PAY FOR PERFORMANCE AND VALUE BASED PURCHASING:

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Objectives

- Define what Pay for Performance is and why CMS wants us to move in this direction
- Describe the process of how healthcare organizations are utilizing P4P to improve their quality and safety
- Describe how P4P is different for hospitals and for physician practices/medical groups
- Describe future P4P measures and how hospitals are preparing to submit data for those measures and are being proactive in meeting those measure
- Describe resources that are available to learn more about P4P
What is “Pay for Performance” (P4P)?

“Pay for Performance” describes:

- Arrangements between health care providers and payors that structure reimbursement for care provided, based on the achievement of defined targets on quality and efficiency metrics

- Financial incentives and/or penalties are used to improve outcomes (The Leapfrog Group, 2006)
Pay for Performance: Definition and Purpose

Not Just Medicare!

- State Medicaid programs are tying performance to reimbursement. Texas reduces or denies reimbursement for:
  - Hospital Acquired Conditions
  - Early elective inductions prior to 39 weeks gestation

(Nolan & Kahn, 2012)
Medicare Goals for “Pay for Performance” (P4P)

The Centers for Medicare and Medicaid Services (CMS) has begun to restructure the current fee-for-service payment system that encourages high volumes of poorly coordinated and wasteful care to one that encourages joint accountability for clinical and financial outcomes among all providers and across all settings of care.

(Centers for Medicare and Medicaid Services, n.d.c)
CMS P4P strategy includes several programs:

- Pay for reporting (quality measures)
- Hospital Value Based Purchasing (VBP) program
- Hospital Acquired Conditions (HAC) payment adjustments and reduction program
- Hospital Readmissions Reduction program
- Electronic Health Record (EHR) Incentive and eRx Incentive programs

(Centers for Medicare and Medicaid Services, 2014a; Centers for Medicare and Medicaid Services, 2014b; Centers for Medicare and Medicaid Services, n.d.a)
Hospital Value Based Purchasing (VBP) Overview

- Required by the 2010 Affordable Care Act
- Implemented by CMS in 2012
- Updated and expanded annually
- Eligibility: Hospitals paid under the Inpatient Prospective Payment System (IPPS)
- Budget-neutral incentive program
- Quality measures from the HIQR pay for reporting program

(Centers for Medicare and Medicaid Services, 2014a)
VBP Quality Measures: Data Sources

- **Manual Chart Abstraction**
  - Core Measures – clinical process measures
  - Healthcare Associated Infections (HAI) – outcome measures submitted to the CDC

- **Patient Survey**
  - Patients’ perspective of care obtained from post discharge surveys through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) program

- **Medicare Claims**
  - Outcomes of care measures calculated from the diagnoses, procedures, demographics, and other administrative data submitted to Medicare by providers for care provided
    - Mortality and complications of care measures
    - Cost of care/efficiency measures

(Centers for Medicare and Medicaid Services, 2014a)
FFY 2016 program year

**Efficiency**
Performance Period Jan-Dec 2014

Medicare spending per beneficiary:
3 days prior to and 30 days post admission

**Outcomes**
Performance period:
Mortality = Oct 2012-June 2014
PSI = Oct 2012-June 2014
HAI = Jan-Dec 2014

AMI 30 day Mortality
CHF 30 day Mortality
Pneumonia 30 day Mortality
AHRQ PSI 90
CLABSI
CAUTI
SSI (colon and abdominal)

**Core Measures**
Performance Period Jan-Dec 2014

Fibrinolytic therapy rec'd within 30 minutes of arrival
Initial antibiotic selection for CAP
Prophylactic antibiotic selection for surgical patients
Prophylactic antibiotics dc'd within 24 hours after surgery
Urinary catheter removed on postop day 1 or 2
Surgery patiens on beta blocker prior to arrival who rec'd a beta blocker during the periop period
Surgery patiens who rec'd appropriate VTE proph within 24 hrs prior to surgery
Influenza Immunization

**HCAHPS**
Performance Period Jan-Dec 2014

Communication with nurses
Communication with doctors
Responsiveness of hospital staff
Pain management
Communication about medicines
Hospital cleanliness and quietness
Discharge information
Overall rating of hospital

**Outcomes**
Performance period:
Mortality = Oct 2012-June 2014
PSI = Oct 2012-June 2014
HAI = Jan-Dec 2014

AMI 30 day Mortality
CHF 30 day Mortality
Pneumonia 30 day Mortality
AHRQ PSI 90
CLABSI
CAUTI
SSI (colon and abdominal)
FFY 2017 program year ~ 2% of DRG base reimbursement

**Efficiency**
Performance Period Jan-Dec 2015

Medicare spending per beneficiary:
3 days prior to and 30 days post admission

**Clinical Care - Outcomes (25%)**
Performance period:
Mortality = Oct 2012-June 2014
PSI = Oct 2012-June 2014
HAI = Jan-Dec 2014

AMI 30 day Mortality
CHF 30 day Mortality
Pneumonia 30 day Mortality

**Safety**
PSI 90 October 2013 – June 2015
Infections Jan – Dec 2015

- AHRQ PSI 90
- CLABSI (all)
- CAUTI (all)
- Surgical Site Infections (Colon, Hysterectomy)
- C. Difficile
- MRSA

**Clinical Care - Process Jan-Dec 2015 (5%)**

- Fibrinolytic therapy rec'd within 30 minutes of arrival
- Influenza Immunization
- Elective Delivery Prior to 39 week completed gestation

** for HCAHPS list of domains see previous slide
VBP Quality Measures: Domains (FY 16 VBP)

Clinical Process of Care (10%)

Metrics:
- Fibrinolytic therapy within 30 minutes for Acute MI
- Influenza immunization
- Pneumonia antibiotic selection
- Antibiotic selection (surgery)
- Antibiotic discontinued timely (surgery)
- Urinary catheter removal by postop day 2 (surgery)
- Perioperative beta-blocker (surgery)
- VTE prophylaxis (surgery)

(Tourison, April, 2014)
VBP Quality Measures: Domains (FY 16 VBP)

Patient Experience of Care (25%)

Metrics:
- Communication with nurses
- Communication with doctors
- Responsiveness of hospital staff
- Pain management
- Communication about medicines
- Patient environment is clean and quiet
- Communication of discharge information
- Overall rating

(Tourison, April, 2014)
VBP Quality Measures: Domains (FY 16 VBP)

Outcome of Care (40%)

Metrics:

- 30 day mortality
  - Acute MI
  - Heart Failure
  - Pneumonia
- Patient safety indicators
  - AHRQ PSI-90 composite
- Healthcare Associated Infections
  - Central line associated bloodstream infections
  - Catheter associated urinary tract infections
  - Surgical site infections

(Tourison, April, 2014)
VBP Quality Measures: Domains (FY 16 VBP)

Efficiency (25%)

Metrics:

- Medicare spending per beneficiary
  (Tourison, April, 2014)
VBP: Scoring

Two time periods measured
- Baseline period: historical data
- Performance period: most recent data

(Tourison, April, 2014)

VBP: Scoring

**Two comparisons for each metric**

- Hospital baseline period to hospital performance period
  - Improvement Points: improvement over baseline

- Hospital performance period to national benchmarks (50\textsuperscript{th} percentile & average of best decile)
  - Achievement Points: performance relative to benchmarks

Figure 2. (Tourison, April, 2014, p. 17)

Figure 3. (Tourison, April, 2014, p. 17)
VBP: Scoring

Two opportunities to achieve high scores for incentive payments

1. Highest score chosen from Improvement Points or Achievement Points for each metric
2. Domain score calculated from all eligible metrics from that domain
3. Total Performance Score (TPS) is calculated from the weighted domain scores
4. Hospitals are ranked by TPS and CMS distributes the pool of withheld VBP payments based on a linear exchange function calculation (Tourison, April, 2014)
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Pay for Performance Utilization

- Healthcare organizations are utilizing P4P to improve quality and safety primarily by holding key stakeholders within the organization accountable for outcomes not quantity.

- Accountability and financial impact aimed at driving results.
Pay for Performance Utilization

- Healthcare improvement departments for extensive data extraction and analysis with concurrent chart auditing and reporting to bedside staff.
- Effective communication from leadership down to bedside care providers
- Education of staff members
An example of how a hospital effectively improved and sustained core measure compliance is the work that was done at Johns Hopkins Hospital in 2012.

Johns Hopkins Hospital gained sustained improvement of greater than 96% in compliance in 95% of the core measures by implementing a conceptual modeling containing these four elements:

- Clarifying and communicating goals
- Building capacity using Lean Sigma, education, and clinical communities
- Transparently reporting and ensuring accountability for performance
- Developing a sustainability process (Pronovost et al., 2014).
Johns Hopkins Interventions

- **Communicating goals-**
  - Agree upon goals and measures
  - Structured review process for goal evaluation (Pronovost et al., 2014)

- **Building capacity using Lean Sigma-**
  - Gap analysis performed
  - Community work groups formed
  - Utilized the Lean Sigma problem-solving tool, the A3 report (Pronovost, 2014)
Johns Hopkins Interventions

- **Transparently reporting and ensuring accountability for performance**-
  - Use of monthly color coded performance dashboards for visual management.
  - Development and utilization of a robust accountability plan with escalating implications when goals not being met (Pronovost, 2014)

- **Developing a sustainability process**-
  - Meeting with a Lean Sigma Master Black Belt to ensure a smooth transition for sustainability (Pronovost, 2014)
Care coordination re-design is another approach in achieving P4P requirements. (Gilbert, Rutland, & Brockopp, 2013)

Discharge coordination is the key to driving down re-admission rates.

“Medicare beneficiaries readmitted to the hospital within 30 days of discharge are thought to cost the healthcare system $17.4 billion annually” (Gilbert et al., 2013)
Care Coordination Redesign

- Contributing factors to readmissions include:
  - No patient-provider follow up within 7-10 days of discharge
  - Poor medication compliance
  - Patient confusion regarding disease management
  - Lack of home care services (Gilbert et al., 2013)

- Baptist Health Lexington utilized the following approaches to achieve a 50% reduction in re-admissions for AMI, HF, and pneumonia in 2012:
  - Utilizing a re-admission risk tool (LACE) to identify patients at high risk for re-admission
  - Assuring planned follow up appointments occurred
  - Helping patients understand their medication regimens
  - Referring to appropriate home care/support services, when needed (Gilbert et al., 2013)
Another way organizations are utilizing P4P to improve quality and safety for patients is by the various efforts to improve patient satisfaction scores via the HCAHPS survey.

HCAHPS survey results drive 30% of the reimbursement for VBP (Dempsey, Reilly, & Buhlman, 2014)
HCAHPS

- “Communication with nurses” HCAHPS domain is key to patient satisfaction (Dempsey et al., 2014)
- Nursing engagement is also a critical piece to the puzzle.
- Teaching nurses the rationale of VBP in relation to importance to quality of care and patient satisfaction is more impactful than trying to motivate to move the HCAHPS scores (Dempsey et al., 2014)
HCAHPS Interventions

- Some of the ways organizations are influencing their performance on HCAHPS scores and thus reimbursement from CMS for VBP are:
  - Formal and ongoing training on patient experience for staff
  - Purposeful hourly rounding
  - Bedside shift report
  - Senior leadership rounding on patients and staff
  - Improving patient flow/reducing wait times
  - Nurse manager training (Dempsey et al., 2014)
  - Discharge phone calls (Natale and Gross, 2013)
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P4P for Hospitals

- The domains are weighted differently each year. FY15’s domain weights are 30% Patient Outcomes, 30% HCAHPS, 20% Clinical Process, and 20% Efficiency (Centers for Medicare and Medicaid Services, 2013)

- Hospitals are reimbursed based off performance compared to a baseline period that is usually 2 years prior to the performance period (Centers for Medicare and Medicaid Services, 2013)

- How well a hospital performs in the various VBP domains that calculate the Total Performance Score determines the reimbursement monies awarded to the hospital
Currently physician quality reporting is optional through a program administered through CMS named Physician Quality Reporting System (PQRS) (Centers for Medicare and Medicaid Services, n.d.b)

PQRS currently incentivizes physicians by awarding a payment of 0.5% of their total estimated Medicare Part B allowed charges during the reporting period for those that meet the criteria for satisfactory submission of quality data via one of the approved reporting mechanisms as outlined by PQRS (Centers for Medicare and Medicaid Services, n.d.b)

Physicians will be held more accountable for quality by one of the adjustments planned in the PQRS program in 2016.
The Value-Based Payment Modifier Program, which is a way to provide comparative performance information to physicians so that care can be improved (Centers for Medicare and Medicaid Services, n.d.b)

In 2015, eligible physicians in groups of 100 or more, will be subject to the value modifier based off their performance from 2013 (Centers for Medicare and Medicaid Services, 2014)

The physician group gets to determine which quality indicators they will be reporting on based off the quality measures outlined by the PRQS and which mechanism for reporting they prefer (Centers for Medicare and Medicaid Services, 2014)

Failure to comply will result in a 1% value modifier adjustment to payment (Centers for Medicare and Medicaid Services, 2014)

In the near future, the government also plans to take into consideration efficiency measures such as Medicare spending per beneficiary in order to encourage less unnecessary testing and more aggressive outpatient treatment efforts to avert hospitalizations (Rau, 2013)
Potential barrier to successful implementation of P4P in small to medium practices was administrative and financial burdens (Herald, Alexander, Shi, & Casalino, 2013).

Between July 2007-March 2009, one study of 1734 small to medium-sized physician practices in the US was performed to analyze this potential barrier and found to show results that relatively few (21.9%) of these practices reported high levels of administrative problems due to a lack of standardization on performance measures (Herald et al., 2013).

Good indicator of potential successful implementation of P4P even in small to medium medical practices.
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VBP: Future Measures

- Evolving toward outcome and efficiency measures
  - Domain categories and weights revised
  - New measures introduced
  - Topped out measures removed

(Centers for Medicare and Medicaid Services, 2014a)
VBP: Future Measures
Planning for Success

- Data collection in process
  - Already required for HIQR
- Performance improvement
  - Assume new HIQR measures will be future VBP measures
  - Improvement initiatives around every HIQR measure set
Potential Future Measure Topics

- **Proposed Measures**
  - Risk-Standardized Complication Rate Following Elective THA and TKA
    - Clinical Care-Outcomes Domain (*beginning FY 2019*)

- **Possible Measure Topics for Future Program Years**

<table>
<thead>
<tr>
<th>Medical Episodes</th>
<th>Surgical Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Kidney/Urinary Tract Infection</td>
<td>• Hip replacement/revision</td>
</tr>
<tr>
<td>• Cellulitis</td>
<td>• Knee replacement/revision</td>
</tr>
<tr>
<td>• Gastrointestinal hemorrhage</td>
<td>• Lumbar spine fusion/refusion</td>
</tr>
</tbody>
</table>

*Measures must be publically reported for one year before being proposed for VBP*
Nursing Depts Utilization of P4P

- Nursing has significant influence in the following areas of Value Based Purchasing Nursing:
  - Core Measures
  - Work flow and supply chain management efficiencies
  - Infection control
  - HCAHPS patient satisfaction
Nursing Depts Utilization of P4P

- HCAHPS scores are heavily influenced by the patient’s perception of nurse communication (Dempsey, et al., 2014)
- Nursing influences this score in various ways but the most impactful has been shown to be purposeful hourly rounding (Meade, 2006)
A large, 6-week nationwide study was performed in 2006 in 27 units in 14 hospitals on the effectives of nursing hourly rounds with some hospitals doing two-hour rounding and other doing one-hour rounding (Meade et al., 2006).

The study was looking to see what the effects were on use of call lights, patient satisfaction, and rate of patient falls (Meade et al., 2006).

The results of the study showed:
- Significant reduction in the use of the call light in the one-hour rounding group
- Both groups showed significant improvement in patient satisfaction scores
- Significant reduction in fall rates in the one-hour rounding group (Meade et al., 2006)
Nursing Impact

- This study is important because it shows how a bedside nursing intervention, such as hourly rounding with effective communication, can have a positive impact on both patient satisfaction and quality indicators.

- HCAHPS scores remain one of the constant domains in the VBP program and thus vitally important that we are empowering our nurses with the communication and process tools needed to deliver the quality and service our patients deserve.
P4P in Clinical Settings

**Pros**
- Teamwork and Critical Thinking
- Data Transparency
- Multidisciplinary Collaboration

**Cons**
- Resource Intensive
- Accessibility of Tools
- Accessibility of Source Data
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Value Based Purchasing Resources

- Medicare websites
  - Quality Net https://www.qualitynet.org/

- State Medicare contractors (QIOs)
  - Arkansas Foundation for Medical Care http://qio.afmc.org/LinkClick.aspx?fileticket=MEAhQnM6-5E=
  - Qualis (Idaho and Washington) http://www.qualishealthmedicare.org/healthcare-providers/hospitals/value-based-purchasing


- Your Health Care Improvement department
Pay for Performance describes many programs where reimbursement for care provided depends on performance on a variety of quality and efficiency measures:

- Medicare reimbursement to hospitals
- Medicaid reimbursement to hospitals
- Medicare reimbursement to physicians

Medicare’s ultimate goal is to establish a system of reimbursement that encourages joint accountability for clinical and financial outcomes among all providers and across all settings of care.
Conclusion

- Medicare’s Hospital Value Based Purchasing program is well established and continually evolving to incentivize hospitals to improve care outcomes and costs.
- Medicare’s Physician pay for performance programs are in the implementation phase but already planned for rapid expansion.
Conclusion

- Hospitals are already using the P4P data to redesign care delivery for better outcomes and lower costs
- Successful improvement requires
  - Effective communication between leadership and staff
  - Nursing engagement
  - Understanding the rationale for quality measurement
  - Transparency of data
  - Accountability is a must!
- Hospitals should stay on the leading edge by assuming that all regulatory-required measures may become tied to reimbursement in future
References


References


References
