and public healthcare purchasers to better align the level of provider payment with the quality of care delivered.

P4P Initiatives Are Increasingly Prevalent

Initiatives to pursue quality-based purchasing have come to be commonly referred to as pay-for-performance (P4P) initiatives, or, in more recent parlance as pay-for-value (P4V). With the endorsement of high-profile organizations, like the Institute of Medicine (IOM), the evolution of quality measures, and the support of large healthcare purchasers such as The Centers for Medicare and Medicaid (CMS), a variety of payors have begun implementing P4P initiatives in different healthcare settings.

According to a 2006 survey, 28 states had already adopted some type of P4P program in their Medicaid programs – half having been in existence for five or more years. In a separate survey from 2004/2005, researchers found that 28% of primary care physicians in group practices reported that P4P financial incentives were incorporated into their compensation arrangements. Other systematic surveys have found that more than half of the health plans in randomly selected healthcare markets had P4P initiatives.

While increasingly prevalent, it is important to remember that while many large health plans may have P4P initiatives, these programs often apply to only a subset of contracting provider groups and that individual providers are not always aware of the P4P incentives in their contracts. In fact, discussions of P4P programs often focus on a handful of ambitious efforts, some of which are outlined below in Table 1.

Table 1

P4P Initiative	Practice Setting	Form of Financial Incentive
Integrated Healthcare Association (IHA)	Physicians in group practice in California	Bonus payments determined independently by each participating payor
Bridges to Excellence	Physicians and group practices across the U.S.	Bonus payment per patient from diagnosis groups for which achieved higher quality than peers
CMS/Premier Hospital Quality Incentive Demonstration	Not-for-profit hospitals across the U.S.	Bonus payment in form of increase reimbursement diagnosis groups for which achieved higher quality than peers
CMS Home Health P4P Demonstration	Home healthcare	Bonus payment for better quality or improvement than peers on select outcome measures

Measuring Quality Performance

Measuring quality is inherently challenging given the abstract nature of the concept and the fact that it has multiple meanings depending on setting and audience. Despite this challenge, in today's environment, each P4P initiative establishes its own system for measuring and rewarding quality performance. In general, providers are evaluated on whether they exceed thresholds for specific quality measures or how they rank compared to their peers. Depending on the initiative, providers are either incentivized to perform well in order to receive financial reward or to avoid financial punishment in the form of reduced payment.

The quality measures incorporated into P4P initiatives, as one might expect, depend on what is deemed most meaningful to the practice setting in question and what data is actually available for measurement without too much additional burden. Such quality measures are often grouped into one of three categories: process measures, outcome measures and patient satisfaction measures.

Process measures

Typically based on evidenced-based medicine, these indicate that a provider did the right thing at the right time to the right person. For example, a hospital or emergency room physician may be judged on what percentage of their patients presenting with acute myocardial infarction received aspirin upon admit. Different process measures apply to different groups of patients – you would be less concerned whether a patient presenting with an asthma attack was given aspirin as you would be for patient present with chest pain. Similarly, different process measures apply to different provider types. You would not expect a thoracic surgeon and a family physician to be judged on the same measures.

Challenge: The magnitude of the diversity in process measures can present a challenge within P4P systems in terms of tracking, grouping, and efficiently determining and disseminating financial incentives. Similarly, providers worry that they will be "punished" when they deviate from standard practice to meet the individual needs of a patient.

Outcome measures

These reflect how a patient clinical status has changed over time while receiving care from a provider rather than what the provider actually implemented during this care. Outcome measures often involve comparing a patient's clinical status at two points in time. In the home health setting, outcome measures, such as improvement in pain, can be derived by comparing a patient's level of pain at start of care to his/her level of pain at end of care. Whether a patient "got better," some argue, is more important than what the provider did to get the patient there. Others suggest, that process measures are a fairer manner by which to evaluate provider performance as they reflect on clinical practices that the provider can actually control.

Challenge: Providers who care for more clinically complicated patients worry that they will have a hard time scoring well on quality measures based on patient outcomes. While in theory, quality measures or composites can be adjusted to account for these differences in patient mix, in reality, the methods available may not lend themselves to the P4P programs, be acceptable to providers, or adequately "level the playing field."

Patient satisfaction measures

Also used to evaluate the quality of provider performance. These measures indicate whether the patient was satisfied with the care they received regardless of their clinical outcome or the clinical practice of their provider. Rather, they indicate such things as whether a patient was confident with the provider's skill, if they felt their wishes were respected, and if they would recommend this provider to friends and family. Proponents of satisfaction measures suggest that at the end of the day, if the patient is happy with their healthcare experience that suggests they received patient-centered care and a boost to their quality of life.

Challenge: Based on perception, patient satisfaction measures, by their very nature, are subjective and are perhaps more difficult to measure and target for performance improvement as compared to a more objective process or outcome measure. In a way, they are an attempt to measure a subjective concept (quality) with a subjective measure (satisfaction). Unlike process and outcome measures which are often based on claims data or existing documentation, satisfaction measures rely on patient feedback, typically in the form of surveys, which adds an additional data collection and processing burden accompanied by risk for low response rate.

Composite measures

Many agree that quality of patient care is not a one-dimensional concept that can be assessed by a single measure or group of single measures reported separately. To deal with this challenge, many P4P initiatives incorporate composite scoring to roll-up the measurement of multiple dimensions of quality. For example, the CMS/Premier Demonstration Project, underway since 2003, employs a composite methodology that combines both process and outcome measures for specific patient subsets based on diagnosis seen at the hospital by using

information obtained from hospital information systems and patient medical records.

Challenge: While composite measures provide summary scores which are easier to talk about at a global level with multiple audiences (consumers, payors, and providers) pave the way for easier manipulation in managing a financial incentive system, they are not without their challenges as well. In particular, the methodology for getting to a summary composite score, especially one that combines process, outcome, and satisfaction measures, can be very complicated.

P4P in Home Care Appears Inevitable

Given a growing patient population of Medicare beneficiaries and the introduction of outcome-based quality indicators and public reporting within home health setting, it is not surprising that CMS has implemented a Home Health P4P Initiative. Medicare is the primary payor of the majority of patients receiving home healthcare and with the projected growth in the number and percentage of individuals 65 and older with chronic conditions, Medicare is motivated to find ways to reward providers that help patients achieve high quality outcomes and in so doing hopefully reduce overall expenditures.

With the widespread use of standardized data collection, initiated in the 1990s as part of the CMS Quality Initiative, home healthcare is already ahead of the curve in overcoming the challenge faced by many healthcare settings – that of acquiring relevant performance data by which to develop and maintain a P4P system. Designed to objectively measure patients' home health outcomes, assess organizations' quality of patient care and used to determine prospective payment for Medicare patients, the Outcome and Assessment Information Set (OASIS) has been widely adopted as a standard of practice by home health agencies for nearly a decade. Furthermore, the quality outcomes based on OASIS data in home health have the added advantage of incorporating risk-adjustment – a subset of which are already available for public consumption on the CMS Home Health Compare web site.

Finally, part of the widely accepted benefit of home care services is the notion that home care can provide high quality care in a lower cost setting, as compared to hospitals and other institutional settings. As these other settings are increasingly evaluated (and reimbursed) based on the quality of the care they provide, there will be a movement to incorporate a broader view of the patients they serve – i.e., what are the outcomes and quality measures for patients post-discharge. Thus, in the case of Home Health P4P (described below), CMS will be evaluating the impact of home health services within the context of overall Medicare expenditures.

Home Health P4P Demonstration

The presence of standardized data, established risk adjusted outcome measures and a culture that already compares performance has paved the way for the implementation of a CMS sponsored Home Health P4P Demonstration. Begun in January of 2008, the goal of this demonstration is to test whether a specific approach to comparing home health agencies' performance, identifying high performers, and the prospect for financial reward will actually result in cost savings for Medicare that can then be shared with participants.

In a nutshell, participant agencies are randomly assigned to a treatment or control group. The treatment group will be "eligible" to receive additional payments based on the assessment of their patients' outcomes relative to their peers. However, they will only receive a bonus payment if the demonstration results in Medicare cost savings for patients in their region. Specifically, participant agencies will be ranked on seven (7) different risk adjusted outcome measures derived from OASIS data.

Agencies are deemed eligible for financial reward if they score in the 80th percentile of a particular measure. Agencies that are not eligible based on this comparative threshold but are above the 30th percentile for the measure and show an improvement in that measure will also be eligible for financial reward.

It is anticipated by CMS that participating agencies will not receive notification of eligibility until 3 to 6 months after each performance period – end of full year 2008 and end of full year 2009. Further, incentive payments may not be available (assuming the demonstration shows cost savings) until 9 months to 1 year after the end of each performance period. An evaluation of the impact of P4P on potential cost savings will then follow.

While it will be a number of years before the Home Health P4P Demonstration is completed, assuming it provides evidence that incentivizing quality is associated with overall cost savings for Medicare, it seems reasonable to believe that lawmakers will be motivated to implement a tested P4P approach in home health to help off-set expected ballooning Medicare expenditures.

Moving Forward with P4P in Home Care

Transitioning from demonstration to full implementation

The underlying dataset that forms the basis for measurement and, therefore, payment is at the heart of all P4P initiatives. At present, the OASIS is the core dataset for the Home Health P4P demonstration. Though many argue that the OASIS dataset has limitations, it is at least as robust as any publicly available dataset in the healthcare industry and has the advantage of being integrated into daily operations of home health providers as well as being tested out in the current P4P demonstration. Thus it will likely serve as the basis of any P4P program implemented by Medicare in the home care industry following the demonstration.

Agreement on risk adjustment.

Beyond establishing a core dataset, adjusting for the varying levels of severity in the patient population is an important step in the structuring of a P4P program. Every healthcare sector has its version of the "my-patients-are-sicker" argument, especially when payment is at stake. In home health, it will be important for policy-makers to debate whether the current risk adjustment methodologies included in the P4P Demonstration are appropriate and adequate to address this important point and, if not, to debate designing and incorporating an alternative. Although the current risk adjustment methodologies for home health outcomes have been widely accepted for use in Home Health Compare and in OBQI reporting, policy-makers will want to revisit whether stratifying or creating patient groupings based on common conditions better lends itself in a P4P system where desired outcomes for one patient group

may be different from another.

For example, perhaps it may make sense to segment congestive heart failure patients (CHF) in a different comparative group from post-surgical orthopedic patients. Aside from the fact that most existing P4P models in the physician and hospital markets segment patients in this manner, the underlying population, goals for treatment and likelihood of improvement for these population groups in home health vary considerably.

Rewarding overall quality or organizational improvement

As P4P programs are introduced into different healthcare segments, an important consideration relates to what should be rewarded—attainment of quality, or quality improvement. One school of thought suggests that organizations which have made the necessary investment in quality and have had consistently high quality scores provide the most value to patients and should, therefore, be rewarded. Another approach is to focus on rewarding improvement efforts for those organizations that have the most room for improvement. In the latter approach, it is possible that an organization with lower quality scores would receive more "reward" than one with consistently high scores.

This issue has been hotly debated in every healthcare sector. Often higher quality scores are associated with an underlying patient population with more resources and access to care. A potential approach is to create some type of composite score—with elements of both improvement and achievement in the measurement.

In the current Home Health P4P Demonstration, providers are eligible to receive a financial reward either by demonstrating overall quality or quality improvement. As policy-makers evaluate the current demonstration and fine-tune a P4P program to be implemented across the home care industry, they will revisit the merits of this approach. Does rewarding both dilute the cost-saving pool to such a degree that it results in financial rewards that are too small to provide incentive? Is there a way to create a composite score that incorporates both or does one approach better align with CMS' vision on how to affect the greatest overall improvement in patient outcomes?

Moving beyond outcome measures

At present, the Home Health P4P Demonstration evaluates provider performance based on quality outcome measures alone. Yet many argue that process measures and/or patient satisfaction measures should be included as they measure different aspects of quality care. Although data to compute process measures and patient satisfaction measures are not currently collected in a standard fashion among home health providers, unlike outcome data, it is within the realm of possibility that such data may be required to participate in a future P4P program implemented in home health given that the IOM has recommended that P4P programs reward clinical quality (outcomes) as well as healthcare that is patient-centered (satisfaction) and efficient (process). Furthermore, policy-makers will likely look to what is being measured in other health settings (e.g. process measures in hospital setting) and debate how that might translate in home health.

Learning from other initiatives

While the home care industry must wait several years to evaluate the merits of the

current Home Health P4P Demonstration, the industry can look to what has been learned thus far from other ambitious P4P initiatives – namely, Integrated Healthcare Association, Bridges to Excellence, and the CMS/Premier Hospital Quality Incentive Demonstration. Based on the results published by these three initiatives, average quality scores for participating providers have consistently improved suggesting P4P programs can foster continued quality improvement. In addition, those programs have reported cost-savings, suggesting high quality need not be dependent on high cost care. These findings bode well for the home care industry.

Similarly, the current Home Health P4P Demonstration contains some of the elements that have been reported as being important for the success of the Bridges to Excellence and IHA P4P programs. First, the Home Health P4P Demonstration uses standard performance measures. Second, it aids providers in determining whether to participate or not by clearly defining the costs and benefits of participation. Third, the demonstration uses a third-party to implement and measure performance.

Missing from the demonstration, however, are specific incentives to adopt better systems of care, to include health information technology, which has been deemed as a critical element in successful P4P programs targeted at physicians. Further it remains to be seen what the size of financial reward will be for home health providers participating in P4P. This is important as successful programs have noted that size of incentive has a relationship to a provider's decision to participate in care process improvement. Finally, the Home Health P4P demonstration is also different from other P4P programs in that it represents an effort by a single payor (Medicare) rather than an effort driven by multiple stakeholders that include a variety of payors and healthcare purchasers. The degree to which this will impact the final structure of a P4P program in home health or the interest providers have in participating remains to be seen.

Summary

In healthcare (and in life) reimbursement drives behavioral change. If providers are reimbursed based on the quantity of services provided, it is likely that the quantity of services will increase. Likewise, as payment shifts towards reimbursement based on quality or value – then those metrics will be more closely evaluated and managed. The current Home Health P4P Demonstration gives the home care industry a good idea of the baseline metrics that will likely be included in any P4P program to be broadly implemented across home care in the future. What remains to be seen, however, is whether the methodology and structure of the demonstration will be associated with real cost savings, and, if so, what magnitude of savings. These findings will surely impact the degree to which the current methodology and structure will be adjusted or revised prior to seeking full implementation. Until such findings are revealed, one can be sure, savvy home care providers will be focusing on how to get a handle on what patient populations drive their performance on the risk-adjusted outcome measures included in the current P4P demonstration and exploring approaches in care to achieve continued improvement.

Contact Us

Address: 1818 E Mercer Street
Seattle, WA 98112
Email: info@ocsys.com
Website: www.ocsys.com
Tel: 888.325.3396
Fax: 206.720.6018

Resources

The Robert Wood Johnson Foundation, “Paying For Quality: Understanding and Assessing Physician Pay-For-Performance Initiatives.” Research Synthesis Report No. 13. December 2007. “Premier Hospital Quality Incentive Demonstration.” CMS Fact Sheet. June 2008.