

# Pay-For-Performance (P4P): Evaluating Current and Future Implications

## *Issues for Pharmacy*



### ● INTRODUCTION / BACKGROUND

The health care system in the United States is at a crisis point. Discussions on health care reform can be heard at every turn. The recent Senate Finance Committee report, *Transforming the Health Care Delivery System*, states “In 2008, the United States spent more than 17 percent of our gross domestic product (GDP) on health care—more than any other industrialized country in terms of total and per capita spending. By 2017, health expenditures are expected to consume almost 20 percent of GDP, or \$4.3 trillion annually. While spending is high, our nation ranks low in many areas of quality.” Furthermore, this report concludes “This combination of high spending and lagging quality is unsustainable for patients, business and state and federal governments.”<sup>1</sup> One strategy for addressing these problems is value-based purchasing (VBP), which asserts that buyers should hold providers of health care accountable for both costs and quality of care. An example of VBP is pay-for-performance (P4P). P4P is an incentive-based reimbursement system that rewards top performers. P4P programs are currently active in health systems, managed care settings, and private and group physician office practices. P4P is likely to have a significant impact on the entire health care environment and will provide yet another opportunity for pharmacy to not only assist, but also to take a leadership role in improving the quality and efficiency of care in the U.S.

### ● ISSUES BRIEF

#### Why P4P and why now?

Chassin et al.<sup>2</sup> summarized 4 strategies for addressing health care quality issues. The 4 strategies include government regulation, continuous quality improvement, marketplace competition, and payment incentives. The latter strategy was intended to address the inherent faults in current health care reimbursement models. Fee-for-service provides payment for quantity or process and does not take into consideration quality, efficiency, and cost management. A flaw seen in the managed care models is that, in an attempt to control spending, care that could lead to improved quality and outcomes may be restricted. The medical severity diagnosis related groups (MS-DRGs) currently used in the hospital setting are designed to control costs, but because they primarily focus on inpatient treatment, transitional and outpatient care concerns are generally ignored.

Pay-for-performance has emerged as a new model built on defined measures, data collection, and public reporting with payment incentives aimed at quality, efficiency, and patient satisfaction. The focus of P4P is on value, which takes into account the relationship between quality and cost. While P4P is not a new concept, it has arrived at the health care gate due to a convergence of events including increasing cost of care, consumerism (“informed choice”), the progression of evidence-based medicine, the patient safety movement, electronic data systems, and, the Internet.

#### Does P4P work?

The key question is whether P4P is viable part of a solution to the current health care dilemma. While the concept of P4P is sound and logical, data from demonstration and pilot projects as well as full implemented programs have generated conflicting reports.

The Premier Hospital Quality Incentive Demonstration Project (HQID), which was supported by the Centers for Medicare and Medicaid Services (CMS), involved 260 hospitals in the Premier Health Care System. This 3-year demonstration project evaluated the effect of P4P in 5 distinct areas of care (coronary artery bypass graft, pneumonia, acute myocardial infarction, heart failure, and hip and knee replacement). Thirty validated



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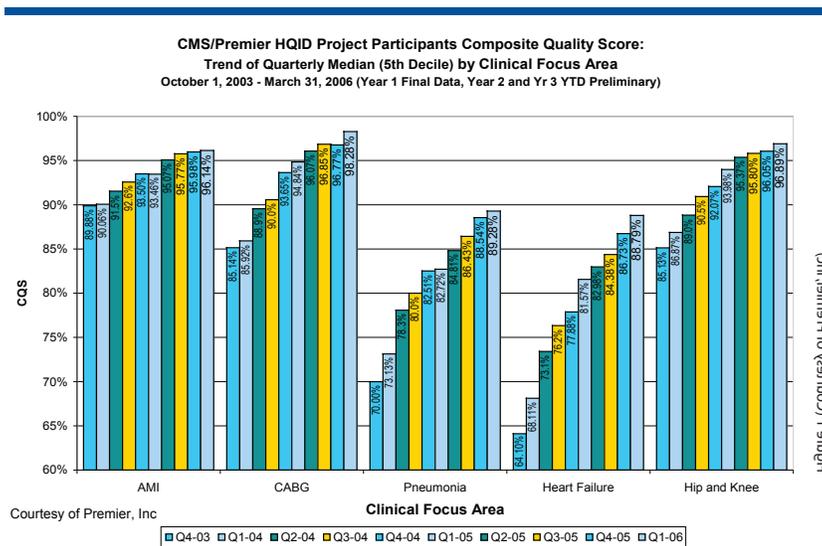
quality measures were used to track outcomes. Incentives included a promised increase in Medicare payment by 2% for the top decile performers and 1% for second decile performers. Also, data from hospitals that ranked in the top half of all project participants for each condition were publicly reported. Results tabulated near the end of this project showed overall improvements in all 5 care areas with the most robust improvements in areas that had lowest baseline performance scores (Figure 1).<sup>3</sup> With no control groups in place, a key question was whether these improvements were truly driven by the P4P model?

An early peek at results related to this question was published by Grossbart,<sup>4</sup> who compared the results of hospitals from the Catholic Healthcare Partners (CHP) that participated in the Premier project with those CHP hospitals that did not. The results were limited to the first-year outcomes from the demonstration project. The composite quality scores were higher for P4P participants (9.3% vs 6.7%,  $p < 0.001$ ); however, this could be attributed in large part to the improvements in the treatment of heart failure (19.2% vs 10.9%,  $p < 0.001$ ) which was the only clinical area to show a significant difference. A similar analysis by Lindenauer et al.<sup>5</sup> compared 406 hospitals reporting quality of care via the national public-reporting initiative with 207 hospitals that participated in Premier HQID. Significant but modest improvements were observed in a number of care measures for the P4P participating hospitals; absolute improvement ranged from 2.6% to 4.1 % over the 2-year period.

### CMS Hospital Value-Based Program (VBP)

Acute care hospitals in the US are required to submit data to CMS via the “Reporting Hospital Quality Data for Annual Payment Update” (RHQDAPU) program. Failure to comply with this requirement will cost a facility 2% of its annual Medicare payment update (“market basket”). The Deficit Reduction Act of 2005 required the Department of Health and Human Services to formulate a value-based purchasing program for acute care hospitals by 2009. The early plans for this program are now in. Meanwhile, hospitals are still required to continue to submit data for the measure set for RHQDAPU (currently at 42 measures) and public reporting through the Hospital Compare website. It is important that hospitals—and pharmacy departments—understand the new CMS VBP including basic timelines, performance reporting, program funding and payment structure.

The CMS Hospital VBP will officially begin in FY2012 with data collection and performance reporting. In FY2013, payment adjustments based on performance will begin. Also, the measure set will expand quickly to drive



**Figure 1**

a comprehensive performance program that will result in a broad-scale transformation of the health care system. These measures will represent at least 3 performance domains: clinical quality/process (RHQDAPU + new quality/care measures), patient perspectives of care (HCAHPS), and outcomes (30-day mortality measures for acute myocardial infarction and heart failure). From these measures a composite performance or quality score will be generated annually. This score will be based on comparisons of the current measure performance versus the institutions baseline performance using results from the previous year. Furthermore, attainment of benchmarks (performance thresholds) or rates of improvement (degree of change) will be determined based on the performance data from the national pool of participants. This relative scoring is intended to drive continuous improvements and to raise overall performance.

There are two similar proposals for funding and payment determination for the VBP. CMS proposes to fund the VBP program by reducing wage-adjusted inpatient operating payments between 2% and 5% for all hospitals and by placing these funds into a pool of money. That pool would then be distributed based upon performance scores. The Senate Finance Committee recommends an escalating reduction in these IPPS payments starting with 2% in FY2013 and increasing 1% per fiscal year to 5% by FY2016. In each of these proposals, payment would represent a portion of a DRG payment, not the market basket update (as with RHQDAPU). Redistribution of residual funds would be “budget neutral” for CMS. Both the Senate Finance and CMS payment proposals provide a maximum payout of 100% of the amount a hospital contributes into the VBP pool.

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Sample performance reports for your hospital based on assumptions from the 2 different funding and payment proposals are available for your review. Contact your state hospital association and/or quality improvement organization (QIO) for more information.

Another example of how the CMS is moving toward a value-based purchasing model is the newly introduced “hospital acquired conditions” policy, which allows CMS to deny payment for preventable health problems that develop during the hospital stay. Examples of preventable conditions include the following:

- Pressure ulcers
- *Staphylococcus aureus septicemia*
- Object left in surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infections

In effect this is “no-pay-for-no-performance,” but it clearly sets in place incentives to improve outcomes and patient safety. Whether all of these events are truly avoidable is an area of controversy. Staff documentation of pre-existing conditions, provision of appropriate care and billing coding will be critical to assure proper payment of claims.

### The Impact of P4P on Health Systems Pharmacy Practice

Clearly, in a health care environment where doing less with more is the recurring theme, these new approaches aimed at improving the quality of care at decreased cost will place more demand on hospital leaders and staffs. Therefore, it is critical that pharmacy departments take proactive steps so they are prepared to deal with the new age of pay-for-performance. Following are several strategies for preparing for P4P:

#### 1. Know your institution's strategic plan on P4P.

Because pharmacy resources are limited, it is critical that you understand the institution's plans and goals for P4P so that you can put the pharmacy in a position to participate. Given the number of quality measures that are medication-related, pharmacy expertise is needed to guide and inform appropriate decision making. Following are some key questions to consider:

- Who is addressing P4P at your workplace?
- Who are the key players? Are they in quality improvement, performance improvement, finance, administration, or special committees?
- What are the key elements in the P4P plan?
- With which plans will you likely be participating?
- What will be the priority clinical areas for improvement?
- How will resources be allocated?

- How is pharmacy represented at the P4P table?

#### 2. Develop a strategic plan for the pharmacy department that explains how it will deliver value.

It is critical that you are “doing the right things” and not just “doing things right”. Make the most of your resources. Examples of ways to ensure that the pharmacy is providing value include

- Aligning pharmacy department's goals with the institution's targets and priorities.
- Ensuring that the department's practice model is patient-centric, outcomes-focused, and efficient.
- Tailoring staff roles and daily activities to achieve targets
- Where possible, assigning accountability to staff for performance measures
- Assure frontline staff are participating in care and process redesign teams

#### 3. Increase awareness of current and proposed performance measures and know your performance status.

Following is a list of questions to consider:

- How is your hospital currently performing on RHQDAPU measures?
- Where do gaps or deficiencies in care exist?
- Which of these gaps or deficiencies can be addressed by the pharmacy department?
- Can you prioritize these areas for improvement?
- Are you using accepted QI methodology (ie, PDSA cycles) to address these deficiencies?
- Are you watching for new opportunities based on future performance measures and requirements (i.e., CMS new focus on reducing readmissions and improving transitions in care may justify support for patient medication adherence instruction by pharmacists).

#### 4. Ensure that you have access to critical and timely data that can be used to drive value. Below are examples of ways to obtain and maintain data:

- Use departmental and institutional databases to generate timely reports.
- Identify improvement opportunities using “real time” or surveillance data (ie, HF patients not on ACEIs, surgical and ICU patients with no VTE prophylaxis).
- Develop reminders or flagging systems to communicate with staff.
- Create dashboards that show timely performance data.
- Ensure that the pharmacy's information technology resources support the performance goals.

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### 5. Communicate and collaborate

It is critical that administrative and management staff are not the only persons aware of P4P activities. It is also clear that collaboration within an institution and across the care continuum will be critical to achieving results. Examples of ways to communicate the importance of P4P activities to all staff include

- Dedicating discussion time to performance measures at each staff meeting.
- Posting performance data for key measures in highly-visible areas.
- Getting staff to understand their goals and responsibilities and eliminating barriers to progress.
- Working in teams that include all significant stakeholders.
- Cross linking with other disciplines/departments to improve efficiency.
- Developing strategies for transitioning patients from the inpatient to ambulatory settings.
- Rewarding success!

### ● SUMMARY

Strategies to improve quality and to lower the costs of health care in the U.S. include value-based purchasing. Pay-for-performance is a type of value-based purchasing that utilizes an incentive-based reimbursement system to drive positive change. Despite definitive evidence that pay-for-performance (P4P) can improve quality in a cost-effective manner, it is clear that CMS and other payers are moving quickly toward this model. Pharmacy departments will need to ensure that their goals are aligned with the institutions' goals and evaluate carefully current services and practice models to ensure that they are delivering safe, effective, and efficient care. Data collection and analysis will be critical for both identifying areas for improvement and tracking outcomes. Effective communication of performance goals to staff, establishing accountability for front-line staff, and working collaboratively with other disciplines and departments will be important steps in successfully meeting P4P demands.

### ● ONLINE RESOURCES

#### PAY-FOR-PERFORMANCE

1. AHRQ Pay-for-Performance Resources: [www.ahrq.gov/QUAL/pay4per.htm](http://www.ahrq.gov/QUAL/pay4per.htm)
2. CMS Pay-for-Performance Initiatives: [www.cms.hhs.gov/apps/media/press/release.asp?counter=1343](http://www.cms.hhs.gov/apps/media/press/release.asp?counter=1343)
3. Premier HQID project info. [www.cms.hhs.gov/HospitalQualityInits/35\\_hospital\\_premier.asp](http://www.cms.hhs.gov/HospitalQualityInits/35_hospital_premier.asp)
4. Hospital Value Index: Rankings for over 4,500 hospitals <http://hospitalvalueindex.com/>

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