

Pay-for-Performance / Quality Incentives

Discussion Paper for the MMA §623e Advisory Board

Prepared by CMS/ORDI/MDPG

May 24, 2005

- Pay-for-performance (P4P) is a major priority for the current Administrator of the Centers for Medicare & Medicaid Services (CMS) who believes Medicare should seek opportunities to encourage improvements in the quality of care provided to Medicare beneficiaries.
- The ESRD program has a long history of concern for quality of care. Medicare, the National Institutes of Health, the National Kidney Foundation, the American Society of Nephrology, the Renal Physicians Association and others have actively participated in efforts to develop data systems that support the measurement and improvement of quality. These efforts have identified opportunities for quality improvement and have achieved notable improvements in patient care and outcomes. These organizations also candidly acknowledge that opportunities for improvement remain.
- The history of quality improvement efforts, the availability of data systems and quality standards, and consensus on opportunities for quality improvement combine to make ESRD a good candidate for possible P4P initiatives. ESRD is, in fact, the focus of a CMS Break-through Initiative in the area of quality. The FistulaFirst initiative is the first of several 'break-through' initiatives that CMS is undertaking to improve quality and implement the strategies outlined in the recent 'quality chasm' reports from the Institute of Medicine.

Quality / P4P Incentives

- Purpose of P4P / quality incentives
 - Traditionally payment reflects process
 - P4P allows outcome to affect payment
- “The right care for every patient every time”
 - Safe
 - Effective
 - Patient-centered
 - Timely
 - Efficient
 - Equitable

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- P4P represents a fundamental break with traditional thinking about provider payment. Traditionally, Medicare and other third parties have based payment on the ‘process’ of care. The specific services and procedures provided to patients determine provider payment. Questions about medical necessity and effectiveness enter into coverage decisions, but payment is traditionally determined by what was done ‘to’ a patient. The goal of P4P is to allow outcome—what treatment does ‘for’ a patient—to influence payment. Under P4P, providers who ‘do more’ for their patients in the sense of providing better outcomes would be paid more.
- CMS has defined the goal of its P4P strategy as promoting the right care for every patient every time. Following the lead of the Institute of Medicine, it defines the “right care” as care that is safe, effective, centered on the patient’s needs, timely, efficient, and equitable (i.e., independent of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status).
- A P4P component of the bundled payment demonstration would seek to address opportunities for improvement in any or all of these six areas. For example, P4P incentives might be used to promote safer and more effective care such as reliance on fistulas for venous access unless fistula is not a viable option for a patient. A significant question, however, is whether (or the conditions under which) P4P incentives should address aspects of performance that lie somewhat outside the scope of a bundled payment.

P4P and Bundled Payment

- Relationship of P4P and bundled payment
 - The goal / purpose of bundled payment
 - The goals / purposes of P4P
- A matter of perspective
 - P4P as an add-on to bundled payment
 - Bundled payment as a P4P initiative
- How can P4P support bundled payment?
 - Issues bundled payment cannot address
 - Issues bundled payment may create

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- The question of what dimensions of performance to address in P4P is large and complex. A basic question for the bundled payment demonstration concerns the relationship between the purposes and goals of bundled payment and those of an associated P4P initiative. Are the goals of P4P independent of those bundled payment? Is P4P something that is merely 'grafted on' to the bundled payment system? Or is P4P more properly viewed as a potentially complementary—or even integral—component of a bundled payment system?
- P4P principles can be seen as supporting the purposes of bundled payment. But it is also possible to view bundled payment as itself one element of a broader P4P initiative. For example, the goals of bundled payment include the promotion of:
 - More effective management of significant complications and co-morbidities of dialysis (e.g., anemia, infections, etc.).
 - More efficient use of resources (e.g., appropriate use of EPO, elimination of duplicative laboratory testing).
 - Promotion of medical practices that involve less risk for the patient (e.g., conservation of venous access).
- Given the close potential relationship between the goals of bundled payment and P4P, it is possible that P4P could support the bundled payment demonstration in two ways.
 - It could offer a means of addressing issues that bundled payment cannot readily address such as the alignment of incentives among physicians and dialysis facilities.
 - It could offer a means of mitigating unintended consequences of bundled payment such as potential adverse effects on quality or access.

P4P Technical / Policy Questions

- What are P4P incentives for?
- How should P4P incentives be funded?
- How large should P4P incentives be?
- How should P4P be earned?
- What performance measures will be used?
- Whose performance will be measured?

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- Whether and how specific and explicit P4P principles can be used to promote the broader goals of the bundled payment demonstration is likely to depend on the answers to a number of narrower technical questions related to the design of any P4P system.
 - What are the P4P incentives for?
 - How should the P4P incentives be funded?
 - How large should the P4P incentives be?
 - How should the P4P incentive be earned?
 - Whose performance will be measured?
 - What aspects of performance will be measured?

What are P4P incentives for?

- Using P4P to support bundled payment
 - PPS creates incentives to improve efficiency
 - P4P creates explicit incentive to improve quality
 - Adequacy of renal replacement therapy
 - Effective management of co-morbidity
- Using P4P to reach beyond the bundle
 - Management of vascular access
 - Coordination of care for underlying diseases
 - Encouragement of appropriate modalities
 - Appropriate use of inpatient hospital care

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- It has already been noted that the purposes of the bundled payment demonstration can, broadly speaking, be seen as part of an effort to improve quality by promoting safer, more effective and more efficient care. The quality objectives that guide CMS's P4P initiatives also influence the design of the bundled payment system. Ideally, a well-designed prospective payment system would promote safe, effective, patient-centered, timely, efficient, and equitable care. However, additional and more explicit incentives to improve quality could be incorporated into the bundled payment system.
 - Prospective payment creates strong incentives to improve efficiency. Improvements in efficiency may be seen, however, as being achieved at some risk to quality or access. P4P might be used to mitigate these risks.
 - P4P incentives might be designed to explicitly recognize superior performance on the adequacy of RRT, the management of anemia, management of infection, or other measures of quality and access.
- There are limits to the improvements in quality that can be achieved within the feasible scope of a bundled payment. Indeed, some improvements in safety, efficiency, effectiveness, etc., involve providers and resources that are outside the scope of the bundled payment. The question is whether and how to use P4P to achieve improvements in quality that involve resources outside the bundled payment. For example:
 - Management of vascular access and underlying diseases involves providers that are only indirectly influenced by dialysis facilities and associated practitioners.
 - It may be difficult to encourage adoption of appropriate modalities relying solely on the resources and incentives inherent in the bundled payment system.
 - Encouraging appropriate use of inpatient hospital care may be more effective if savings from eliminating inappropriate use were made available to dialysis facilities and their associated practitioners.

How should P4P be funded?

- **Implicit efficiency incentives**
 - Efficiency of renal replacement therapy
 - Effectiveness of renal replacement therapy
 - Management of complications / co-morbidity
 - Other dimensions: safe, timely, patient-centered
- **Explicit quality improvement incentives**
 - Additional funding
 - 'External' savings
 - Withhold / set-aside for quality performance

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- Perhaps no issue precipitates as much animated discussion as the question of how to fund P4P incentives. The options are fairly simple to list. In descending order of preference (from at least a provider perspective) these options include: (1) additional funding, i.e., 'new' money; (2) savings from improved quality and reduced use of expensive but potentially avoidable services; and (3) a withhold, set-aside, or reduction in existing payment levels.
- Before discussing these three options, it may be worth drawing attention to the distinction between the 'implicit' funding of incentives to improve efficiency and related aspects of care that is inherent in a prospective payment system and the 'explicit' funding of quality improvement incentives. As noted earlier, prospective payment inherently rewards providers who can more efficiently deliver effective renal replacement therapy, successfully reduce the frequency and manage the cost of complications and co-morbidity, and promote safer, more timely, and more patient-centered care. This opportunity represents a kind of 'implicit' funding of 'implicit' (if intended) P4P incentives.
- A P4P program would explicitly fund incentives to pursue specific improvements in performance. These incentives might be supported by 'new' or additional funding. In establishing the bundled payment demonstration, Congress explicitly authorized an increase in payment rates although it did not direct CMS to use these funds to support P4P-like incentives.
- A second source of funding might be savings that are achieved from reduced use of services other than those provided by the dialysis facility. A good example of such savings would be reduced use of inpatient hospital services arising from better management of vascular access, complications (e.g., infections), or co-morbidity (e.g., anemia and diabetes).
- A third source of funding might be a withhold or set-aside from the bundled payment amount. This funding method would probably make sense only if the performance objectives and incentive payments involved activities that were themselves covered by the bundled payment amount.

How large should incentives be?

- Purpose of incentive payment
 - Source of operating revenues
 - Bonus for investment in improved service
- Considerations
 - Compensation for cost of improving performance
 - Incentive needed to motivate change in behavior
- Allocation to specific objectives / measures
- Allocation among providers

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- Pay-for-performance arrangements differ widely in terms of the size of the incentives that are offered. Some P4P initiatives have started by putting a relatively small amount of money on the table, but have adopted a goal of expanding the percentage of revenue that providers will be expected to derive from performance incentives.
- A fundamental question concerns the purpose of the incentive payment. Some proponents of P4P believe that the incentive payment should be an integral component of a provider's total revenue. Other's see the incentive payment as akin to a 'bonus'—revenue that the provider can use to improve service and quality but that is not essential to support a 'basic' level of day-to-day operations. A somewhat larger incentive payment might be justified if it is viewed as supplying part of a provider's operating revenue, but only if the provider can confidently expect to achieve performance targets.
- A further set of considerations run somewhat parallel to this fundamental question. One view would peg the size of the incentive to the investment that is needed (or the cost associated) with improvements in quality. According to this pragmatic view, the size of the incentive should be sufficient to cover costs that are incurred to earn the incentives. A slightly different perspective would peg the incentive to an amount that is deemed necessary to motivate a change in provider behavior. Of course, some economically-minded analysts might see little difference between these two perspectives.
- Two further considerations are related to the question of how much money should be set aside to support P4P incentive payments. The first is the extent to which the incentive payment is allocated to specific objectives or performance measures. The larger the number of measures and the more tightly incentive payments are tied to specific indicators, the larger the incentive pool might need to be. In general, as the number of measures rises a provider's confidence in its ability to earn the full amount of the incentive may decline. Similarly, to the extent that incentive payments must be allocated among multiple providers the minimum size of the incentive pool may tend to rise.

How are P4P incentives earned?

- Absolute / consensus-based standard
- Competitive standard
- Improvement standard
- Hybrid approaches

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- A fundamental question for any P4P system concerns the nature of the standard that is used to earn or distribute incentive payments.
- One alternative is to focus on the provision of care that meets a consensus-based standard of quality. Those providers who meet the standard will be rewarded. Providers who do not meet the standard will not. A common objection to this kind of standard is that the providers who do not meet the standard could potentially make the best use of, additional resources to improve quality. A response to this objection is that performance incentives represent a return on a provider's investment in quality improvement, not an grant to support those investments.
- As an alternative to professional or industry consensus, the actual performance of providers could be used to set an empirical benchmark. Competition among providers would both determine the standard and determine the distribution of incentive payments. A provider would earn an incentives by performance that is superior to its competitors. A critic of this approach would object that it denies additional resources to those providers whose unsuccessful performance may point to a need for additional resources. However, a proponent might respond that the successful competitor will expand access to higher quality care as its market share increases.
- A third alternative is to focus on improvement in quality. A provider whose performance falls short of an absolute or competitive standard could still earn an incentive payment if it improves its performance. Proponents of this kind of standard note that it provides poor performers with an the means and opportunity to improve performance but gives even those with 'superior' performance an incentive to strive for further improvement. An objection to this approach is that it implicitly rewards performance that is below either an absolute standard or that is inferior to the attainable performance of other providers.
- In practice, the various approaches can be combined. Providers might earn an incentive payment both for meeting a consensus-based target and by improving performance over a prior period.

P4P Quality Measures

- Number of quality measures
- Possible clinical / performance indicators
 - Adequacy of renal replacement therapy
 - Incidence of complications / co-morbidity
 - Vascular access
 - Anemia management
 - Modality choice
 - ...
- Criteria for selection of measures

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- The selection of measures to use in a P4P arrangement is an enormously difficult but critically important task. Even basic questions concerning the number of performance measures to use can be controversial. An approach that relies on many measures increases the likelihood that a provider can achieve at least some improvements in quality, but it also diffuses quality improvement efforts and may reduce the ability of a provider to implement strategies that are based on a confident expectation of earning incentive payments.
- The specific measures of performance to use in a P4P arrangement will, of course, depend on its goals. Possible measures might focus on the adequacy of renal replacement therapy, the incidence of complications and co-morbidity, promoting safe and effective methods of vascular access, successful management of anemia, and choice of modality. No doubt, many other measures can be identified. For example, the ESRD Disease Management demonstration proposed a quality incentive that used five measures: Kt/V, hemoglobin, serum albumin, AV fistula, and bone disease.
- A final difficult issue concerns the criteria that should be used to guide the selection of measures. This is a subject that has received considerable attention from professional groups representing ESRD physicians and providers. It has also been the focus of attention by MedPAC. The central issue is whether it is possible to set performance targets that accurately reflect the performance of the providers whose payment is at risk under the P4P provisions.

MedPAC Measurement Principles

- Use of accepted, evidence-based measures
- Collection without undue burden
- Acceptance of risk adjustment methods
- Possibility of improvement
 - Apply to a broad range of care
 - Performance should be under provider's control
 - Focus on areas needing improvement

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- The MedPAC in its March 2005 report (pp 186-187), proposed four criteria to guide the selection of quality measures.
- First, quality measures should be based on evidence and should be accepted by independent quality experts, purchasers, providers and consumers.
- Second, the data needed to implement these quality measures should be collected without undue burden on either providers or on CMS. To the extent possible, currently available data should be used, but it may be necessary to collect additional data.
- Third, when risk adjustment is needed methods should be adopted that are accepted as sufficient to avoid creating barriers to access. Generally, MedPAC believes that 'outcome' measures are more likely to require risk adjustment than measures of quality that focus on the 'process' of care.
- Fourth, most providers should be able to demonstrate improved performance. MedPAC believes that this means that the measures should be applicable to a broad range of care and a substantial percentage of all patients. A provider's performance on a measure should be under the provider's control, not the influence of factors that a provider can do nothing about. Finally, measures should focus on areas needing improvement, not areas in which performance is already high.