

Pay-for-Performance

An overview of what's happening, what's coming, and what you can do to prepare

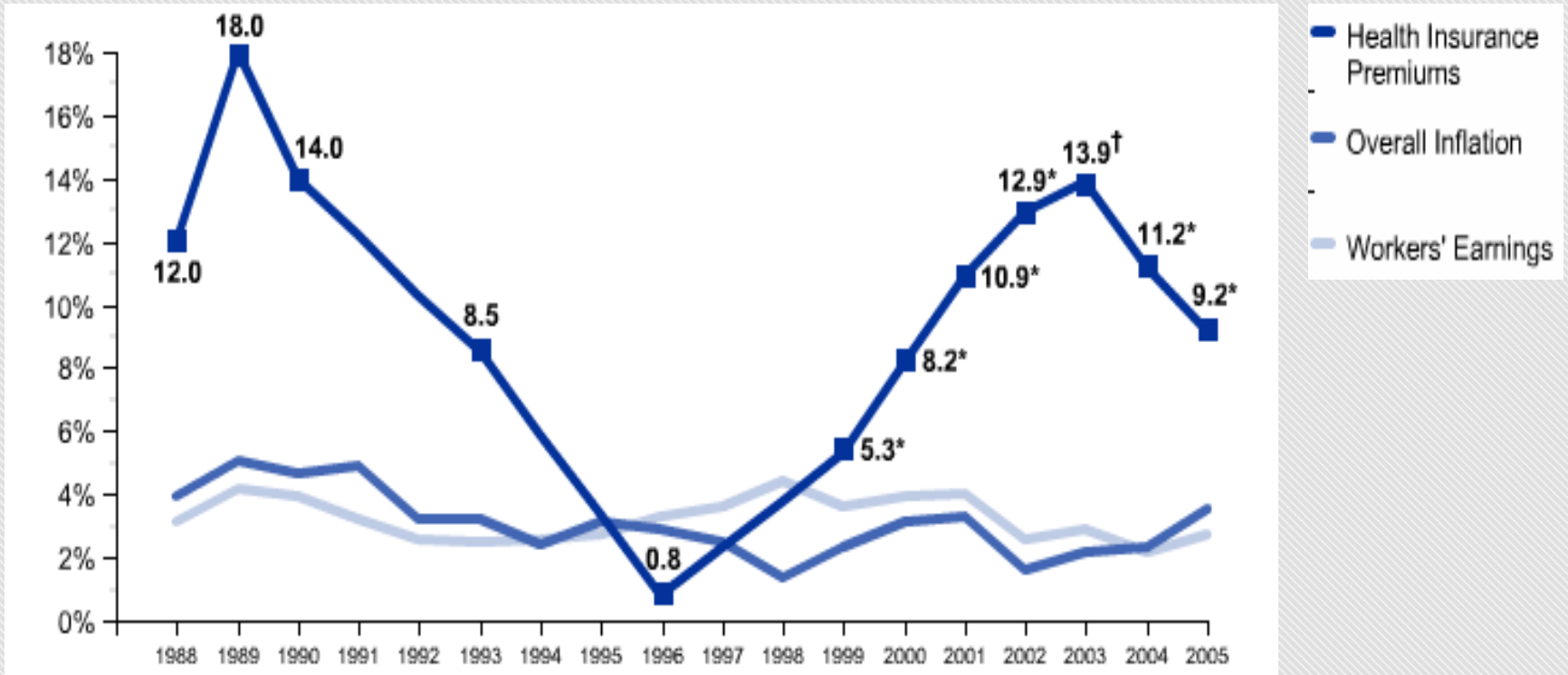
By the Numbers:

- **1 out of 5**
 - Dollars spent on health care
- **73%**
 - Amount family premiums have increased since 2000
- **15%**
 - Amount wages have increased since 2000
- **\$10,880**
 - Average annual family premium
- **2x**
 - Rate of health care cost increase over inflation

Premiums Outpace Earnings

Kaiser Family Foundation

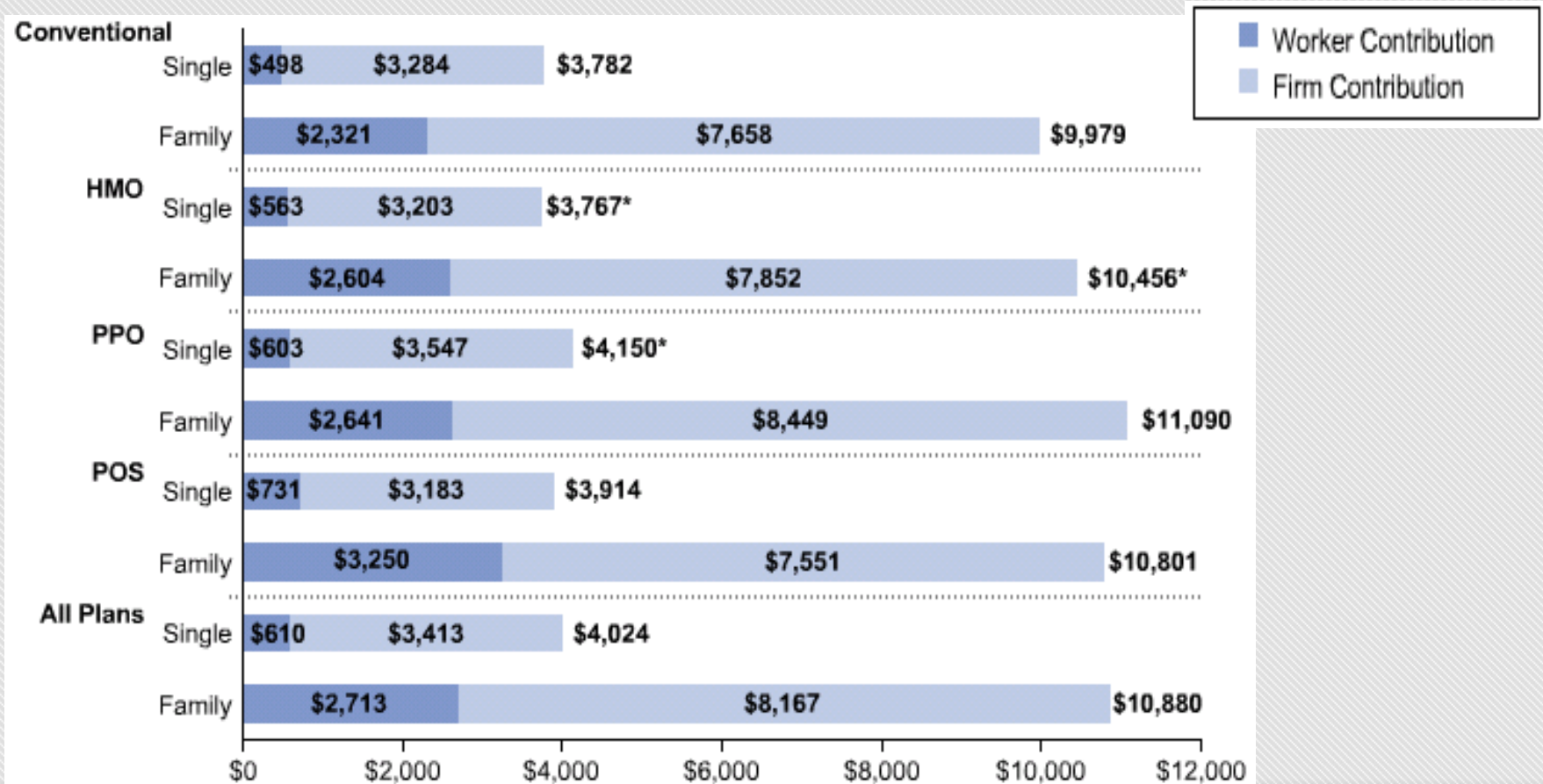
Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2005



Employers Paying More

Kaiser Family Foundation

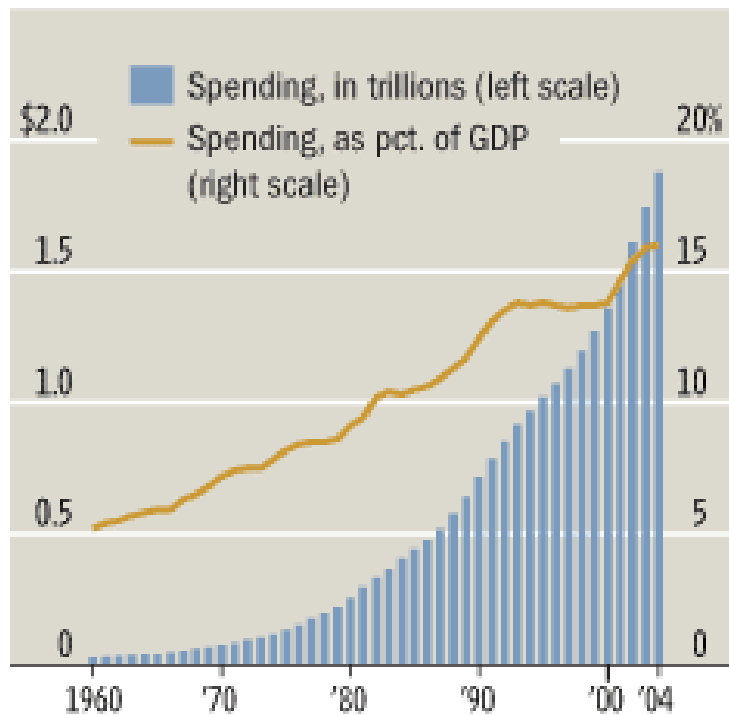
Average Annual Premiums for Covered Workers by Plan Type, 2005



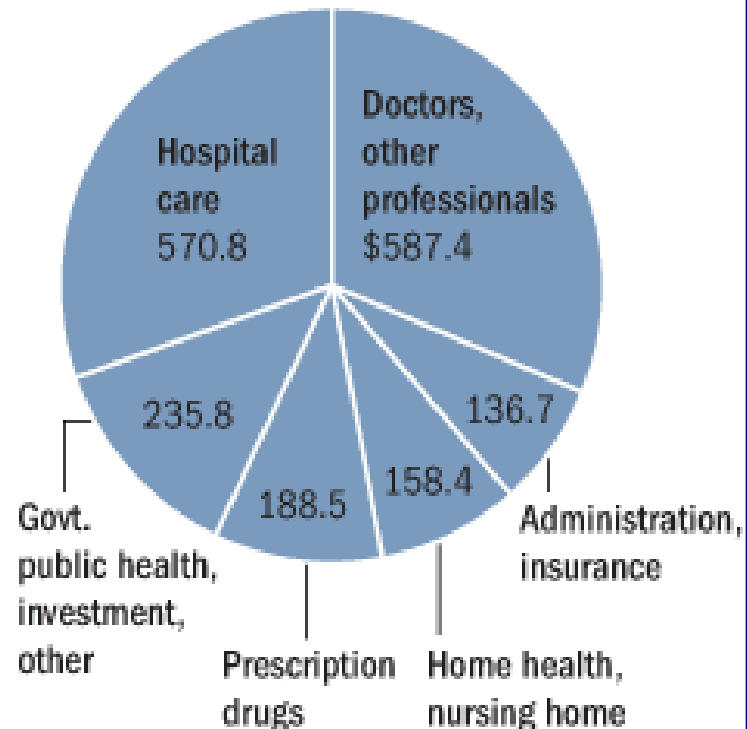
US Spending Even More

Centers for Medicare & Medicaid Services

Up, up and still up



Where the money goes, in billions



Return on Investment?

- **46.6 Million**
 - Uninsured Americans
- **Bottom quartile**
 - Rank of US for life expectancy & infant mortality (OECD)
- **55%**
 - How often US adults receive recommended care (McGlynn et al., 2006)
- **54%**
 - Americans dissatisfied with quality of care in US (Kaiser Family Foundation Survey, 2006)

We know...

- You've dedicated years of your life to training
- You're pressured to see more pts. in less time
- You receive less compensation for the care you provide than you used to
- You are committed to your patients
- You practice quality medicine
- **You're already working as hard as you can...**

Current Payment Structure

- Traditional fee-for-service rewards volume and complexity of services provided
 - Discourages E&M, time spent on patient education, coordination of care
 - Encourages seeing more pts. more often
 - Emphasis on procedures, sickness
 - Pays for low quality care at same rate as high quality care
- **Current system fails to build on strengths of health professionals to ensure that care is appropriate, timely, and safe**

IOM Report: Crossing the Quality Chasm; 2001

Sound Familiar?

- **Payers already using new methods affecting providers:**
 - Transparency
 - Public reporting
 - Economic credentialing
 - Tiered or narrow networks
 - Preferred provider designation (★ ★★)
 - Performance-based contracting
 - Direct provider incentives (\$\$\$)

Pay-for-Performance (P4P)

- A strategy to pay providers for higher-quality care as measured by selected evidence-based standards and procedures
- **Goals:**
 - Encourage performance improvement
 - Support innovation & constructive change in the health care system
 - Promote better outcomes & care coordination

IOM Report: Rewarding Provider Performance; September, 2006

How Should P4P Work?

- P4P relies on a combination of **quality measures** (clinical outcomes, clinical processes, structural factors, pt. satisfaction)
- Collected data will be **measured** (compared to a set standard)
- **Incentives** (bonus payments, feedback reports) are given to providers

P4P *Should Not Be...*

- Overly burdensome
- Used just to save money
- Arbitrary
- A threat to your clinical judgment
- Cookbook medicine
- Considered as a silver bullet that solves all of health care's problems

Who's Using P4P?

- Employers, private payers, Congress (HR. 6111), and the Centers for Medicare & Medicaid Services (CMS) are all moving forward with P4P or variations of it
- Over 100 performance incentive projects have been started over the last 10 years
- Though the evidence showing effectiveness of P4P is not complete; trends indicate potential in quality-aligned incentive programs

IOM Report: Rewarding Provider Performance; September, 2006

Premier Demonstration Project

- 2003: CMS & Premier Inc. partnered to launch the first national P4P demonstration
- Included > 260 hospitals in 38 states
- Tracked 5 clinical conditions:
 - Coronary artery bypass graft (CABG)
 - Acute myocardial infarction
 - Community acquired pneumonia
 - Hip & knee replacement
 - Heart failure

CMS/Premier Hospital Quality Incentive Demonstration (HQID)

Premier Findings

- **Use of evidence-based processes increased quality and lowered costs**
- For pneumonia & CABG pts. in first year:
 - \$1 billion saved
 - 3,000 deaths avoided
 - 6,000 fewer complications
 - 6,000 fewer readmissions
 - 500,000 fewer days in hospital

- Medicare's pilot P4P for physicians
- Started in 2006
- Captures data about the quality of care provided to Medicare beneficiaries
- Confidential performance feedback reports
- Participants have opportunity to give input
- New 1.5% bonus reporting incentive (starts July 1, 2007)

HR. 6111: Tax Relief and Health Care Act of 2006

- Became Public Law 109-432
- Stopped the scheduled 2007 cut in the Medicare Sustainable Growth (SGR) rate by freezing payments at the 2006 (& 2005) rates.
- **AND...**
- PVRP became the Physician Quality Reporting Initiative (PQRI)
 - 1.5% reporting bonus begins July 1, 2007
 - Participation details still evolving
 - Includes stroke measures

Stroke Measures

- Deep vein thrombosis (DVT) prophylaxis for ischemic stroke or intracranial hemorrhage
- Discharged on antiplatelet therapy
- Anticoagulant therapy prescribed for atrial fibrillation
- Tissue plasminogen activator (t-PA) considered
- Screening for dysphagia
- Consideration of rehabilitation services
- Carotid imaging reports
- CT or MRI reports

PVRRP: Sample Scenario

- ***Measure:*** Discharged on Antiplatelet Therapy
- ***Rationale:*** Following a stroke/TIA, pts. should be on antiplatelet therapy to decrease risk of additional strokes
- ***Reporting:*** You see a stroke pt. & document:
 - Yes or No – pt. prescribed antiplatelet at discharge
 - Yes or No – documentation of medical exclusion for antiplatelet therapy
 - Yes or No – documentation of pt. reason for not prescribing antiplatelet therapy

(cont.) Sample Scenario

- Based on the data submitted to CMS, participants in PQRI will be assessed according to how often antiplatelet therapy was prescribed per eligible patient
- Physicians will receive 1.5% bonus based on total CMS claims from July-Dec., 2007 for reporting on eligible pts. 80% of time
- Feedback reports will show participant results and peer comparisons

PQRI: Feedback Reports

Physician Voluntary Reporting Program (PVRP)								
Reporting Period: Quarter 1-2006 ¹			Practice-Level Report			Report Run Date: 8/1/2006		
Tax ID (EIN): 123456789 Address: 123 Main St.						Name: Dr. John Doe City, State: Washington, DC		
Topic and Measure Description	Practice Reporting Data			Practice Performance Data			National Comparison Data	
	#Cases with Condition ²	#Cases with Measure Reported ³	Reporting Rate ⁴	#Cases in Denominator ⁵	#Cases in Numerator ⁶	Performance Rate ⁷	Reporting Rate ⁸	Performance Rate ⁹
Acute Myocardial Infarction								
Aspirin at arrival for acute myocardial infarction	48	39	81.3%	25	20	80.0%	67.0%	75.0%
Beta blocker at time of arrival for acute myocardial infarction	60	40	66.7%	30	30	100.0%	45.0%	80.0%
Diabetes								
Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus	80	60	75.0%	50	40	80.0%	83.0%	61.0%
Low density lipoprotein control in patient with Type I or Type II diabetes mellitus	79	58	73.4%	49	30	61.2%	59.0%	52.0%
High blood pressure control in patient with Type I or Type II diabetes mellitus	75	60	80.0%	48	40	83.3%	49.0%	76.0%
Heart Failure								

Neurology and P4P

- **P4P has the potential to affect every US member of the Academy**
- The AAN is committed to preparing members to adapt to P4P & do so in a way that reflects challenges unique to the field of neurology:
 - 53% of AAN members have small practices
 - More chronic illness
 - Time to collect evidence-based data
 - Limited experience with P4P

- **Objective:** develop, validate, disseminate neurology-specific performance measures
 - Evidence & consensus based
 - Develops clinical data standards and definitions to support (future) EHR reporting
- Currently working on measures for:
 - Stroke
 - Screening for Geriatric Falls
 - Multiple sclerosis
 - Parkinson's disease
 - Epilepsy

How Can You Prepare?

- Whether or not you're learning about P4P for the first time, all AAN members should prepare now for system-wide change
- Familiarize yourself with proposed indicators
- Think about which 3-5 indicators you might (eventually) be able to report on
- Participate in the Medicare PQRI
 - www.cms.hhs.gov/PQRI

AAN Resources

- AAN P4P Webpage (www.aan.com/p4p)
- 2007 Annual Meeting
 - Practice Colloquium – Sat. April 28 (3:30-5:30pm)
 - Practice Hot Topics – Wed. May 2 (5:15-6:15pm)
- AAN EHR Vendor Report
- P4P stories in AAN publications
- AAN Position Statement on P4P
- Email p4p@aan.com

You Can Shape P4P

- **“The end of the beginning”**
 - There’s still time to shape how P4P will be administered
 - We don’t have all the answers today
- Based on your experience, your feedback can be used to make adjustments and other improvements – the goal is to replace a system that isn’t working with one that does
- **Be involved!**

Talk About What Neurology Needs

- Common measurement set
- Phased-in implementation to allow time for indicator development & provider preparation
- Risk adjustment – Protections for providers treating high-risk patient populations
- Reward providers who improve as well as those providing high quality care
- Adequately support burdens of data collection, esp. for small and solo practices

QUESTIONS?