

Pay for Performance Incentive Programs in Healthcare:

Market Dynamics and Business Process

Executive Briefing

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Pay for Performance Incentive Programs in Healthcare: Market Dynamics and Business Processes

Introduction

This executive briefing summarizes research on provider pay for performance incentive programs (P4P) in healthcare in the United States. The research was conducted by Med-Vantage, Inc., a healthcare consulting firm specializing in care management information technology and P4P deployment, under sponsorship by ViPS, Inc., a leading provider of healthcare business intelligence solutions.

This executive briefing features highlights from the full research report, *Pay for Performance Programs in Healthcare: Market Dynamics and Business Processes*. To obtain the full report from ViPS, please see the back cover for details.

Med-Vantage conducted research in late 2002 and early 2003 to evaluate the experiences of physician and hospital P4P incentive programs in the United States. The Med-Vantage research included:

- Telephone interviews with executives, physicians and thought leaders at 30 organizations currently operating P4P programs (see Figure 1)
- Case study research and in-depth interviews with executives and physicians responsible for P4P programs at six health plan organizations
- Review of secondary literature and data related to P4P and other incentive programs in healthcare

FIGURE 1
DISTRIBUTION OF SURVEY RESPONDENTS BY TYPE

Participant Type	Organizations and Individuals Interviewed
Employer Coalition/Benefits Consultant	Pacific Business Group on Health, Mercer
Health Plans	HealthPartners, Blue Cross Blue Shield of Florida, PacifiCare, Blue Cross Blue Shield of Massachusetts, Tufts Healthplan, Horizon Blue Cross Blue Shield of New Jersey, Blue Shield of California, HIP of New York, Excellus Blue Cross Blue Shield, Blue Cross Blue Shield of Hawaii, CareFirst, Independence Blue Cross, Harvard Pilgrim
Technology Vendors	CSC, DocSite, DxCG, EDS, Health Benchmarks, IHCIS, Medstat, QCSI, ViPS
Thought Leaders	Tom Sculley (CMS), Beau Carter (Integrated Healthcare Association); Brent Greenwood (Reden and Anders); Jordan Lovy, MD; Dave Ogden, Milliman and Robertson; Anita Murcko, MD, Health Services Advisory Group/QIO

IMPETUS BEHIND P4P

The momentum behind P4P comes from a response to rising medical cost trends, the growth in chronic care conditions, healthcare utilization, consumer directed healthcare and demands by purchasers for improvements in the quality of care. In addition, a progressive movement has emerged in the U.S. that has, among other things, been promoting P4P initiatives. The impetus behind P4P comes from the quality improvement imperative. Organizations such as Institute of Health Improvement (IHI), Institute of Medicine (IOM), Leapfrog Group, National Quality Foundation, state Quality Improvement Organizations (QIO, formerly PRO), URAC, Joint Commission on Accreditation of Health Care Organizations (JCAHO) and National Committee for Quality Assurance (NCQA) have strongly endorsed P4P initiatives across the U.S.

"We're at the earliest stages of identifying, recognizing and rewarding quality. Over time, we would want to say a lot more than just, 'Did a mammogram get done?'"

Sam Nussbaum, MD
Chief Medical Officer
Anthem

An early catalyst in the evolution of P4P was the IOM. In the landmark March, 2001 report, *Crossing the Quality Chasm*, the IOM strongly recommended that the federal government identify, test and evaluate various payment options that more closely align compensation methods and quality improvement goals with input from relevant private and public interests.

The IOM report argued that current reimbursement methods provide little financial reward for improvements in the quality of healthcare delivery and may even inadvertently pose barriers to innovation. Fee-for-service payments encourage overuse, while capitated payments encourage under-use. Neither reimbursement methodology systematically rewards excellence in quality. In fact, current payment mechanisms allow, and even reward, defective care because they are unable to reward future benefit.

P4P DEFINED

P4P incentive programs are designed to overcome the limitations of current reimbursement arrangements by aligning financial reward with improved outcomes. P4P incentive programs differentiate payment among providers based on performance of quality and efficiency measures so that desired outcomes occur through changed behavior.

"Our goal is to tie provider incentives and consumer benefits to provider performance on quality measures."

Sam Ho, MD
Chief Medical Officer
PacifiCare Health Systems

QUALITY, COST CONTROL AND P4P

Several of the health plans surveyed indicated they take a holistic view towards P4P, viewing P4P as part of an integrated strategy for effective care improvement. These plans view P4P as part of an overall quality and cost management strategy that includes consumer-driven benefit plan design, publicly disclosed provider report cards for consumers, tiered networks and integrated care management (disease and population health management, and wellness).

CHALLENGES AND CONCERNS AMONG PURCHASERS AND PAYERS

Despite growing purchaser enthusiasm for P4P, the long-term benefits and results remain uncertain. The study found that most P4P programs are in the early stages of market adoption; fewer than 25 percent of the programs had more than 5 years of operational experience. This is because most P4P programs are pilots. P4P results are still largely anecdotal and not reported publicly or peer reviewed. Provider P4P participation is largely voluntary and focused on primary

care physician measures, e.g., improving the Health Plan Employer Data and Information Set (HEDIS®) scores, patient satisfaction, physician access or electronic claims submission.

More fundamentally, there remain challenges related to funding, ease of administration, data collection, reporting of actionable information to providers, identifying outcomes and savings results, provider acceptance and transparency of results for consumers. Indeed, recent survey research on perceptions of the impact of P4P on the healthcare industry shows considerable levels of uncertainty or outright concern.

Despite this uncertainty, there is a strong belief among purchasers that P4P programs represent a positive development. This sentiment was echoed by numerous respondents to our survey.

Goals and Motivations behind Pay for Performance

The study revealed distinct goals, motivations and concerns among three stakeholder groups that drive P4P adoption today. These groups are:

- purchaser (employer) groups
- health plans
- healthcare providers

PURCHASER (EMPLOYER) MOTIVATION AND RESPONSE

At the center of the P4P movement are large employer coalitions building their business case for paying for quality. With rising hospital and pharmaceutical costs, new technology, increased utilization and government regulations stretching healthcare affordability to its limits, purchasers are demanding benefit programs that offer better value for their premium dollar.

By rewarding improvements in the care process, these coalitions believe they can save money by keeping patients healthier and by reducing avoidable hospital admissions.

FIGURE 2
AREAS OF PAY FOR PERFORMANCE OPPORTUNITY IDENTIFIED BY EMPLOYERS

Reducing clinical practice variation
<ul style="list-style-type: none"> • Encourage adoption of evidence-based medicine practices at the point-of-care locations, given that patients receive only about 55 percent of evidence-based recommended care
Reducing errors
<ul style="list-style-type: none"> • Promote accepted best clinical and medication safety practices
Reducing acute exacerbations
<ul style="list-style-type: none"> • Use measures that assess the appropriateness of hospital stays and emergency room visits and serve to optimize care for chronically ill patients
Increasing transparency of provider performance for price/quality sensitive consumers
<ul style="list-style-type: none"> • Use decision support tools that result in informed, empowered consumers

Purchasers also expect that incentives for better quality will lead to changes in both patient and provider behavior.

The preceding Figure 2 on page four summarizes several areas of opportunity within P4P that support purchaser strategies. Additional details can be found in the full research report.

HEALTH PLAN MOTIVATION AND RESPONSE

While health plans share many purchaser concerns and motivations, they must weigh additional internal and external objectives, such as market share, market image, administrative simplicity and costs.

Consequently, health plan survey respondents said they favor a balanced scorecard approach to provider P4P with domains weighted for quality, appropriateness, market share, administrative efficiency and point-of-care clinical infrastructure.

With respect to a health plan's improved competitive positioning, respondents emphasized the potential to use P4P for marketing purposes by improving member and provider satisfaction ratings.

Additionally, several health plan respondents emphasized administrative efficiency and simplicity, plus reduction of administrative cost as critical areas.

PROVIDER MOTIVATION AND RESPONSE

Providers are the most cautious with regard to P4P since they may view monetary incentives as punitive tools that emphasize risk more than rewards. Providers, however, are likely to endorse P4P conditionally if the program represents additional reimbursement. In addition, provider acceptance can increase if the measures can be defined in a defensible, credible, relevant and understandable manner. The survey identified three forms of provider motivation:

"Health plans talk about shifting to outcomes based payment models, putting more demands on doctors to meet standards of care by developing "best practice" approaches, while at the same time providing no additional reimbursement to do so."

Jordan Lovy, MD
Internist, Houston, TX

- Providers want "to do the right thing"
- Physician groups that win incentive awards also achieve a competitive advantage through increased practice recognition
- Providers risk losing market share and patient volume if they do not participate in P4P programs

Market Adoption

As of July, 2003, the study found that more than 30 million beneficiaries, primarily in urban areas, participate in 40 P4P programs sponsored by state governments, the Centers for Medicare and Medicaid Services (CMS), employer coalitions and health plans. Based on current growth trends and market adoption rates, the number of P4P sponsor organizations will increase to at least 80 by 2006.

Two concerns drew considerable detailed commentary from health plan respondents: competitive positioning and administrative simplicity.

P4P programs initially start with fully insured health maintenance organization (HMO) products. In 63 percent of the sponsoring organizations surveyed, P4P programs were offered only for fully insured HMO products. Adaptation of P4P to preferred provider organizations (PPOs) and self-

insured, Administrative Service Only (ASO) arrangements still remains in the early stages.

While some industry executives anticipate even faster growth, others disagree that P4P represents a significant trend. Med-Vantage forecasts strong rates of growth for P4P programs over the next three years, but not the universal adoption predicted by some industry experts.

Perhaps as significant, we anticipate further refinement of existing programs to include hospitals, specialists and more sophisticated measures for performance assessment.

MARKET CONDITIONS FAVORABLE TO P4P ADOPTION

The Med-Vantage survey identified several local market dynamics that must be present to create a successful P4P initiative. In general, the minimum thresholds described below must be met for a P4P initiative to succeed:

- minimum HMO market share of 25 percent or more, since HMO products are usually the first and easiest product in which to introduce P4P
- minimum percentage of 10 percent or more of physician or group practice revenue represented by P4P. There has to be sufficient patient volume to make the P4P effort worthwhile to the providers. With low patient volumes, P4P payment calculations may suffer from the low-end problem as sample size declines and data accuracy for determining practice performance on preventive care measures, for example, becomes more problematic
- minimum percentage of total payouts from incentives sufficient enough to change behavior

Other factors critical to P4P adoption, include:

- positive previous experiences with incentive programs among providers
- compatibility with existing market-wide quality improvement initiatives, such as CMS Quality Improvement Organization (QIO) efforts

P4P PROGRAM EVOLUTION

Responses to our survey indicate that P4P program sophistication varies widely by plan and purchaser and typically evolves over time. As programs evolve, they become more administratively complex, use more sophisticated business and clinical measures and involve specialists and facilities. Figure 3 illustrates a condensed view of P4P program evolution. For additional details on P4P program evolution, please see the full report.

The three phases of P4P program evolution identified above should not be understood as a predetermined, linear path to ever greater sophistication. The study showed that not all P4P programs continue to evolve. Indeed, several programs have stalled in their development and provider participation levels, having achieved relatively modest goals without strong impetus from employers or providers for continued expansion or refinement.

“There still remains considerable skepticism about outcomes-based assessment, outcomes-based payment measures, and differential pricing for providers based on outcomes measures.”

Chuck Saunders, MD
President of Healthcare
EDS

**FIGURE 3
THREE PHASES OF DEVELOPMENT IN PAY FOR PERFORMANCE PROGRAMS**

Phase(duration)	Features	Benefits
I (1-2 years)	Pilot programs, early experimentation HMO- and PCP-focused simple, already understood measures	Low complexity and administrative cost Limited actionable information for providers and consumers
II (3-4 years)	Additional and more complex clinical, efficiency and quality measures Expansion beyond HMOs to PPOs, but specialists still excluded Increased administrative cost	Broader release of more actionable information Focus on measures with efficiency ROIs and improvements in quality outcomes within 12-18 months
III (5+ years)	Increased sophistication and complexity Balanced scorecard that weights multiple domains Specialists included	Actionable, detailed, practice-level information Widely available to consumers Ability to substantiate ROI Point-of-care clinical IT integration with P4P sponsor

Funding and Incentives

Divergent and sometimes conflicting views on the issue of P4P program funding exist among providers, purchasers and health plans. Generally, providers want the incentives to represent new money, while purchasers and health plans want to fund incentives through utilization savings and/or substitute fee schedule increases with performance payments.

PROVIDER PERSPECTIVE: NEW FUNDS FOR P4P

Providers have strongly resisted the substitution of performance-based payments for fee schedule increases. Providers argue that additional dollars are needed up front from purchasers and health plans to support investments in point-of-care clinical information systems. With the average cost of an electronic medical record (EMR) exceeding \$5,000 per physician per year and multi-million dollar investments required for computerized physician order entry (CPOE) and clinical information systems, it is difficult for some providers to self-fund these costs despite the societal benefits of reduced medication and safety errors and improved compliance with evidence-based standards.

PURCHASER/HEALTH PLAN PERSPECTIVE

Purchaser and health plans appear unwilling to pay for any incentive amounts on top of unmitigated medical cost increases. From the health plan perspective, there are

“Initially, providers were very nervous about whether P4P offered ‘new money’ and how much it would be. Since all six California plans announced their payment amounts, the providers are satisfied that there is enough money on the table and have moved forward to become active players.”

Beau Carter
President
Integrated Healthcare Association

challenges to funding P4P incentives with additional premium dollars. First, health plans may not accrue the benefits of investments in population health initiatives given that they face annual membership turnover of 20 percent or more. Additionally, health plans cannot add extra dollars without reducing their administrative overhead or profits. Consequently, health plans may argue that incentives should be funded through savings from decreased service utilization.

Alternatively, some health plans appear more willing to substitute provider fee schedule increases with performance-based payments. Despite provider demands for large fee schedule increases, the consensus among P4P sponsors is to reallocate monies from fee schedule increases to pay for performance incentive budgets.

FUNDING AMOUNTS AND INCENTIVE PAY-OUT APPROACHES

What constitutes a meaningful payment amount for providers? Though funding amounts among health plans vary widely, Med-Vantage learned that the average P4P program pays a 10 percent bonus or return of a 10 percent withhold for professional services. Anything less than 10 percent may not be meaningful or worth the time and investment required for a practice to comply with the administrative requirements. For hospitals, the range is 2-4 percent of all paid claims.

P4P incentives take several forms. The survey, however, did not focus on employee incentives for wellness, benefit design or contract incentives between purchasers and healthplans. Employee incentives and purchaser-health plan incentives do play a meaningful role and do interplay with provider incentives as noted below. A summary of the most common payment approaches follows:

- **Bonuses** - These generally take the form of annual payments by health plans that range from 5-20 percent of total physician reimbursement based on meeting minimum target requirements for several measures. Bonuses are also applied to hospital incentive programs. Bonus-based performance incentives are easier to implement since provider contracts do not require renegotiation or rewriting. Participation in bonus programs can also be made voluntary.
- **Withholds** - Health plans may withhold a percentage of reimbursement and subsequently return all or portions of the withhold based on the provider meeting minimum target requirements for several measures. Generally, providers are not receptive to withholds since they prefer arrangements where there is upside risk only. Unlike bonuses, withhold-based performance incentives have to be written into assigned contracts and are not voluntary.
- **Adjustable fee schedules for specialists** - The tiered fee schedule of a physician, typically a specialist, is adjusted retroactively for prior period performance on several measures.
- **Quality grants** - The health plan or purchaser provides funding for specific quality improvement projects to a medical group, independent practice association (IPA), management services organization (MSO) or integrated delivery network (IDN).
- **Additional reimbursement for chronic care, care management and investment in point-of-care clinical information systems** - Physicians receive a small payment for completing care tasks (e.g., creating action plans for patients with diabetes, asthma or heart failure), achieving specific evidence-based milestones for disease states; and/or reporting results from patient registries.
- **Employer-health plan incentive agreements** - Under these agreements, employer coalitions or large employers place a portion of the administrative services only (ASO) contract fee or

“The notion of employers paying an additional 10 percent across the board to fund pay for performance is not popular at all. Generally employers want to pay for higher quality at the same or lower cost.”

David Hopkins, PhD
Director of Quality
Measurement and Improvement
Pacific Business Group on Health

percentage of premium (fully-insured) at risk for health plan performance based on specified measures. The employer indirectly influences providers through contract incentives for the health plan. Health plans report provider performance results to purchasers so that employees can make informed choices about networks, products, etc. Conversely, a health plan may provide strong incentives for the employer to lower population risk among employees. For example, one health plan in the study offers a 1 percent reduction in premium for all employees who complete a health risk assessment survey. The survey is used by the health plan's care managers for early risk identification and intervention purposes. Employers, in turn, can offer lower monthly healthcare benefit deductions to encourage employee completion of the surveys.

NON-FINANCIAL REWARDS AND BALANCED REPORT CARD

Several types of non-financial incentives also exist within the P4P framework. These are summarized below.

- **Patient Benefit Design and Tiered Networks** – Benefit design can drive market share by explicitly channeling patients with cost differentials that reward selection of high-performing provider networks. These cost differentials effectively reward consumers who select high-performing provider networks, while rewarding these providers with increased patient volume. These networks can include “hard” or “soft” tiers. Hard tiers include benefit and contractual segmentation of providers based on performance. Soft tiers include the use of benefit design and provider cost transparency for consumers without contractual segmentation.
- **Administrative Relief** - High-performing providers may be exempted from onerous referral authorization requirements. Decisions are automatically pre-approved by the health plan to reduce hassle and bureaucratic barriers to treatment.
- **Public Report Cards, Community Recognition and Honor Rolls** – Health plans and employer coalitions may use this highly effective approach in concert with P4P incentive programs to recognize best demonstrated practices among high-performing providers. For the physician practice or hospital, the additional prestige of being on the honor roll or report card, can create considerable public relations benefit. With public prestige comes increased patient volume and increased practice revenue.

Typically, health plans and purchasers seek a balance between cost and quality measures in the form of a report card or score card. The balanced score card can include several categories that are valued using different weights. Funds from a common funding pool are then distributed based on these weighting values and provider performance based on relative ranking or achievement of targets for specific measures.

INCENTIVE PAYMENT FREQUENCY

Depending on the measure and domain, incentive payouts can be made quarterly, semi-annually or an annual basis.

Frequent provider payouts, such as quarterly or monthly payments, have the advantage of reinforcing provider behavioral change. However, frequent payouts are not feasible when the administrative process is manual and time consuming, or when payout is funded from utilization savings, as this requires annual reconciliation and claims run-out.

More frequent payments require sophisticated reporting and data collection capabilities, dedicated operations resources and highly automated statistical analyses.

Annual incentive payments to providers are most common among health plans because they are the easiest to administer. Annual payments can also be timed better with annual patient satisfaction survey scores, HEDIS results and budget neutral efficiency measures. Annual payments allow for manual reconciliation of complex, tiered measure-point calculations used in the scorecard.

Quarterly and monthly payments can be used for compliance and process measures that do not require annual reconciliation. The survey identified that combining quarterly or monthly payments with web-based reporting is most effective when providers are shown how to improve their performance. Specifically, several of the sophisticated health plans interviewed can now deliver timely, web-based or faxed patient reminders (care alerts) to physicians. In addition, these plans can also deliver defensible and credible evidence-based information with reminders to reduce physician practice variation.

Finally, if a health plan decides to use an efficiency measure, such as episode treatment groups (ETGs), that requires a statistically meaningful sample size, it may require using a rolling or moving quarterly average approach with a minimum historical baseline of 12-18 months of experience.

Measuring Performance: Physicians and Hospitals

The questions of what to measure and how to define a P4P measure raise significant issues. P4P participants need to assess whether the data for a measure can be reliably collected and whether process measures can be linked to outcomes. They must also recognize that measures evolve over time.

In selecting appropriate measures, health plans and purchasers must satisfactorily answer the following three questions:

- What behavioral changes are being promoted by these measures?
- Will there be political acceptance by providers for these measures?
- What is the feasibility of collecting and generating data for these measures?

Many early stage P4P programs start with administrative process measures since data for these measures can be gleaned from existing claims. As markets progress in sophistication, point-of-care data collection tools such as patient registries and other roster tracking devices allow for collection of information around clinical variance.

TYPES OF PHYSICIAN MEASURES

The majority of health plans and sponsoring organizations now use HEDIS (primarily preventive care and diabetic measures) and patient satisfaction surveys such as the Consumer Assessment of Health Plans survey (CAHPS) for their P4P program.

There are limitations with relying solely on HEDIS or population-based measures in a P4P program. While broad P4P participation in preventive care measures may be desirable, a sponsoring organization may wish to fund incentives with shared savings from a target condition within a defined time period and/or broaden the P4P program to include specialists or PPO/point-of-service (POS)/ASO self-insured lines of business.

Several of the surveyed primary care physician respondents, with three or more years of operational experience, recommended measures that target evidence-based compliance for

managing chronic conditions, areas of inappropriate utilization (e.g., efficiency) and point-of-care clinical IT adoption (e.g., chronic care model).

PHYSICIAN MEASURES: MAJOR CONCERNS

It is very difficult to establish measures at the individual physician level due to small sample size. To reduce random variation, survey respondents stated that it was easier to pay incentives at the tax identification number (TIN) level (e.g., group practice level). However, survey respondents recommended that incentives be pushed down to the individual provider level, if possible.

Not all measures will be valid for all participating physicians and specialties. Consequently, the sponsoring organization needs to establish eligibility criteria for physician participation on each measure.

Risk adjustment is necessary for efficiency measures, particularly when comparing physician performance for payment purposes. Risk adjustment is not necessary for compliance measures, clinical IT domains and clinical process or outcomes measures.

HOSPITAL MEASURES, SAMPLE SIZE AND RISK ADJUSTMENT

There was consensus among survey participants on the types of measures used for hospital P4P programs, as well as for public reporting (transparency) of hospital measure results to consumers. The majority of health plans and sponsor organizations use Leapfrog, JCAHO, National Quality Foundation, and/or CMS measures in their P4P program for hospitals. The study found that purchasers use four general categories for hospital incentive measures:

- safety
- compliance with evidence-based medicine practices
- connectivity or use of clinical IT
- medical records

The study showed that there can be a “small-numbers” problem that restricts the use of certain measures for some hospitals. Smaller hospitals may not even provide services that are measured.

There are valid, reliable, comparable and salient quality measures that have been shown to provide a potent stimulus for clinicians and providers to improve the quality of the care they provide.

American Hospital Association

Consequently, not all hospitals can participate in all measures sponsored by a P4P organization. Finally, risk adjustment is necessary for efficiency measures, particularly when profiling hospitals for comparative performance and reimbursement purposes.

There are several sources of well-accepted and frequently used measures for P4P incentive programs. The sources for many of these evidence-based measures are available from specialty and professional societies, the disease management industry and quality improvement organizations. Additional details on measures used by various health plans and sources for measures can be found in the full research report.

Although more complicated to administer, a menu approach to provider participation allows the physician practice to participate voluntarily in one, several or all domains and measures.

CHANGING MEASURES AND PERFORMANCE THRESHOLDS

A program sponsor should evaluate the efficacy of all incentive measures and domains used in a P4P incentive program at least annually. Initially, measures that employ thresholds should have the bar set low enough so that there is broad participation. As targets are achieved, measures can be replaced with others that are relevant to community based practices and hospitals.

In addition, the balanced scorecard of different categories should be constructed so that domain weightings can change over time to reflect the evolving quality, cost management and administrative priorities of the sponsoring organization and local provider community.

SCORING PROVIDERS FOR PAYMENT DISTRIBUTION PURPOSES

The survey identified several approaches to scoring provider performance for payment purposes. These approaches ranged from simple to complex point calculations based upon point tiers, paying providers for one or a combination of the following scoring systems:

- **Threshold Scoring** - This simple scoring approach is based on a provider meeting or exceeding a threshold.
- **Scoring Based on Rank** - Another approach is to rank providers on a statistical distribution. Payment is increased for providers who perform in the top tier, but decreased for those who perform in lower tiers.
- **Tiered Scoring (Threshold and Ranking)** - An alternative approach is to provide some reward for progress towards a specific set of goals. This approach relies on scoring systems that use weighted values assigned to categories (e.g., balanced scorecard), point scores for performance within each category and eligibility criteria for domains and measures within each P4P category. Typically, the provider has to achieve compliance or exceed a threshold across multiple domains, not just one or two measures.

P4P Operations and Business Processes for Health Plans

The administrative challenges associated with designing, deploying, managing and refining P4P programs for both health plans and providers are significant. At the highest level the major administrative areas include:

- data sources and business workflow processes
- clinical decision support systems
- budgeting and accounting
- network management
- product design
- provider acceptance education and participation
- program evaluation

Each one of these areas, in turn, comprises numerous additional administrative challenges, all of which must be addressed and monitored. In practice, some of these operational areas at health plans are more developed than others. In the area of budgeting, provider scoring, P4P reimbursement, report cards, and retrospective program evaluation, for instance, many calculations are manual or commonly performed using spreadsheet software or complex statistical software. The survey responses showed that there are few, if any financial and clinical decision support systems available to track and report provider performance in P4P scoring systems. Most P4P administration systems have been internally developed at health plans.

Med-Vantage has identified best-in-practice operational processes for health plan P4P programs. We used these best-demonstrated practices to develop a general operational model (discussed and illustrated in further detail in the full research report) that comprises seven major steps. These steps are discussed below. Actual health plan operational programs may vary due to several factors.

STEPS 1-3: DATA SOURCES AND BUSINESS PROCESSES

Most of the health plans surveyed rely on current administrative data sets (claims, Rx, eligibility, provider files, etc.) and HEDIS data collection efforts for their P4P incentive programs. Health plans that focus on chronic conditions and clinical IT infrastructure incentives collect additional, point-of-care data (medical charts).

This reliance on existing data sets results from the fact that collection and standardization of non-administrative data sets often can increase P4P program administration costs for both providers and health plans alike.

Typically a relational database management system (RDBMS) is used to aggregate and integrate multi-source transaction data. The health plan constructs data marts within the RDBMS for consumption by more dedicated clinical/business intelligence tools.

FIGURE 4
BUSINESS INTELLIGENCE-CLINICAL INTELLIGENCE SYSTEM COMPONENTS

Component	Purpose
Data integration and transformation	Clean, map and transform data into meaningful clinical information.
Electronic patient health record	Capture patient-specific information and care alerts relating to appropriateness of care, interventions taken and actions required.
Predictive modeling	Identify/stratify/predict highcost patients. Correlate measures with downstream outcomes and utilization.
Compliance alert system	Provide confirmation that the care delivered is the correct care. Identify patients that may need a screening or test. Communicate actionable reminder information to providers.
Point-of-care clinical IT data results integration	Deliver point-of-care alert notification at time of eligibility verification or ensure that results are communicated frequently and electronically to provider EMR or patient registry. Select medical chart results electronically sent to P4P sponsor.
Outcomes reporting, statistical analysis, comparative profiling, public report cards	Offer robust, web-based, business intelligence capabilities for communicating results to P4P stakeholders.

STEP 4: BUSINESS INTELLIGENCE AND CLINICAL DECISION SUPPORT SYSTEM

Respondents to the Med-Vantage survey identified business-clinical intelligence systems with patient health record capability as a critical operational component of health plan P4P programs.

These systems integrate data and provide intelligence, automation, communication and actionable reporting to improve the administration of P4P programs for plans and provider participants. The preceding Figure 4 summarizes the six key components of such an integrated system.

STEP 5: BUDGET DETERMINATION AND ACCOUNTING RECONCILIATION

Prior to payout, health plan finance departments establish overall budgets based on expected savings, premium dollars or other funding sources. Once the P4P reporting period is complete, an analysis of provider performance is required. A reconciliation may be required, particularly if “withholds” or efficiency measures based on utilization have been used for providers.

Respondents to the survey generally indicated that the process for calculating and determining provider payments is largely manual, performed in either Access databases, spreadsheets or other statistical software packages. Some respondents expressed the need to automate the payment calculation process and for stronger analytics to support the P4P program.

STEP 6: PROVIDER RELATIONS/NETWORK MANAGEMENT

Provider collaboration, education and understanding of performance expectations are essential to achieving improvement under P4P. Several of the health plans surveyed emphasized the importance of continuing communication and outreach to providers.

“I really think that we need to get providers involved in designing the metrics in quality measures.”

Deleys Brandman, MD
Commerce Net

P4P sponsors would be well advised to address the question: “Did we do what we said we would do, in the time frame in which we said it would be completed, and at a cost that was greater or lesser than we predicted in terms of revenue, quality and satisfaction?”

STEP 7: RETROSPECTIVE EVALUATION

Like the disease management industry, the purchasing/employer community emphasized the importance of measuring the magnitude of savings/outcomes and careful timing of the impact of investments in P4P programs. This includes: 1) identifying whether the P4P program caused an effect; and 2) establishing a sound design for program evaluation to see what the outcome would have been in the absence of a P4P program.

Key Lessons Learned and Critical Success Factors

This report identified key lessons and critical success factors in seven key areas of P4P program design and implementation. A detailed discussion of each category and its associated lessons can be found in the full research report, *Pay for Performance Programs in Healthcare: Market Dynamics and Business Processes*. A brief summary of each category follows below:

STRATEGY

A P4P program should be part of a multi-faceted quality and cost management strategy. Toward that end, payers should design P4P programs to achieve specific goals whose progress can be measured within a defined time frame. The program must be relevant from business and clinical perspectives.

FUNDING

Funding for P4P programs should come from budgeted savings and/or reallocation of monies from provider fee schedule increases. For measures funded through savings, savings need to be generated within a reasonable time period (under 18 months) to support incentive pay-outs. Sponsoring organizations may need to provide additional funding for point-of-care clinical IT systems for providers (e.g., patient registries).

MEASURES

Measures should reflect program goals and thus should be relevant to the program's major constituents: health plans, purchasers (employers) and providers. P4P programs are more effective when using a balanced scorecard approach that weighs concerns for quality, efficiency, and infrastructure (e.g., point-of-care clinical IT). Providers will reject any measures that make them responsible for results beyond their control. As programs evolve, so too should the measures used.

EVALUATION

Credible results are very important for continued P4P program success. P4P programs should embed the process for quantifying, proving and validating ROI and outcomes. Identify parties and programs responsible for the improvement in measures. This process should incorporate methodologies and predictive modeling tools used in disease management for assessing performance. Program results should be reviewed against cost, efficiency and quality criteria.

OPERATIONS AND BUSINESS PROCESSES

For a P4P program to be successful, it must not be overly complicated or expensive to administer. Processes must be well structured and as simplified as possible. Where feasible, existing data streams and processes should be leveraged. P4P administration cuts across multiple functional areas and business units. Overlapping accountability for a measure improvement should be clearly delineated (e.g., disease management vendor, patient benefit design, physician, care management, etc.).

PROVIDER ACCEPTANCE

Overcoming provider resistance is the key to the success of any P4P program. Starting small with voluntary, pilot programs and educating providers on the benefits of the programs will help convince this key constituency. Providing actionable feedback will encourage confidence in the program. To justify the time and cost of P4P to providers, P4P programs should: 1) be clinically relevant; 2) offer meaningful incentives so that provider net margins improve; 3) provide sufficient patient volume to attract provider attention; and 4) use measures that do not create undue administrative burdens.

CONSUMER DIRECTED HEALTHCARE

Public disclosure of provider results in the form of balanced scorecards will strengthen a P4P program. Recognize that some providers are completely unwilling to accept any measurement system. Results on physician and hospital performance should be accessible and meaningful at the retail level for consumers to act upon.

Conclusion

The healthcare system in the United States is at a crossroads. Resurgent medical cost inflation, combined with increasing utilization by an aging and newly empowered consumer population, has put considerable strain on both healthcare delivery and finance.

These cost issues are compounded by a growing chorus among industry experts and consumers alike calling for improvements in the quality of care.

Numerous attempts at containing costs and improving quality have been previously attempted, but with little success. Initiatives based on quality alone have not worked to contain the growth of healthcare expenditures. Likewise, purely utilization-driven programs, such as generalized pre-authorization, have proven burdensome and financially ineffective.

P4P programs, in contrast, hold promise for effectively addressing these dual concerns – perhaps precisely because P4P addresses both issues as part of a holistic approach to providing care.

Clearly, numerous challenges to implementing P4P exist across the entire delivery system, from provider acceptance to administrative simplicity, program design and other areas. Early pioneers have well established mature P4P programs. Now, a second generation of programs has emerged, CMS has launched pilot programs, and another growing wave of health plans has launched their own P4P programs.

The experiences captured in this report show that when properly executed, P4P programs can achieve cost and quality goals.

The combination of setting the right incentives, facilitating access to the right information at the right time and measuring compliance with markers of high-quality clinical delivery promise to steer the healthcare system toward its desired goal – effective care for those who need it.

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