Effect of pay for performance model on healthcare

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As the federal agency responsible for the Medicare program, the Centers for Medicare and Medicaid Services needed to ensure that beneficiaries received the highest quality care. The implementation of the pay for performance programs by the Centers for Medicare and Medicaid Services may have the source for improvement of the care delivered to Medicare patients. In 2006, a *Health Law Review* article defined pay for performance as " a reimbursement method under which some physicians and hospitals are paid more than others for the same services because they have been deemed to deliver better quality care and their patients appear to have better outcomes" (Mayes 17-22). Through these pay for performance programs, the Centers for Medicare and Medicaid Services would incentivize or penalize providers (e. g., hospitals, physicians, home health agencies) based on their performance on clinical, outcome and patient experience measures.

For decades, the Centers for Medicare and Medicaid Services and other insurance payers have reimbursed providers using a fee-for-service payment model. The term fee- for-service is defined as " a method in which doctors and other healthcare providers paid for each service performed…. services include tests and office visits" (Healthcare. gov). In their 2011 *Health Law Review* article, the opinion of Mayes and Walradt was that the P4P program was " developed largely in response to the cost control problems and perverse incentives associated with fee-for service reimbursement, which is the dominant model in the US" (1). Throughout the last ten years, Congress has enacted legislation such as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Deficit Reduction Act of 2005

and the Affordable Care Act of 2010, as a means of moving away from this fee-for-service model to a pay for reporting model and eventually to a pay for performance model (Frequently Asked Questions 8).

The journey to ensure improved patient care began with the creation of the pay for reporting programs. The pay for reporting programs included the Hospital Quality Alliance, the Reporting Hospital Quality Data for Acute Payment Update later known as the Hospital Inpatient Quality Reporting Program and the Reporting Physician Quality Reporting System. The pay for performance programs included the Hospital Value Based Purchasing program, the Physician Value Modifier and the Accountable Care Organizations.

The following paragraph will give a brief history of the transition of the pay for reporting program to the pay for performance program. In 2005, as a result of the Modernization Act of 2003, hospitals voluntarily submitted data on ten quality measures to avoid a 0. 4 percentage points reduction in their annual payment update for fiscal years 2005, 2006 and 2007 (Hospital Quality Initiative 3). The quality measures focused on four conditions or diseases that were among the most common, most expensive to treat and most serious conditions for Medicare beneficiaries. These conditions were acute myocardial infarction, heart failure, pneumonia, and surgical care improvement (Hospital Quality Initiative 4). Between 2004 and 2007, the measures increased from ten to thirty-six. The signing of the Deficit Reduction Act of 2005 brought six additional measures and hospitals who did not voluntarily report were at risk of a 2. 0 percentage point reduction to their annual payment update for fiscal year 2009. The 2009 Centers for

Medicare and Medicaid Services paper, *" Roadmap for Implementing Value-driven Health Care in the Traditional Medicare Fee-for-Service Program",* notes that the Centers for Medicare and Medicaid Services proposed moving from a pay-for-reporting program to a pay-for-performance program as part of the Deficit Reduction Act of 2005 (14). The start of this pay for performance program, which was best known as the Hospital Value Based Purchasing program would change the future and the practice of medicine in hospitals and other healthcare facilities for many years to come. This program drove the most change in care provided to Medicare patients. According to CMS. gov:

On April, 29, 2011, the Centers for Medicare & Medicaid Services issued the final rule establishing the Hospital Value Based Purchasing program…This program, which was established by the Affordable Care Act, [would] implement pay-for-performance…The final rule adopt[ed] performance measures, drawn from the measure set that hospitals have been reporting under the Hospital Inpatient Quality Reporting program.

During his presentation at the Agency for Healthcare Research and Quality on September 14, 2009, Michael T. Rapp, MD, JD, FACEP, Director, Quality Measurement, and Health Assessment Group, listed the supporters for the Hospital Value Based Purchasing program. Supporters included the Institute of Medicine, private health plans, and employer coalitions. When the Institute of Medicine released their *" To Err is Human and Crossing the Quality of Chasm Report"* they called for " raising standards and expectations for improvements in safety through the actions of oversight organizations, professional groups, and group purchasers of health care" (6).

The support for the Hospital Value Based Purchasing program could be seen as early as November 1999 in the IOM report, “ One way this can happen is by purchasers and consumers requesting and using information to direct their business to the best organizations and providers in a community” (19). For many years, the need for standardization of care was needed and no other program but the Hospital Value Based Purchasing program could have brought that change. The quality of care given by providers would now be an open book and this would surely drive significant change.

The supporters felt the program would bring change but there were also those opposing the Hospital Value Based Purchasing program. Opposition for the program came from hospitals, state hospital associations, and physician associations. Those with oppositions felt the program would pose significant operational challenges due to the number of measures being reported. Smaller hospitals would have the most challenges due to hiring additional work force to perform the chart abstraction required to report on the measures. Some measures would also require changes in processes that often take financial resources. To summarize the 2008 Modern Healthcare article, many healthcare groups felt the Centers for Medicare and Medicaid Services was heading in the right direction by implementing the Value Based Purchasing Program but felt such a program should not be used to reduce Medicare spending (Lubell 1). The healthcare groups felt the program would lose credibility among providers since it was only a short-term fix to reduce Medicare spending (Lubell 2).

The first year of payment with the Hospital Value Based Purchasing program would be fiscal year 2013. With this program, hospitals would need to show

improvement over the baseline during the performance period. The Centers for Medicare and Medicaid Services established that the baseline period would come from measures previously reported to the Hospital Inpatient Quality Reporting Program for discharges from July 1, 2009 – March 31, 2010 and the performance period would be July 1, 2011 – March 31, 2012. The initial measures included twelve of the Hospital Inpatient Quality Reporting Program measures. Since these were the original pay for reporting measures, many hospitals had already been working on improving their performance. The use of previously reported measures also helped many facilities know where they needed to improve. The results of patient satisfaction surveys would also be part of the program. The Centers for Medicare and Medicaid Services required hospitals to survey patients with a survey know as the Hospital Consumer Assessment of Healthcare Providers and Systems survey. The initial measures were all measures that focused on processes. These included providing discharge instructions to patients, controlling a patient’s glucose after having heart surgery and ordering venous thromboembolism prophylaxis to surgical patients. Although patients would have better outcomes, such as less pulmonary embolisms and less infections with these measures, the use of process of care based measures would only show improvement in changes made to processes. The process measures that showed the most improvement over the baseline included Primary Percutaneous Coronary Intervention Received Within 90 minutes of Hospital Arrival and Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2. The Primary Percutaneous Coronary Intervention measure improved by 1. 9% from 93. 44% to 95. 34% showing the percentage of heart attack patients who had the blocked vessel causing the

heart attack to be opened up with in 90 minutes of arriving to the hospital. The urinary catheter improved from 92. 86% to 95. 79% for an overall improvement of 2. 93%. Surgical patients often need a urinary catheter after surgery. If left in place for too long patients can develop an infection. This indicator measured the percentage of patients who had their urinary catheter removed with in first or second day after they had surgery. These two measures are some of the few process measures that made a difference in the care and outcome of patients. The Primary Percutaneous Coronary Intervention measure improved the chances of survival for heart attack patients and the urinary catheter measure helped prevent infections. Patients who survived a heart attack as a result of the care they received at a hospital are surely to tell others of their experience.

Word of mouth is the most common source of recommendation for a product, restaurant, or even hospital. The New York Times reiterates this in an October 2013 article by stating, “ While private and public payers are making important progress on performance measures and outcomes-based reimbursement, patients still rely largely on the recommendations of loved ones and friends about the quality of care provided by individual doctors, hospitals and other providers”(Blando 2). Although this may be true, the Centers for Medicare and Medicaid Services still created the Hospital Compare website. The website would provide consumers information on how hospitals compared to other hospitals on each of the process of care measures. The website could be compared to the Consumer Reports website in that prior to making a major purchase consumers can research information on the quality of the product they plan on purchasing. This

website would enable the consumer to make an informed decision regarding their healthcare. It also opened up a world of transparency for hospitals and consumers. Quality data on hospitals had never been shared with their competitors or their patients. Hospitals changed many processes in order to improve their performance of the measures that were displayed on the Hospital Compare website.

Can it be determined if there has been improvement in the care provided or is it still to early to tell? In an attempt to answer this question, the Centers for Medicare and Medicaid Services contracted with the Rand Corporation to evaluate the effects of the Hospital Value Based Purchasing program. In 2014, the Rand Corporation released their research report entitled “ Measuring Success in Health Care Value-Based Purchasing Programs”. Their research found only “ 49 studies that examined the effect of P4P on process and intermediate outcome measures” (xxi). The RAND article states, “ Any identified effects were relatively small” (xxii). When compared to the initial baseline period, the process of care measures have shown improvement during the performance periods. This journey has been painful for so many facilities. Many of which were not prepared for how quickly the pay for performance program would become reality. Although this program has increased the amount of work for facilities, many have worked diligently to ensure the changes needed to processes to improve patient care were implemented. Improvement in care will only be seen with the implementation of outcomes based measures. As stated above, more heart attack patients have survived. Fewer infections from urinary catheters being taken out in a timely manner will most likely be seen. In the future, the

outcome measures should be better predictors of the effects of the pay for performance program. Examples of outcomes based indicators includes measuring readmissions back to hospitals, measuring infections and measuring mortality of patients for the four common conditions mentioned in the previous paragraphs. The Centers for Medicare and Medicaid Services only recently implemented these outcomes measures. As with the process of care measures, until additional years of data are available their effect cannot be determined. At this time with the limited data available, it is still too early to tell if the Hospital Value Based Purchasing program has made an impact on the care provided to Medicare beneficiaries.