

# Pay for Performance (P4P)

## Financial incentives for meeting quality targets

Presented by:

American Academy of Allergy, Asthma & Immunology (AAAAI)

American College of Allergy, Asthma & Immunology (ACAAI)

Joint Council of Allergy, Asthma and Immunology (JCAAI)



# Why Pay for Performance?

- Institute of Medicine (IOM) – US health care system “in need of fundamental change.”
- Current failure to “align payment incentives with quality improvement.”
- Urged purchasers and regulators of health care to “create an environment that fosters and rewards improvement.”

Reference: Crossing the Quality Chasm, IOM, 2001.



# Scope of Pay for Performance

- Result of IOM report – P4P
- 2004 – 35 programs
- 2005 – 115 programs
- 2006 - ? Many more
- Estimate 2008 – 160 programs covering >75 million Americans

Source: [www.medvantageinc.com](http://www.medvantageinc.com)

# Targets of Pay for Performance 2006

- Primary Care Physicians mainly
- Specialists
  - Cardiology
  - Orthopedics
  - OB
  - Endocrine
- This will change to include all of medicine

# Methods of Reward

- Bonus
- Added income from improvement tasks
- Payment from withholds
- Quality grants
- Differential fees
- Increased capitation rates

# National Initiatives

- National Health Plans – largest P4P programs
  - Cigna, Aetna, Humana, United etc.
- Coalitions
  - Bridges to Excellence
    - 3 measures: office systems improvement, diabetes and cardiac care

Source: [www.aafp.org/fpm/20060700/69what.html](http://www.aafp.org/fpm/20060700/69what.html)



# National Initiatives continued

- Integrated Health Care Association
  - Bonus based on clinical performance, patient experience and use of information technology (IT). Bonuses range from \$5,000-\$10,000 per year.

Source: [www.aafp.org/fpm/20060700/69what.html](http://www.aafp.org/fpm/20060700/69what.html)



# Medicare Initiatives

- Medicare Care Management Performance Demonstration
  - Improved care thru Electronic Medical Records (EMR) - diabetes and heart disease
  - Voluntary Physician Reporting System 2006
    - Voluntary reporting of 16 measures
    - Report to Centers for Medicare and Medicaid Services (CMS) using G codes
    - Easier to report if you have EMR
    - May become mandatory in 2008

# Organizations in Pay for Performance

- American Medical Association (AMA) Consortium for Physician Quality Improvement
  - Develop Measures
- National Quality Forum (NQF)
  - Validates Measures
- Ambulatory Quality Care Alliance (AQA)
  - Implementation of Measures by Carriers and the Government



# AMA Quality Activities

- AMA Consortium for Physician Quality Improvement -
  - Developed 90 quality measures by end of 2005
  - Has agreed to develop 140 evidence based measures by end of 2006
  - Reason – reverse Medicare cut in fee schedule for 2006

Source: NY Times, Managed Healthcare Executive



# National Quality Forum (NQF)

- Private not-for-profit congressionally recognized organization.
- Validates measures of quality using consensus based national standards.
- By law – CMS can use only evidence based quality measures or those endorsed by NQF.



# National Quality Forum (NQF)

continued

- NQF cannot validate all measures 2<sup>d</sup> cost;
- All measures developed by AMA consortium and by other sources must be validated prior to CMS and other payers using them;
- This problem is not yet resolved.

# Ambulatory Quality Care Alliance (AQA)

- Founded by American College of Physicians (ACP), American Academy of Family Physicians (AAFP), Americas Health Insurance Plans (AHIP) and Agency for Healthcare Research & Quality (AHRQ) - 2004
- Kevin Weiss, MD, Chair
- Leader for implementation of validated measures
- AQA wants every specialty to develop its own measures



# Does Evidence Based Care Reduce Costs?

- Joint Private Sector-Government P4P project
  - Inpatient Study
- 260 hospitals affiliated with Premier Inc. – a health care alliance
- Study looking at 28 process and 8 quality indicators – 3 year study

# Does Evidence Based Care Reduce Costs? continued

- Preliminary results – June 2006
- Evidence based care of pneumonia and coronary artery bypass graft (CABG) could save US almost \$1 billion annually
  - Decrease mortality by 3,000
  - Result in 500,000 fewer inpatient days

# Does Pay for Performance Improve Quality of Care?

- Meta analysis of 17 studies (1980-2005)
- Payment system level incentives:
  - One study \$3,000 savings per nursing home admit
  - 7/9 studies – partial or + effects of provider group level incentives for quality of care
  - 5/6 studies – partial or + effects of physician directed incentives on quality of care
  - Recommend more and better designed studies

Reference: Peterson LA et al Ann Int Med 2006

# Potential Pay for Performance Strengths

- Improve healthcare quality
- Minimize cost
- Maximize efficiency
- Reduce variability in healthcare delivery
- Improve adherence to evidence based practice guidelines

# Potential Pay for Performance Weaknesses

- Cost control not quality improvement
- Evidence-based medicine isn't really evidence based
- Practice guidelines usurp clinical judgment
- Patients are not interchangeable

# Potential Pay for Performance Weaknesses

continued

- One plan believes at least 10% of MD reimbursement must be at risk to change provider behavior.
- No severity adjustment.
- Patients may not comply and doctor is blamed.
- Health plans inconsistent in their application of measures and physicians get different ratings from different plans.

# AMA and Allergy Activities



# AMA Physician Consortium for Performance Improvement

- AMA Initiative:
  - Representatives from 50 Medical Specialty Societies
    - Academy and College represented
  - State Medical Societies
  - Agency for Healthcare Research & Quality (AHRQ)
  - CMS
  - Methodological Experts
  - Collecting Evidence Based measures



# Asthma Measures

- Developed by AMA asthma physician consortium
- Purpose – to facilitate individual physician quality improvement
- Performance measures are NOT clinical guidelines
  - Developed from evidence-based clinical guidelines
  - Indicate whether or not or how often a process or outcome of care occurs
- 2 asthma measures developed to date

# Asthma Assessment Clinical Performance Measure

- Percent patients evaluated at least once during reporting year for frequency of daytime or night-time asthma symptoms.
- Numerator – patients who were evaluated during at least one office visit for frequency of daytime and nocturnal asthma symptoms.
- Denominator – all patients aged 5-40 with bronchial asthma seen in the past year.

# Pharmacologic Therapy

- Performance Measure – percent of patients with persistent asthma who were prescribed either preferred controller or an acceptable alternative.
- Numerator – Patient prescribed either preferred long term controller or acceptable alternative.
- Denominator – all patients aged 5-40 with persistent bronchial asthma seen in the past year.

# Joint Quality Measures Task Force: ACAAI/AAAAI/JCAAI Asthma Subcommittee

- Educate membership on P4P in general
- Educate payers and membership on asthma measures currently adopted for use by allergy-immunology
- Develop “higher bar” asthma measure for allergist-immunologists specifically

# Joint Quality Measures Task Force: ACAAI/AAAAI/JCAAI Rhinitis Subcommittee

- Rhinitis-Allergy in lead; Ear, nose & throat (ENT) on the committee
- Sinusitis-ENT lead; Allergists on the committee

# AAAAI Guideline Implementation Tool Task Force

- Creation of user friendly electronic tools for allergists that would facilitate:
  - Asthma care that conforms to new National Asthma Education Prevention Program (NAEPP) guidelines
  - Quality care as defined by performance measures (including P4P)
  - Documentation of quality of care for Maintenance of Certification (MOC)
- Sponsored by Genentech



# Possible Future Activities

- Submission of validated asthma specialist performance measures to NQF.
- Development of asthma module for National Committee for Quality Assurance (NCQA) “Bridges to Excellence” Program.
- Development of performance measures for other allergic diseases.

# What Does the Allergist Need to Know Before Signing Up for a Pay for Performance plan?

- Know the basis and application of the measures and the type of data that supports them (claims or clinical/chart)
- Evaluate the impact on current practice – patient care, clinical process impact and economic impact

# Pay for Performance Need to Know?

- Determine the impact of data collection on office operations and overhead.
- Others will monitor your practice to assess possible issues of patient “cherry picking”.

# Pay for Performance

## Need to Know continued

- Is the design of the program an incentive or withhold?
- What type of reporting of performance will occur--internal participants only or to the general public?
- Verify system classification of your provider status.

# Pay for Performance

## Need to Know continued

- Evaluate the frequency and quality of reports.
- Is quality improvement recognized, achievable and rewarded?

# Allergist Experiences to date

- JCAAI survey of P4P experience of allergists
- September 28, 2006
- E-mail 2,200 members
- 342 responses
- 29 allergists participate in one or more P4P programs

# Number of Allergists Participating in Pay for Performance Programs

Number of P4P Plans	Number of Allergists
1	13
2	5
3	5
4	3
7	1
Unknown number	2

# Type of Pay for Performance Incentives for Allergists

Type of incentive	Number of Allergists
No withhold	10
Bonus	12
Differential fees	5
Unknown	6

# Conclusion

- Pay for Performance is here to stay
  - It will properly align incentives if it works
- Will cover all the major diseases treated by allergists
- Indicators must be developed by allergists
- Financial carrot must be added payment
  - Cannot maintain status quo in payments
- Will require investment in new software

# Contact with Questions

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