Pay for Performance

10 Things You Should Know

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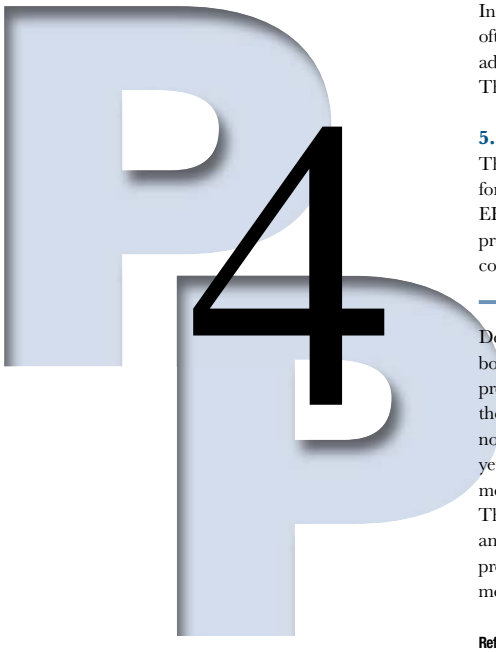
As part of this year's healthcare reform, the Centers for Medicare & Medicaid Services (CMS) is developing a hospital value-based purchasing (VBP) program for Medicare; launch is expected in October 2012. VBP is a new, more comprehensive term for pay for performance (P4P), which may have a negative connotation in some circles. Hospitals initially will have 1% of Medicare reimbursements at risk, and this rate will increase incrementally to 2% in 2017.

Traditional fee for service (FFS) rewards volume over value. It's widely believed that, while FFS has led to more care, it has not necessarily led to better care. Many countries spend less on healthcare than the United States and report better outcomes on numerous measures ranging from infant mortality to life expectancy. P4P programs attempt to realign incentives to promote high-quality, cost-effective care.

One example of P4P is CMS's reduction or elimination of reimbursements for "never events," such as surgery on the wrong body part. Previously, the perverse incentives of FFS meant a "never event" actually increased a hospital's revenue. While these incidents presumably were not done intentionally to increase revenue, there is little doubt that reducing or eliminating reimbursement for the associated costs of "never events" has led to an increased focus on their prevention.

The CMS list of "never events" has grabbed the attention of providers, policy makers, administrators and others within the healthcare community. However, the reach of P4P initiatives extends beyond this list. Here are 10 aspects of P4P that healthcare professionals should know as these programs become part of everyday practice.



1. They're Coming

These P4P programs will impact you and your practice soon, if they have not already. Although initial programs were often aimed at primary care physicians, increasingly they are being put in place for specialists.

2. What's Measured Is Key

While process and outcome measures are used frequently, the ultimate goal is to improve outcomes – and measuring outcomes is complex. Measures need to be accurate and correspond to high-quality and cost-effective care. Often they encourage use of evidence-based medicine. The evidence and corresponding standard of care can change, so measures may need to be updated over time. Administrative data are usually easier to collect than clinical data but are inherently less accurate. P4P may be well suited for the intensive care unit (ICU), as it has the potential to align hospital and physician goals. For example, fewer catheter-related bloodstream infections (CLABSI) should decrease length of stay.

3. Hybrid Measures Are Better

Using multiple measures means it is more likely that an overall indicator assesses value, as opposed to a provider's or institution's ability to get one thing done. For example, many institutions collect data on CLABSI, ventilator-associated pneumonia and catheter-associated urinary tract infections; some experts feel these outcome measures represent low-hanging fruit and could divert focus from less easily measured, but equally important, activities in the ICU.

4. P4P Can Be Expensive

Increased staff time and changes to information systems often are required for reporting. For many providers, any additional reimbursement does not cover these related costs. This is the most common complaint about these programs.

5. Electronic Health Records Can Help

The federal government has provided financial incentives for the adoption of electronic health records (EHRs). EHRs will reduce the data collection costs for many P4P programs. Existing and future P4P programs should be considered when implementing EHRs.

6. Gaming Is a Problem

Providers can improve average outcomes by not giving care to the sickest, most needy, or socioeconomically disadvantaged. Accurate risk adjustment is complex and critical. Fertility specialists can improve their outcomes by not taking on older women; cardiac surgeons can reduce their mortality rates by not operating on the sickest patients. If critical care physicians drew fewer blood cultures, the measured incidence of CLABSI would decrease. But would this correspond to higher or lower quality of care? The answer is, at best, unclear.

7. Health Disparities May Increase

Considerable evidence shows that socioeconomically disadvantaged populations receive worse healthcare and have worse outcomes that are not fully captured by risk adjustment. By creating an incentive for providers to serve patients who are more likely to have better outcomes, P4P programs could lead to an increase in health disparities.

8. Both Improvement and Performance Should Be Rewarded

The biggest increase in value is often from improving the practice of low performers. If improvement is not rewarded, low performers have little incentive to make the necessary investments (though the risk of lower reimbursements is one motivating factor). The maximum bonus is typically 1% to 2% for hospitals, 5% to 10% or more for physicians. Over time, with potentially varying increases in reimbursement, there is little financial difference between bonuses and penalties.

9. Actionable Feedback Is Essential

Providers need to be given the information necessary to understand and improve their scores.

10. Measures Should Be Consistent

CMS is a major player, but other payors and large employers are developing their own P4P programs. Collecting data and trying to improve multiple sets of measures is likely to be expensive and could inhibit overall process improvement. Inconsistent measures also can lead to frustration among providers.

Despite changing incentives, P4P programs do not always work. A recent study at Vanderbilt found that merit-based bonuses for teachers failed to improve student test scores.[1] Numerous studies by behavioral economists have shown that P4P programs can even decrease performance on tasks requiring creative problem solving. One major RAND study[2] found that the standard of care is provided only 55% of the time in healthcare (i.e., there is much we know should be done that is often not done). For example, despite the work of Pronovost et al[3,4] showing clear benefits from the use of checklists, they have yet to be adopted uniformly. Changing incentives could lead to more rapid and widespread adoption of these and other methods of improving the quality of care. P4P is not a holy grail; it will not solve all the challenges facing healthcare today. That being said, determining key performance indicators, measuring them, attempting to improve performance on them, and evaluating their effectiveness in bringing about desired outcomes are vital components of any process improvement program. P4P's biggest contribution may be in making these practices more common as the United States tries to obtain more value from the more than $2 trillion spent annually on healthcare.

References and disclosures are available at www.sccm.org/criticalconnections.