

Healthcare Transitions: Trends In Quality Outcomes & Performance Measures Pay For Performance

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Summary

Few pay for performance programs were in existence before 2001. Today, these programs are flourishing and evolving. These programs are flourishing primarily because of CMS efforts. There are several challenges with pay for performance including incredible variation in the programs across the nation and continuing issues of how to define, measure, and reward quality performance.

Key Points

- Pay for performance programs are flourishing and continue to evolve.
- Pay for performance can succeed if there is an all payer approach, wherein providers face the same metrics and incentives for all of their patients, regardless of their insurance coverage.
- CMS, national quality organizations, professional organizations, health plans, providers, and others are all having an impact on the evolution of these programs.

THERE IS AN EMERGING CONSENSUS that poor quality in the health care system contributes to adverse patient outcomes, and leads to increases in overall costs. This has been brought to national attention through reports on the rate of adverse medication events and medical errors. Employers and the government are escalating their demands for quality benchmarks, outcomes reporting, and the development of a link between quality, performance, and reimbursement. Employers are educating their employees to seek care from providers who deliver high quality care at reasonable costs. Large American companies are collaborating to lead a number of initiatives, including the Leapfrog Group and the National Business Group on Health. More than 70 organizations and 40 private managed care organizations are focused on quality initiatives in health care. Additionally, multiple national quality programs exist, including National Diabetes Quality Improvement Alliance (NDQIA), American Board of Internal Medicine (ABIM), and National Committee for Quality Assurance (NCQA).

In 1999, the Institute of Medicine (IOM) published the report “To Err is Human: Building a Safer Health Care System.” This report, which is available for

purchase at www.iom.edu, focuses on patient safety, medical errors, and adverse outcomes. The report quotes that “as many as 44,000 to 98,000 people die in hospitals each year as a result of medical errors.” The IOM report estimates that preventable medical errors cost the U.S. approximately \$17 billion per year. Although there were disagreements about the content of this report, it did put the national spotlight on patient safety, medical errors, and adverse outcomes. The IOM report issued a call to action to improve quality and safety of U.S. healthcare with specific recommendations, including quality measurement and reporting, public transparency, and incentives for quality improvement (i.e., pay for performance).

Subsequently, in 2001, the second report by the IOM, “Crossing the Quality Chasm: A New Health Care System for the 21st Century,” was published. This report again raised national attention about quality concerns. This report suggests that a fundamental innovation and redesign of the health care system is necessary. The IOM Committee on Quality in Health Care in America developed six aims that health care systems should model (Exhibit 1). They also developed 10 rules to follow for health care design. Health care should be based on continuous

healing relationships with customized care according to the patient needs and values. Control of care should be by the patient with information and knowledge being shared freely. Health care decisions should be based on evidence, principles, and measurements. Safety should be a system priority. Additionally, the system should be transparent to the patient and should anticipate patient needs. Health care systems should continuously look at ways to decrease waste, and, very importantly, prioritize cooperation among clinicians.

The IOM reports were two of the catalysts that brought the quality concern, which most people involved in health care were aware of, to the national level. Soon after these reports, initiatives were being disseminated, and then programs started to develop. Additionally, during this time, the federal government, through the Ways and Means and the Energy and Commerce committees, gave a clear message to the Alliance of Specialty Medicine. These committees said physicians needed to develop indicators, measures, or other methods of assessment that could be used in pay-for-performance programs.

Exhibit 2 illustrates how the number of pay-for-performance programs has grown. In 2007, 148 pay-for-performance programs existed in the U.S. with over 55 million patients involved in those programs.¹⁻³ The Centers for Medicare and Medicaid Services (CMS) have launched multiple pay-for-performance demonstration projects. The American Medical Association (AMA), Joint Commission on Accreditation of Health Care Organizations (JACHO), American Association of Family Physicians (AAFP), and many other organizations set the principles and standards for pay for performance.

Exhibit 1: Health Care System Aims

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient Centered

The goal of a well designed pay-for-performance program is to create a compelling set of incentives that will drive breakthrough quality improvement and patient experience through a common set of measures, a score card, and some payment system based upon performance measurements. The standard measures selected should be aligned with national measures, if possible. They should be clinically relevant, affect a significant number of people, be scientifically sound, and be evidence based. The measures should be feasible to collect using electronic data, a very important concept in any pay-for-performance program. Physician groups should impact the measures and health plans. The measures should be capable of showing improvement over time and, very importantly, be important to consumers. The 2007 CMS clinical measures are given in Exhibit 3. The patient experience measures that are incorporated into many pay-for-performance programs include effective communication, ratings of care, care coordination, specialty care and timely access to care.

Efficiency measures are missing in almost all of the current pay-for-performance programs. Approximately five percent of the programs have one or more efficiency measure in place. Even with missing efficiency measures, these programs do, however, focus on quality and quality information. They do solidify a mechanism for aggregating physician group data from several

Exhibit 2: P4P Programs

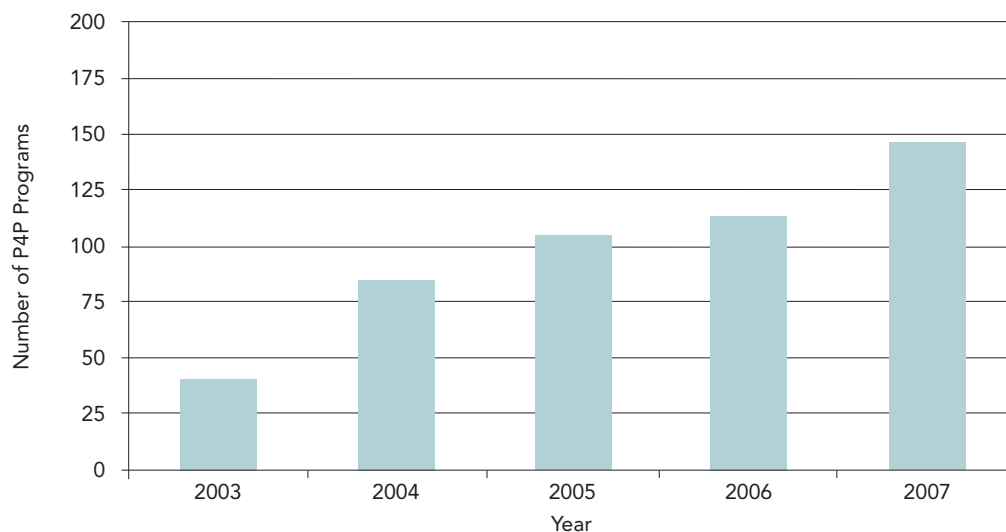


Exhibit 3: 2007 Clinical Measures

Preventive Care

- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunizations
- Chlamydia Screening
- Colorectal Cancer Screening

Acute Care

- Treatment for Children with Upper Respiratory Infection

Chronic Disease Care

- Appropriate Meds for Persons with Asthma
- Diabetes: HbA1c Testing & Poor Control
- Cholesterol Management: LDL Screening & Control (<130 and <100)
- Nephropathy Monitoring for Diabetes

health plans. Current pay-for-performance programs are showing higher administrative HEDIS rates and more valid data.

Stakeholder needs must be balanced in developing and evolving a pay-for-performance program. Purchasers want more measures to provide meaningful information to consumers. Physician groups want more money to support quality improvement efforts and want to focus on a few measures at a time. Health plans cannot justify paying significantly more for basically the same measures year after year. There is a dichotomy or misalignment in many of the pay-for-performance programs that need a realignment of incentives.

Physicians have provided feedback on pay-for-performance programs.⁴ Most of the time, particularly in the mature programs, the reporting is favorable. Physicians have a strong motivation to perform when the data are publicly reported. Pay for performance has inspired many physicians to collect relevant information and data. Physicians are comfortable being held accountable if they have been involved with a measure development. In the markets where pay-for-performance programs are not mature, there is significant physician pushback initially.

Health plan feedback on these programs has included a need for rules on contracting, incorporating the cost with quality to create a business case, and more or better outcomes measures. Lastly, the plans want to address overuse and misuse.

Purchasers, on the other hand, aggressively want new measures added. They want to add efficiency domains that incorporate the total cost of caring for a population. They also want to rapidly increase the portion of the plan payments that go to performance-based groups.

The CMS Physician Quality Reporting Initiative

(PQRI) began in July of 2007. Because the commercial market tends to follow CMS's lead, managed care players need to be aware of this program. There were 66 quality measures posted on the CMS website in December 2006. Eight additional measures were added and the final list of 74 quality measures is available on the web site (www.cms.hhs.gov/PQRI). Currently, this is a measurement program, but it will eventually become a performance-improvement program. Eligible health care professionals who successfully report may earn up to a 1.5 percent bonus. The bonus is calculated based on the total amount of charges. Unfortunately, 1.5 percent is probably not enough to change behavior in today's marketplace.

The 2008 PQRI measures have been published, but are dependent upon adoption or endorsement by consensus organizations, such as the National Quality Forum or the AQA Alliance. Physicians have been involved in the consensus-based process for development. In 2008 and beyond, the program will include structural measures, such as the use of electronic health records or electronic prescribing technology. The 2007 measures came out too early to insist upon electronic health records as being a determination for participation. Standardized specifications for centralized reporting could reduce the reporting burden for participants and CMS. CMS has a comprehensive education and outreach resource for physicians and others, including tools to support successful reporting.

Gastroenterologists, like many other specialists, are concerned that the shift to pay for performance will decimate their income unless the profession responds by developing consensus around quality measures. In 2004, the American Gastroenterological Association (AGA) convened a Quality in Practice Task Force. The Task Force was given two charters: to develop evidence-based quality measures in gastroenterology practice and programs to educate physicians on pay-for-performance practice implications. The task force came out with six evidence-based parameters recommendations (polyp surveillance, performance of colonoscopy, Hepatitis C management, H Pylori management, Crohn's management, and gastroesophageal reflux disease).⁵ In 2006, the AGA Institute began working with the AMA Physician Consortium for Performance Improvement, the Agency for Healthcare Research and Quality (AHRQ), NCQA, JCAHO, and CMS to develop performance measures for GERD. As a result of this collaboration, four measures of the 74 CMS measures are GERD related. These measures are also under consideration at this point for endorsement by the National Quality Forum.

The GERD measures are based upon four simple principles. They are evidence-based, are aimed at

GERD Physician Performance Measurement Set

60. Assessment for alarm symptoms

Clinical Performance Measure: Percentage of patients 18 years and older with the diagnosis of GERD, seen for an initial evaluation, who were assessed for the presence of the following alarm symptoms: involuntary weight loss, dysphagia, and GI bleeding.

The physician should assess and document whether or not the patient has alarm symptoms.

61. Upper endoscopy for patients with alarm symptoms

Clinical Performance Measure: Percentage of patients 18 years or older seen for an initial evaluation of GERD with at least one alarm symptom who were either referred for endoscopy or who had one performed.

Patients with alarm symptoms should have additional assessment and treatment.

62. Biopsy for Barrett's esophagus

Clinical Performance Measure: Percentage of patients 18 years or older with a diagnosis of GERD or heartburn whose endoscopy report indicates a suspicion of Barrett's esophagus who had a forceps esophageal biopsy performed.

If Barrett's esophagus is suspected at endoscopy, a biopsy should be performed and sent to pathology for diagnosis.

63. Barium swallow – inappropriate use

Clinical Performance Measure: Percentage of patients 18 years or older seen for an initial evaluation of GERD who did not have a barium swallow test ordered.

Barium radiology has limited usefulness in the diagnosis of GERD and thus is not recommended.

quality improvement, are something that can be used in practice, and have received a broad consensus among physicians. These measures are assessment for alarm symptoms, upper endoscopy for patients with alarm symptoms, biopsy in those patients suspected to have Barrett's esophagus, and inappropriate use of barium swallow in assessing gastroesophageal reflux disease. The clinical performance measures for each of these is given in Exhibit 4.⁶

CMS in collaboration with the AMA, Mathematica Policy Research, and the NCQA, has developed participation tools for PQRI. These tools are designed to:

- aid in the selection of measures by physicians and other eligible professionals wishing to participate in the program,
- link to background information on the quality measures, and
- aid in required data collection.

These tools are easily accessible on the CMS website.

Recent survey results about pay for performance from 75 purchasers, government agencies, and health plans, revealed several important findings.³ Improving clinical outcomes remains the top reason for implementing pay-for-performance programs. At least 50 percent of the programs have shown significantly improved clinical performance. These programs demonstrate savings in more than 33 percent of the programs. Expanding the scope or number of

performance measures have occurred in more than 70 percent of the programs. Posting public information of provider performance in the provider directories has occurred in more than 30 percent but that is still a challenge. Development of tools to measure improvements in outcomes and eligibility for rewards directly from medical records is occurring in the advanced pay-for-performance programs. In the advanced programs, they are using electronic distribution from health records, and they are more successful than those who do not have electronic means.

Pay-for-performance programs have to evolve over time. They cannot remain stationary or stagnant. They have to change to meet changing needs. In general, pay-for-performance is viewed as a necessary component of a quality driven health care system but certainly not the only or the final solution. It certainly is not going to repair the gaps that we have in our health care systems and the fact that reimbursement is based on sick care instead of well care. Secondly, health plans unfortunately have to tailor pay-for-performance scorecards and measures for specific needs leading to a cornucopia of metrics in the market. In the commercial sector, physician pay-for-performance programs have evolved more fully than hospital plans.

There are still a large number of challenges. There are at least 60 measures in pay-for-performance programs that are used by the 148 programs that exist today. There is not one measure that is used by

all of the programs. Transparency of physician performance is still in its infancy. There is still reluctance to do this. Reimbursements are too low to significantly change provider behavior. Results from pay for performance are sometimes spotty and few plans have set up tracking records. The impact of these programs is muted by the wide variation in program structures, performance metrics, and rewards structures. Pay for performance will have a significant impact on how care is delivered only if we can agree on one universal set of quality measures that providers need to reach in exchange for substantial rewards. This is a large challenge.

Conclusion

As pay-for-performance programs have grown, the results appear positive. There are still many challenges with these programs. Pay for performance can succeed if there is an all payer approach, wherein providers

face the same metrics and incentives for all of their patients, regardless of their insurance coverage. Regardless of the deficiencies in pay-for-performance programs today, there is a lot of attention focused on these. **JMCM**

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