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Making Pay-for-Performance Work for Program Sponsors and the Provider Practice

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Introduction

Aligning provider payments with quality of care is not a new concept.

The early 1990s saw the rise of managed care with incentives to constrain service, but quality and consumer satisfaction measures were a part of the mix. HEDIS performance measures were also introduced, focusing on a small number of chronic diseases and preventive services.

In 2001, the Institute of Medicine (IOM) raised significant issues about the quality of ambulatory care and recommended reforming provider payment to support quality improvement, stimulating early adopters to begin implementing pay-for-performance (P4P) programs. More recently, CMS has become a strong advocate of P4P.

Much of the debate around P4P has focused on program design. Questions focus on which providers to target, the best performance measures and the scope of financial incentives. Evidence that P4P actually results in better quality at lower cost is mixed. Very little attention has been paid to how to best assist providers in complying with the many health plan or other sponsor programs they must manage across their patient panel.

The optimal P4P program design is still unclear and the market will continue to experiment. Making patient-specific clinical reminders and other clinical content available to providers at the point of care is an essential ingredient for success. Provider practices also need an infrastructure that can deliver this content into their routine, daily work processes and permits them to manage the many P4P programs that they encounter in a manner that justifies their efforts relative to the financial incentives for which they are eligible.

Market Challenge

Performance-based payment incentives have become a significant part of the healthcare landscape. This effort to realign payment incentives, better known today as pay-for-performance (P4P), may be the most significant trend since the managed care era of the early 1990s¹. Of course, linking provider financial incentives to cost and quality is not new². While provider financial incentives in the early 1990s focused first on constraining services, there were also incentives for quality of care and consumer satisfaction. It was also during this period that the healthcare effectiveness data set (HEDIS) emerged as a means of comparing HMOs on a limited set of performance measures for selected chronic diseases and preventive services.

In 2001, the Institute of Medicine (IOM) issued its report on "Crossing the Quality Chasm"³. The report raised serious concerns about the quality of ambulatory care and recommended reforming provider payment to support quality improvement. Since that time, P4P programs have proliferated, with more than 100 programs nationwide, becoming a routine part of private and public payer operations, leading some to conclude that we have reached a tipping point⁴, in spite of the limited evidence that such programs improve the quality of care⁵.

Much of the discussion about P4P initiatives focuses on optimizing program design^{6,7,8,9}. For instance: which providers to target – hospitals, primary care, or specialists – whether to focus incentives on individual physicians or medical groups, whether to reward improvement or achieving benchmarks, what to measure and how to risk adjust in fairness to providers with more complicated patient populations. For each element of program design, there is an abundance of opinion on the right choice and mix, but little agreement.

As P4P programs have evolved, the types of providers, numbers of measures and financial incentives have all increased and most providers and healthcare purchasers agree that the current payment system needs to be reformed¹⁰. However, providers eligible for payments from a variety of commercial and government programs with different incentive schemes, who are constrained by limited resources, are finding it difficult to manage their participation in these programs. This may lead to adverse selection i.e., focusing on how to optimize financial incentives at the expense of certain patient groups¹¹. Creating an effective partnership with providers is essential.

Today's Approach

A recent study by Rosenthal¹² looked at the evolution of P4P strategies among early adopters, lessons learned and conclusions. They focused on 27 P4P program sponsors that primarily included large national health plans and regional BCBS plans. The number of members affected by these P4P programs ranged from a low of 52,000 to over 4 million. Total P4P program payments in 2005 ranged from a low of \$106,000 to over \$153 million. Rosenthal also examined targeted providers and specific measure sets employed by these programs (see Figures 1 and 2).

Figure 1

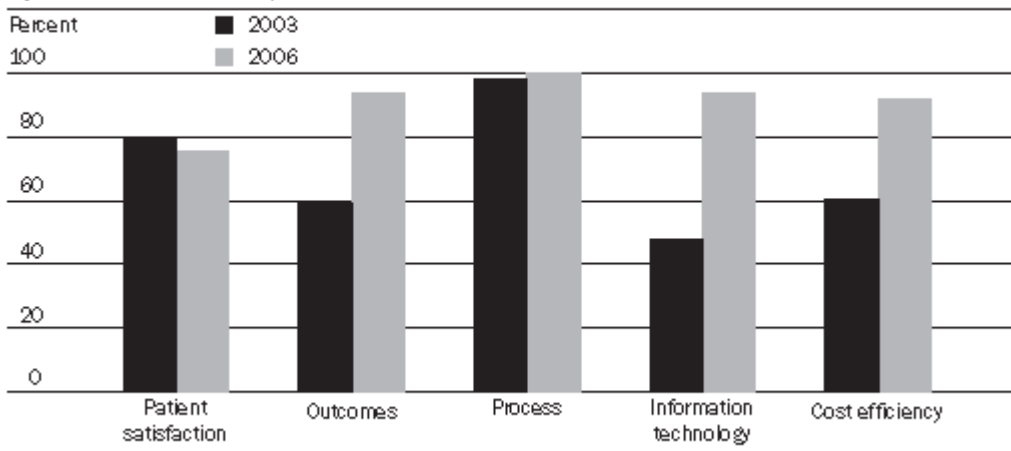
Percentage Of Enrollees Covered By Pay-For-Performance (P4P) Sponsors Covering Primary Care Physicians, Specialists, And Hospitals, 2003 And 2006



SOURCE: Authors' interviews with sponsor representatives, 2003 and 2006.

Figure 2

Percentage Of Enrollees Covered By Pay-For-Performance (P4P) Sponsors That Use Specific Measure Sets, 2003 And 2006



SOURCE: Authors' interviews with sponsor representatives, 2003 and 2006.

While primary care was an early and ongoing emphasis among all programs, specialists have become an important part of the mix. More programs have begun to emphasize health outcome measurements (intermediate outcomes such as HbA1c, LDL cholesterol and blood pressure) and have expanded the total number of measures that factor into financial incentive calculations. There has also been a significant shift in emphasis towards including measures of the use of information technology and cost efficiency.

Although these programs are spending more money per provider, incentive payments amounted to only about 2.3 percent of total provider reimbursement. Respondents were using varying methods to account for variations in patient populations and were beginning to reward improvement on performance measures instead of just reaching benchmarks. Overall, evidence of P4P program impact was unclear, with very few programs having had formal evaluations, many who felt that it was too early to expect changes and some that were not clear whether to attribute changes to financial incentives or to other factors. Concerns persisted about patient "dumping" or paying providers who were already meeting performance targets prior to the P4P initiative without any further improvement in quality after program implementation.

Among the lessons learned by this group of P4P sponsors were the need for early provider involvement and ongoing communication and transparency, and the need to address employer concerns by documenting net savings. Many believed that further tweaking – size of financial incentives, collaborating with other payers, adjusting target measures – would eventually lead to effective programs.

What is perhaps most interesting in this and other reviews of the state of P4P is the general lack of attention to non-financial interventions, such as audit and feedback, recognition, clinical reminders or information technology support, that may affect provider behavior as much or more than financial incentives. Grimshaw JM, et al, reviewed the potential impact of these non-financial interventions¹³.

They found that multifaceted approaches were more effective than single interventions. Passive approaches such as mailing educational material were generally ineffective and audit and feedback reports were moderately effective. Active interventions such as clinical guidelines supported by patient-specific clinical reminders were effective.

Audit reports are a common practice in P4P programs today. These typically take the form of quarterly or end of year, paper-based reports from multiple health plans or other P4P sponsors intended to inform a provider practice of specific patients for whom outcome measures or verification of preventive service are not available. This leaves the practice in the position of implementing extraordinary, manual workflows to contact patients by phone or mail, confirm the need for intervention and, when appropriate, obtain the necessary lab work or procedure or schedule an in-office evaluation to comply with performance measures that affect financial incentives^{14,15}.

A Better Solution

Given the continued evolution of P4P program design and the many programs in which an individual provider may participate, neither translating this paper-based, manually intensive process to bits and bytes nor expecting practices to deal with multiple P4P program Web sites will facilitate provider participation and increase the likelihood of program success. If anything, this may cause program sponsors to spend more on financial incentives than would be necessary if a more efficient and effective infrastructure were in place.

Provider practices have limited resources and need a common infrastructure that insulates them from the complexities of different programs, allowing them to focus on the specific patients for whom quality interventions are required. If they do so, the financial rewards will follow. The ideal solution would also complement the practices' routine work processes rather than expecting them to implement extraordinary and costly manual measures.

NaviNet[®] already has demonstrated the ability to consolidate administrative processes from several health plans into a common, secure and HIPAA-compliant Web site that allows individual practices to manage their work while maintaining each plan's distinct business rules. This approach creates significant operational savings for all parties – health plans, other sponsors and providers. As a by-product of routine administrative transactions performed throughout the day, NaviNet also delivers patient-specific clinical reminders into the provider practice workflow. These transactions occur in close proximity to a patient visit when attached to an eligibility and benefits inquiry/response – a common workflow in NaviNet and one typically performed within 24 hours for scheduled patients. NaviNet also delivers regular electronic audit reports from individual program sponsors documenting specific patients for whom outcome measures or other services may be required and the financial incentives earned to date. Rather than leaving the office to contact patients by phone or mail, NaviNet can further assist staff by automatically generating letters on behalf of the provider to these patients. In addition, NaviNet makes it possible for providers to respond electronically to clinical reminders. This feedback can assist

P4P sponsors seeking to improve their programs. Further, this can facilitate the capture of clinical information from practices that will enhance patient profiling and targeting.

Effective communication with providers is also a key to the success of P4P initiatives. NaviNet, with its national network of engaged providers, can assist sponsors in building provider awareness and can deliver a credible, workflow-based solution that will allow sponsors to realize their cost and quality goals.

Conclusion

Pay-for-performance programs are here to stay, but will continue to evolve as health plans and other sponsors adjust program design to maximize their effectiveness. While financial incentives are up to individual programs, non-financial incentives are also effective in influencing provider behavior. Among these are patient-specific clinical reminders and audit reports that provider practices can access through a single Web site, allowing them to manage the many P4P programs in which they will participate and which complements common practice work processes rather than forces the adoption of costly workarounds. A mix of non-financial and financial incentives is the best way to realize the cost and quality objectives for these programs.

¹ Rosenthal, MB, et al, Climbing up the pay-for-performance learning curve: where are the early adopters?, Health Affairs November/December 2007

² Robert Wood Johnson Foundation (2007) Paying for quality: understanding and assessing physician pay-for-performance initiatives

³ Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press, 2001 (this is available as a PDF download for approximately \$40)

⁴ Epstein AM, Pay for performance at the tipping point, N Engl J Med 2007, 356: 515-517

⁵ Petersen LA et al, Does pay-for-performance improve the quality of health care? Ann Intern Med 2006, 145: 265-272

⁶ Agency for Healthcare Research and Quality (2006) Pay for performance: a decision guide for purchasers

⁷Petersen LA, et al, (2006) op. cit.

⁸ Rosenthal MB, et al, Pay-for-performance, will the latest payment trend improve care? JAMA 2007, 297: 740-744

⁹ Robert Wood Johnson Foundation (2007) op. cit.

¹⁰ Rosenthal MB, et al JAMA (2007) op. cit.

¹¹ Robert Wood Johnson Foundation (2007), op. cit.

¹² Rosenthal MB, et al, Health Affairs (2007) op. cit.

¹³ Grimshaw JM, et al, Changing provider behavior an overview of systematic reviews of intervention, Medical Care, 2001, 39(8), Supplement 2, II-2 – II-45

¹⁴ NaviNet observations based on interviews with a broad spectrum of physician practices

¹⁵ Felt-Lisk S et al, Making pay-for-performance work in Medicaid, Health Affairs June 2007