

# The Building Wave of Pay-for-Performance



***IS YOUR PRACTICE READY  
FOR THE RISING TIDE?***

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# Agenda and Objectives



- Review the basic concepts of pay-for-performance and value-based purchasing as they apply to the healthcare environment.
- Provide examples of current pay-for-performance and value-based purchasing models.
- Outline key strategies that can assist pharmacy in successfully aligning with pay-for-performance requirements.

# The Need for Change

- Costs are escalating
- Quality of care is too low
- Access is limited



# US Health Care Expenditures



- The US spends approximately \$2.5 trillion or close to 17% of our gross domestic product on health care.
- Based on current trends, in 2017 health expenditures will consume 20% of GDP or \$4.3 trillion annually.
- This is unsustainable for government, the business sector and the private citizen.

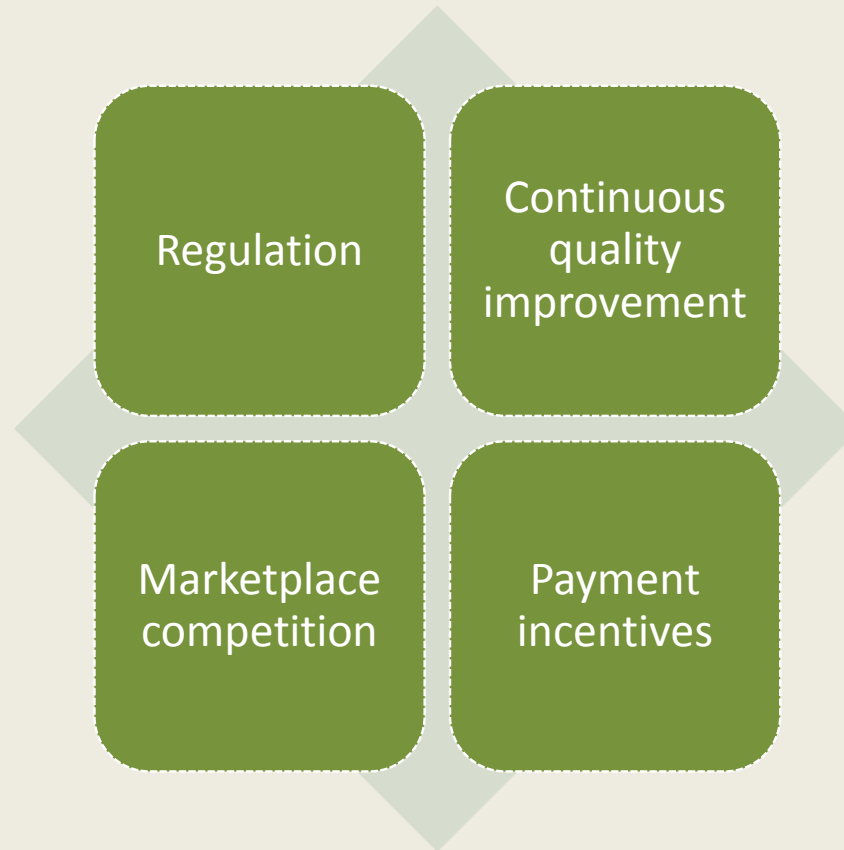
US Senate Finance Committee Report:  
Transforming the Health Care Delivery  
System. April 29, 2009

# Quality of Care in the US



- Lower 1/3 of developed countries in life expectancy at birth
- Highest rate of deaths from conditions that could have been prevented or treated (among 19 countries studied)
- Higher prevalence of cancer, heart disease, stroke in age 50+ population (in comparison to 10 European countries)
- Second highest in adult hospital admission rates for asthma (among 17 countries reporting)

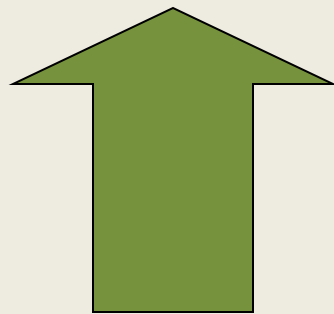
# Strategies for Health Care Quality



Chassin MR, Galvin RW, and the National Roundtable on Health Care Quality. The Urgent Need to Improve Health Care Quality. JAMA. 1998; 280(11): 1000–1005.

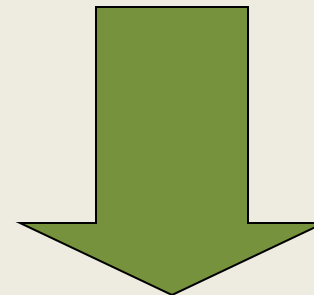
# What is the impact of improving quality on costs?

The business case for improving quality



As Quality goes up

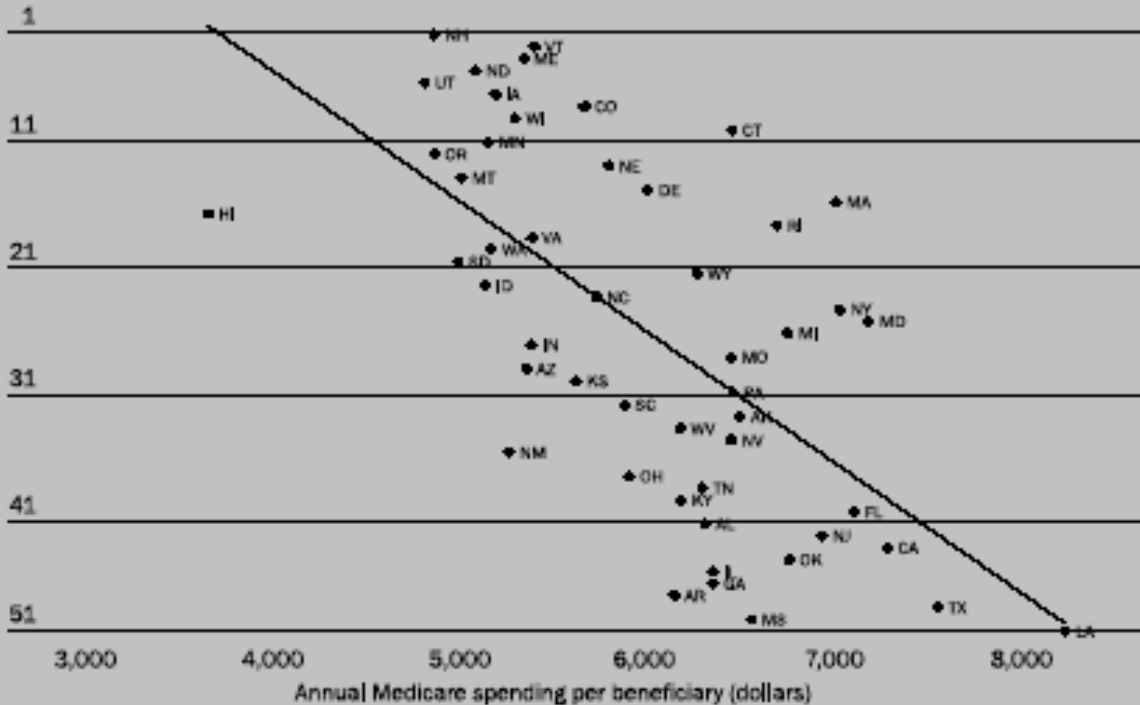
Costs go down



# High Costs Don't Guarantee High Quality

**EXHIBIT 1**  
**Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001**

Overall quality ranking



**SOURCES:** Medicare claims data; and S.F. Jenks et al, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.  
**NOTE:** For quality ranking, smaller values equal higher quality.

- Medicare spending inversely proportionate to quality ranking

# Quality Measures and Cost Outcomes

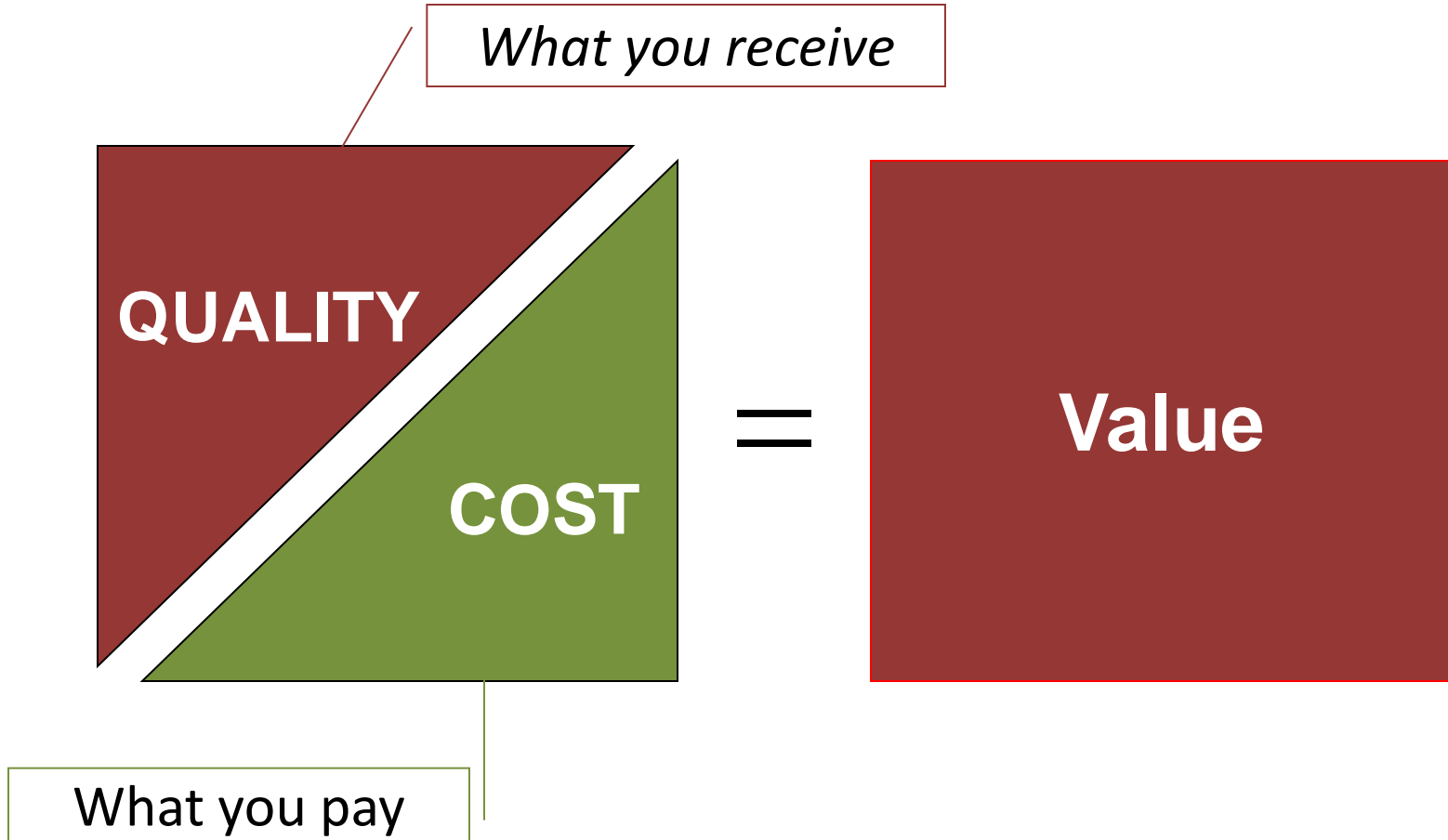


- Quality measures are designed to drive improvement in care.
- They are not designed to generate cost outcomes/savings.
- While cost savings may be achieved there has been a notable lack of focus on interventions that truly consider costs of care.

Health care that is selected based upon relative value to other alternatives, not just on quality.

Source: HHS.gov [homepage on the Internet]. Washington DC: U.S. Department of Health & Human Services; c2008. Available at: [www.hhs.gov/valuedriven/index.html](http://www.hhs.gov/valuedriven/index.html). Accessed Nov 10, 2008

# Determining Value



# Value-based Purchasing (VBP)



- The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care.
- Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health.

Meyer, Rybowski, and Eichler,  
1997

# Pay-for-Performance (P4P)



- P4P is a type of value-based purchasing that provides an incentive-based reimbursement system.
- Financial incentives reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to the payer, and improved quality and patient safety.
- Financial incentives should not be universally taken to mean “larger payment.”

# Problems with Current Payment Models



## EXAMPLES....

- Fee For Service (FFS): Quantity for quantity.
- Capitated care/Managed Care: Incentivized to restrict care
- DRG: Focus on care limited to inpatient treatment episode.

## CONCERNS...

- No linkage of payment to quality of care – Not a clinically driven or value-focused payment models
- Quality not translated to cost
- Payment systems do not encourage cooperation/teamwork to achieve care goals.

# The Foundation of P4P



- Standardized measures
- Data collection, submission & sharing
- Public reporting/transparency
- Payment Structure: Incentivized reimbursement

# Does P4P Work?



**EXAMPLES OF P4P  
DATA TO DATE  
EDUCATED OBSERVATIONS**

# Premier Hospital Quality Incentive Demonstration Project

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CMS initiated testing of this concept through a three-year demonstration project involving 260+ hospitals driven by Premier's Perspective™ database.

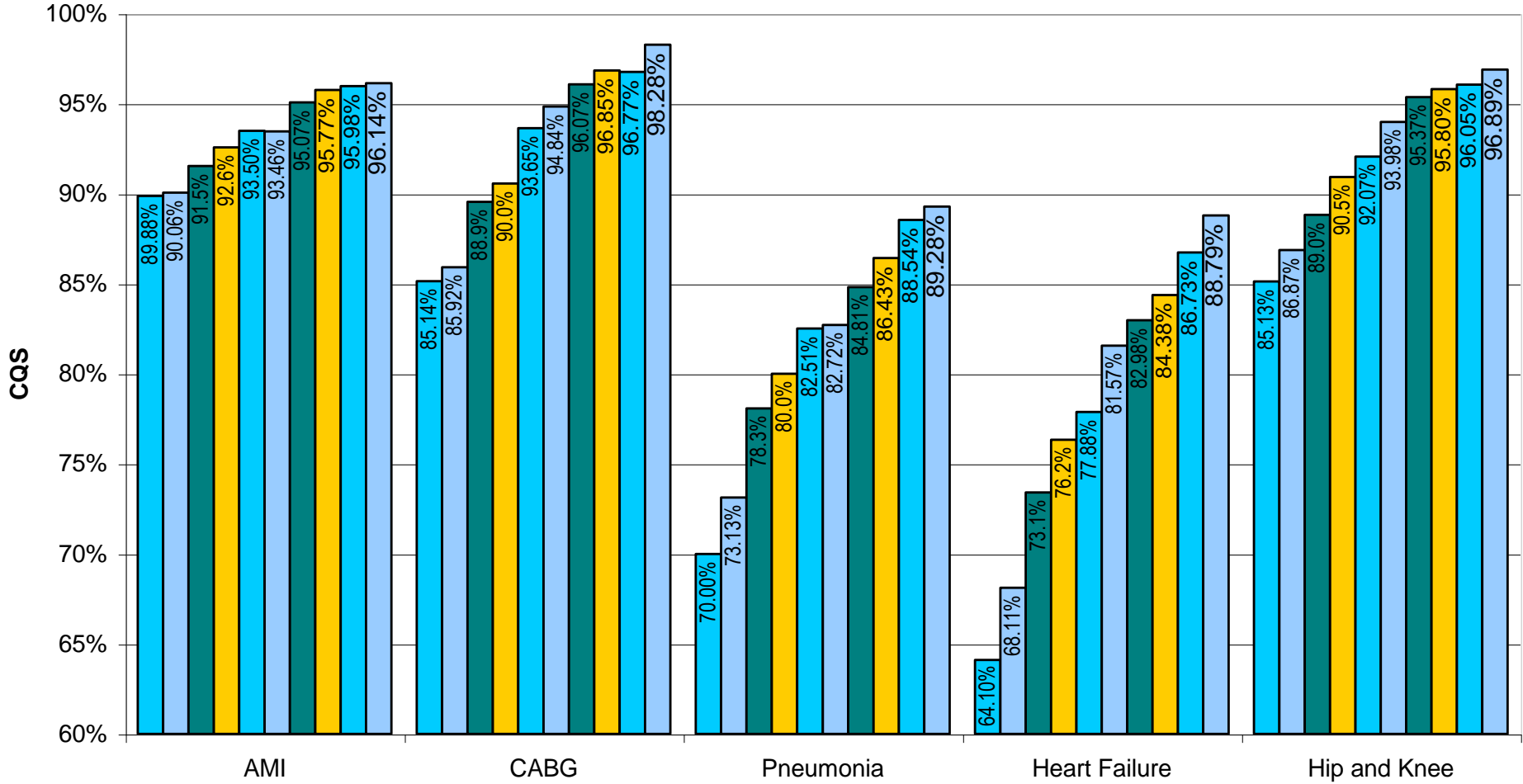
## Project Overview

- Link reimbursement with quality measures for five medical conditions
- Apply a standard set of industry accepted quality indicators scored through Premier's Perspective™ clinical database.
- Increase Medicare payment by 2% for top decile and 1% for second decile performers
- Publicize hospitals that rank in the top half of all project participants for each condition

## Medical Conditions

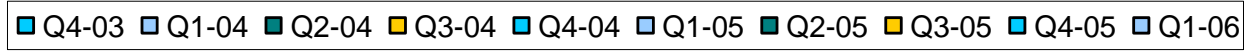
- Coronary Artery Bypass Graft (CABG)
- Pneumonia
- Acute Myocardial Infarction
- Heart Failure (HF)
- Hip and Knee Replacement<sup>1</sup>

**CMS/Premier HQID Project Participants Composite Quality Score:  
Trend of Quarterly Median (5th Decile) by Clinical Focus Area  
October 1, 2003 - March 31, 2006 (Year 1 Final Data, Year 2 and Yr 3 YTD Preliminary)**

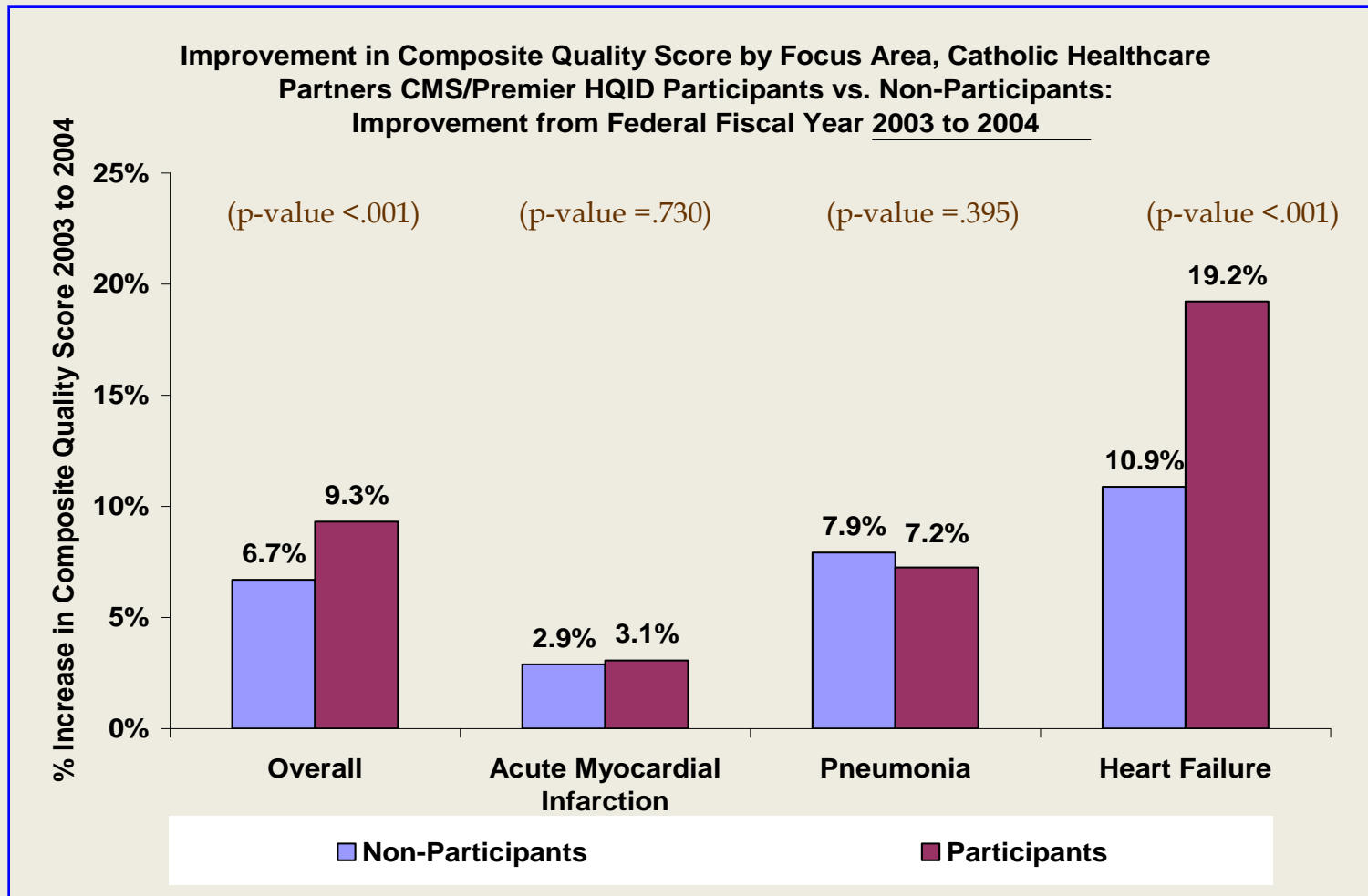


Courtesy of Premier, Inc

**Clinical Focus Area**



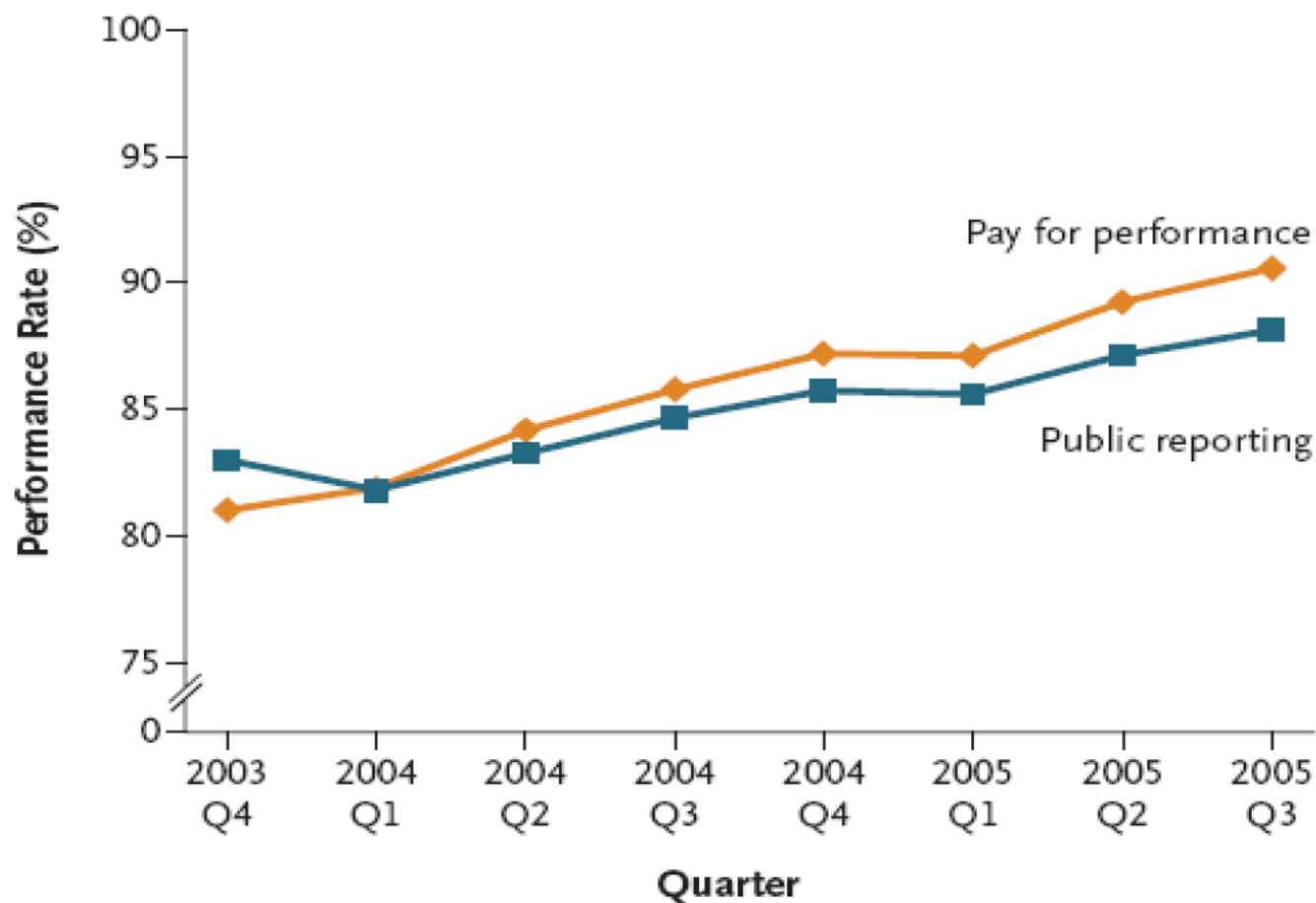
# Did P4P Drive Outcomes in the Premier Project?



# Comparison of Hospitals: NVRI vs NVRI + P4P



**D Composite of 10 Measures**



# LeapFrog Group



## What is it?

- Initiative driven by organizations that buy health care.
- Working to initiate improvements in safety, quality, and affordability of healthcare for Americans.

## Founded by a small group of large employers in late 2000

- Supported by the Business Roundtable (BRT), The Robert Wood Johnson Foundation, Leapfrog members and others.

## Mission

- Support informed healthcare decisions by those who use and pay for health care.
- Promoting high-value health care through incentives and rewards.



**Individual Hospital Performance Report**  
**Example Hospital, Anytown, USA**

Based on Leapfrog Survey submitted December 23, 2008

**Important:** For internal use only! Not for public distribution.

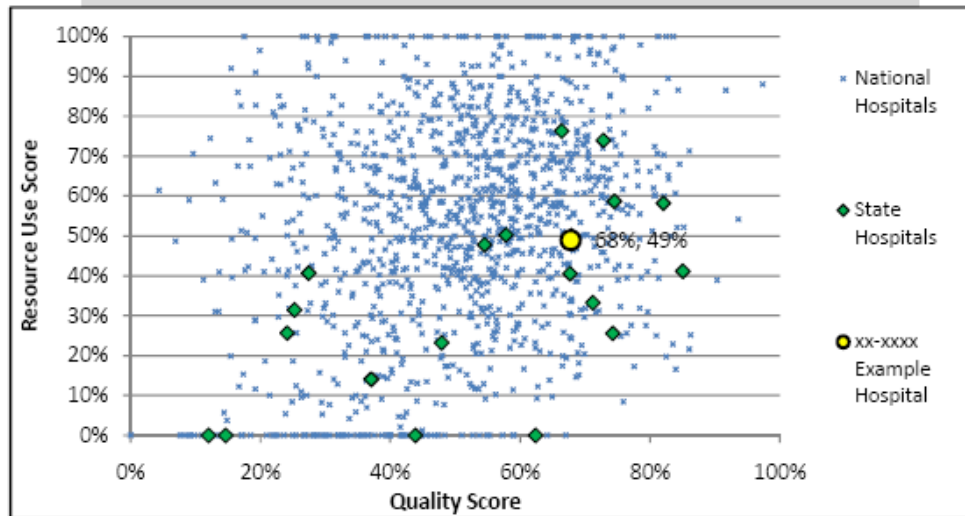
[Click here for a detailed description of the scoring process for the Leapfrog Hospital Rewards Program.](#)

	CPOE	IPS	CABG Quality	CABG Resource	PCI Quality	PCI Resource	AVR Results	AAA Results	AAA Process	Pancreatectomy Survival Predictor	Esophagectomy Survival Predictor	Bariatric Surgery Results	High Risk Delivery Results	AMI Quality	AMI Resource Use	Pneumonia Quality	Pneumonia Resource Use	Pressure Ulcer Rate	Injuries Rate	Never Events	Safe Practices LHRP Score	Quality Score	Resource Use Score	Efficiency Score
National average	36	46	64	50	64	57	68	65	42	39	39	64	61	49	48	52	53	41	43	71	57	51%	52%	52%
State average	53	56	63	33	52	47	57	72	55	48	54	68	64	50	34	69	29	34	35	76	51	54%	35%	48%
xx-xxxx Example Hospital	40	100	51	15	37	92	45	95	100	45	27	84	49	43	20	100	54	85	89	20	96	68%	49%	61%

Cells are color coded as follows:

- Green - 10 or more points better than the NATIONAL average
- Yellow - Within 10 points of the national average
- Red - 10 points or worse than the national average
- Gray - Not applicable

The graph below shows how the quality and efficiency of Example Hospital compare to other hospitals reporting data through the Leapfrog Survey.



The table below highlights the national decile of Example Hospital for the efficiency score (combination of quality and resource use).

Decile	Score Range
Top	71% or better
2nd	66% to 71%
3rd	61% to 66%
>>>> 4th	57% to 61%
5th	53% to 57%
6th	49% to 53%
7th	45% to 49%
8th	38% to 45%
9th	29% to 38%
10th	Less than 29%

All comparative hospital data is current as of 12/31/2008

# CEO Impressions of the Premier Demo Project



## Costs invested > cost recouped

- Significant work to collect, evaluate, validate and submit data
- Coordination of diverse staff to improve outcomes

## Major drivers

- Improving care quality
- Public reporting (image, creating new contracts and customers)

# P4P Evaluation... Jury is Still Out



- Trials in ambulatory care, managed care, physician practice and hospitals have shown winners and losers.
- One-size fits all approach may not work.
- Using funds to directly improve/drive process improvements may be key.



# What is the direction of P4P in Health-Systems?



# CMS Value-Based Purchasing Plan



- Mandated by Deficit Reduction Act of 2005
- Impacts only IPPS/Acute Care hospitals
- Build upon measurement & reporting infrastructure of RHQDAPU
  - RHQDAPU: 42 measures...focus on quality & delivery of EBM.
  - RHQDAPU withholds 2% of market basket for non-reporting
  - Includes public reporting via “Hospital Compare” site

VBP programs shifts from “pay for reporting”  
to “pay for performance”

# CMS VBP Rollout



- Begins FY2012 with data collection and performance reporting
- FY2013 will bring adjusted payments & expanded measures
- Plans to expand quickly to create a comprehensive program to foster broad-scale transformation of health care system
- Include measures in at least 3 performance domains:
  - Clinical quality/process (RHQDAPU + new measures)
  - Patient Perspectives of Care (HCAHPS)
  - Outcomes (30-day mortality measures for AMI & HF)

# CMS VBP: Reporting Performance



- Reward hospitals based on attainment and improvement from prior year's scores
- Performance standards not yet known
- Performance assessment methodology not yet known, but...
  - Will report condition-specific scores and total performance score
  - Performance assessment/payment will be based ONLY on composite quality score (total performance)

# CMS VBP Performance Score Example

**Norman Regional Hospital**  
**Value-Based Purchasing Score Details**  
 Scoring Period: October 2007 - September 2008  
 Base Period: April 2007 - March 2008

Indicator	National		Hospital - Base Year		Hospital - Scoring Year		Attainment Score	Improvement Score	Final Score
	Benchmark	Threshold	Case Count	Performance	Case Count	Performance			
Heart Attack Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)	90.0%	60.0%	40	98%	41	98%	10	Does Not Apply	10
Heart Attack Patients Given Aspirin at Arrival	90.0%	60.0%	179	100%	166	100%	10	Does Not Apply	10
Heart Attack Patients Given Aspirin at Discharge	90.0%	60.0%	199	97%	192	98%	10	Does Not Apply	10
Heart Attack Patients Given Beta Blocker at Discharge	90.0%	60.0%	199	99%	188	98%	10	Does Not Apply	10
Heart Attack Patients Given Smoking Cessation Advice/Counseling	90.0%	60.0%	103	100%	99	99%	10	Does Not Apply	10
Heart Attack Patients Given Fibrolytic Medication Within 30 Minutes Of Arrival	90.7%	66.0%	0	Insufficient Data	0	Insufficient Data	Not Computed	Not Computed	Not Computed
Heart Attack Patients Given PCI Within 90 Minutes Of Arrival	96.2%	76.0%	47	89%	42	86%	5	0	5
Surgery Patients Who Received Treatment To Prevent Blood Clots Within 24 Hours Before or After Selected Surgeries to Prevent Blood Clots	97.5%	85.0%	1395	93%	1393	96%	9	7	9
Surgery Patients Whose Doctor Ordered Treatments to Prevent Blood Clots	98.5%	89.0%	1395	96%	1393	98%	9	8	9
<b>Overall Score</b>							<b>87%</b>		

# CMS VBP...How is it funded?



- Reduction in wage-adjusted inpatient operating payments between 2% and 5% for all hospitals\*
  - The Senate Finance Committee recommends an escalating reduction in these IPPS payments starting with 2% in FY13 moving up 1% per FY to 5% in FY16.
- Funds placed in a pool
- Redistributing that pool of money based upon performance scores.
- Will be “budget neutral” for CMS...this would create a residual pool of undistributed funds.

\*No changes in supplemental funding for DSH or teaching hospitals. Small and CAH hospitals are excluded.

# CMS VBP...

## Proposed Payment Scenarios



Two proposed payment scenarios for the Medicare Value-Based Purchasing (VBP) program

- #1 CMS' proposal outlined in Nov 2007 Report to Congress (curvilinear payment translation)
- #2 Senate Finance Committee Policy Options (linear payment function)

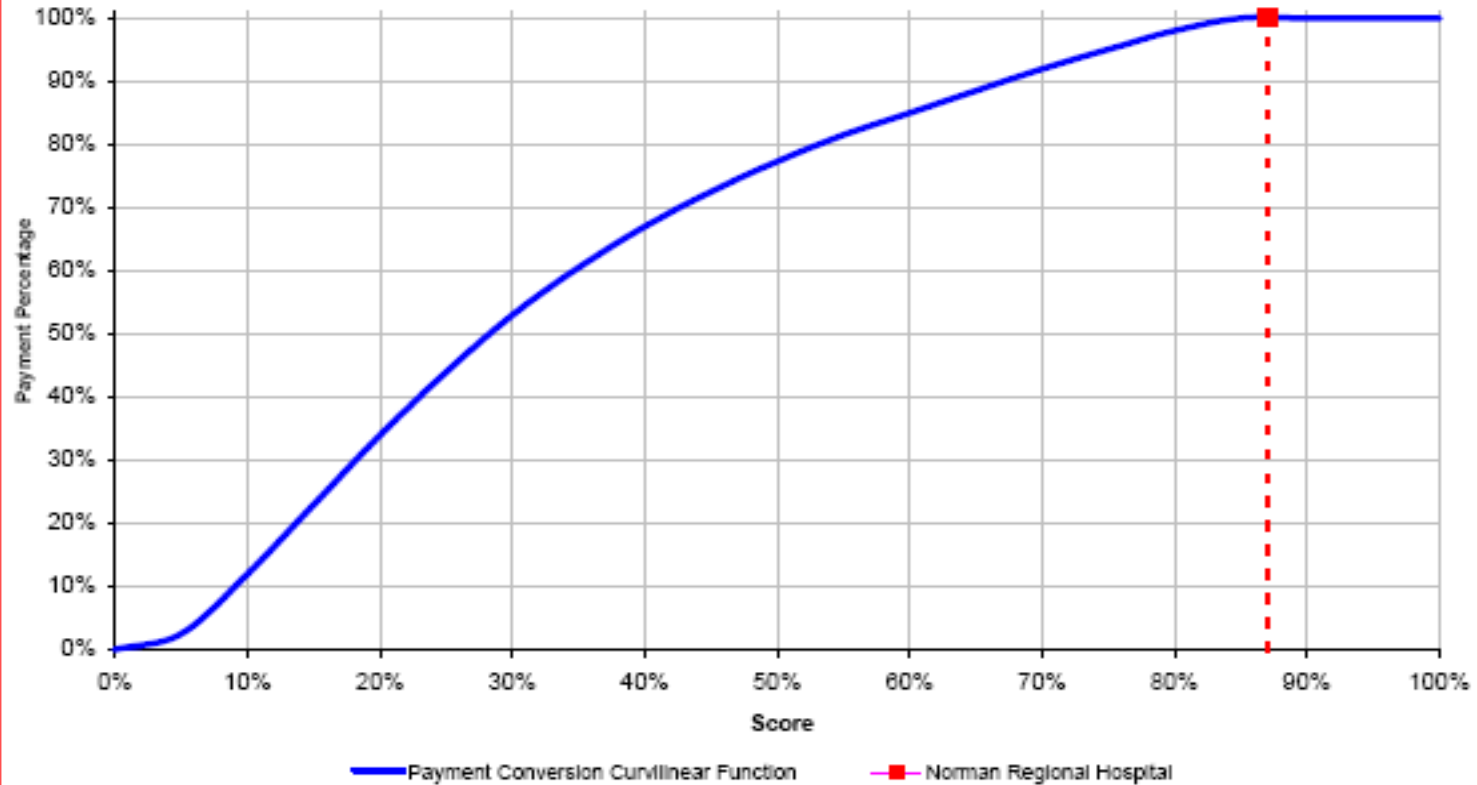
# CMS Finance Proposal

## Norman Regional Hospital

Payment Impact Estimate - CMS Proposed Curvilinear Payment Function  
 Value-Based Purchasing  
 Scoring Period: October 2007 - September 2008  
 Assumes 5% Pool

	Curvilinear Payment Function	
	Norman Regional Hospital	Oklahoma
Overall VBP Score	87%	70%
Payment Percentage	100%	92%
Dollars Contributed to VBP	\$2,261,000	\$59,710,000
Expected Payment from VBP	\$2,261,000	\$54,721,000
Net Loss from VBP	\$0	(\$4,989,000)

### Curvilinear Payment Scenario



# Senate Finance Proposal

## Norman Regional Hospital

Payment Impact Estimate - Senate Finance Committee Proposal

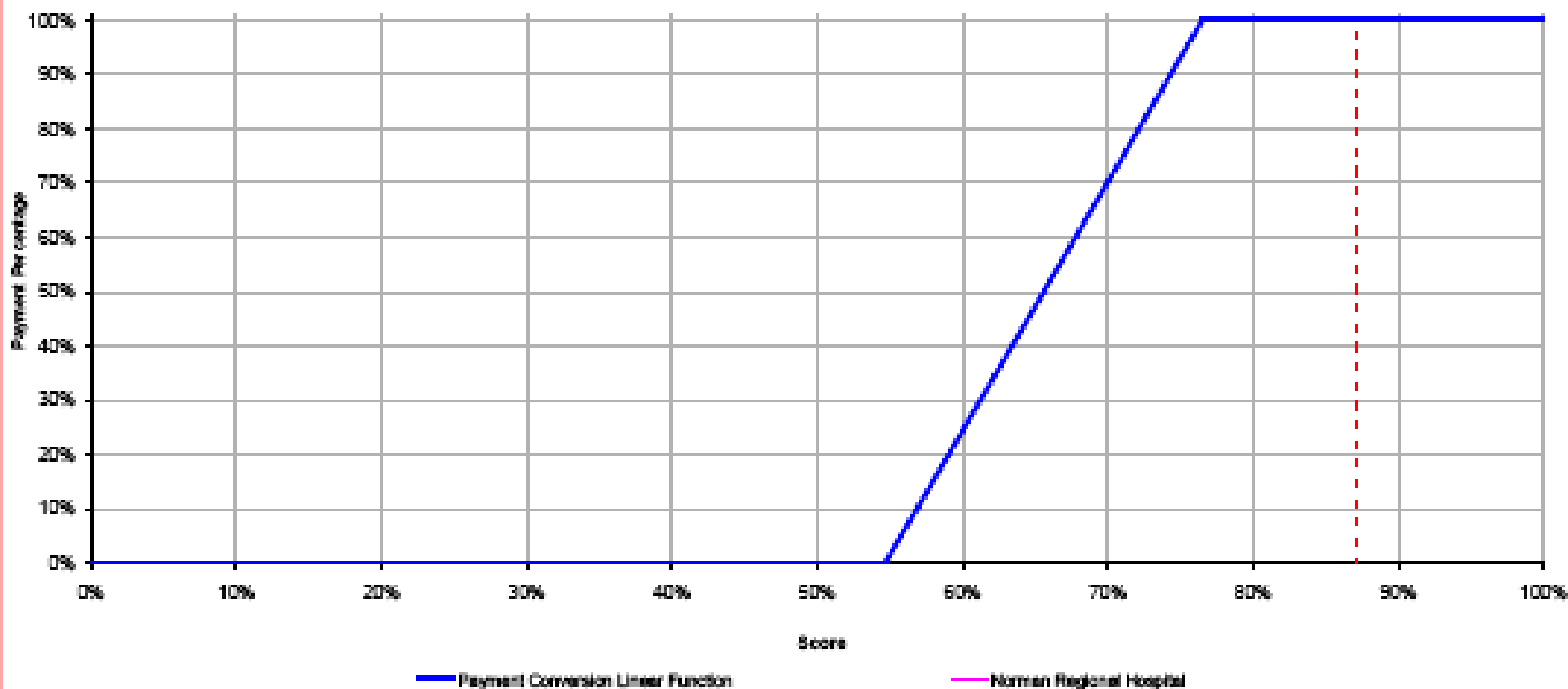
Value-Based Purchasing

Scoring Period: October 2007 - September 2008

## Linear Payment Function

		Linear Payment Function			
		FFY 2013 2% Carve-Out	FFY 2014 3% Carve-Out	FFY 2015 4% Carve-Out	FFY 2016 6% Carve-Out
<b>Norman Regional Hospital</b>					
Overall VBP Score:	87%	\$1,036,000	\$1,598,000	\$2,195,000	\$2,381,000
Payment Percentage:	100%	\$1,036,000	\$1,598,000	\$2,195,000	\$2,381,000
	Dollars Contributed to VBP	\$1,036,000	\$1,598,000	\$2,195,000	\$2,381,000
	Expected Payment from VBP	\$1,036,000	\$1,598,000	\$2,195,000	\$2,381,000
	Net Loss from VBP	\$0	\$0	\$0	\$0
<b>Oklahoma</b>					
Overall VBP Score:	70%	\$36,735,000	\$41,225,000	\$56,616,000	\$59,710,000
Payment Percentage:	72%	\$26,459,400	\$29,682,000	\$40,763,520	\$42,992,200
	Dollars Contributed to VBP	\$36,735,000	\$41,225,000	\$56,616,000	\$59,710,000
	Expected Payment from VBP	\$26,459,400	\$29,682,000	\$40,763,520	\$42,992,200
	Net Loss from VBP	(\$7,276,000)	(\$11,543,000)	(\$15,852,480)	(\$16,717,800)

Linear Payment Scenario



# Hospital Acquired Conditions (HAC)



## No Pay – HAC Event List

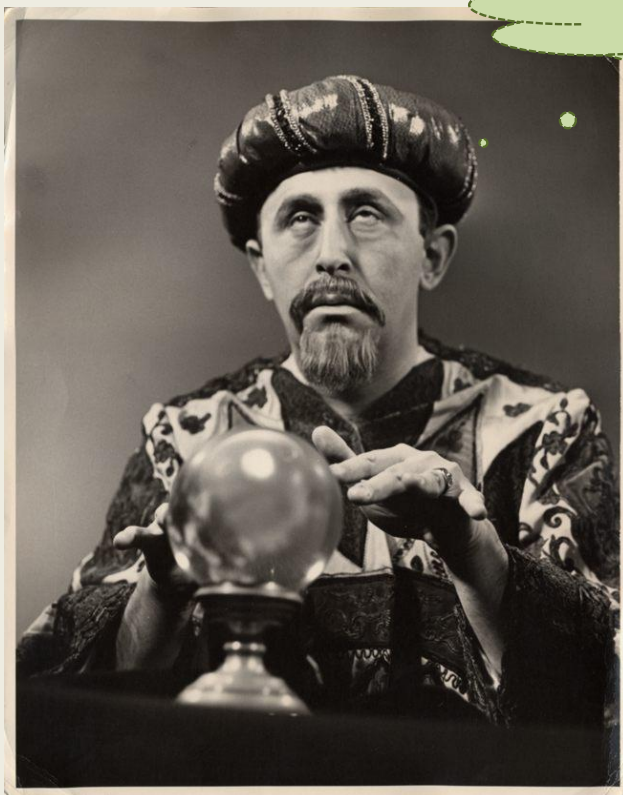
- Hosp Acquired Infections (HAI): Catheter-assoc UTI, surgical site infection, vascular catheter site inf.
- Pressure ulcers
- Staphylococcus aureus septicemia
- Object left in surgery
- Air embolism
- Blood in
- Injuries and trauma
- Maladjustments of poor glycemic control
- DVT/PE post-TKA or THR

**“No-Pay-For-No-Performance”**

- No payment by CMS (and other payers) for hospital-acquired conditions not preventable at admission (DIP) – payment is not bumped up.
- Area of controversy... Not all HACs appear are preventable.
- Impact?
  - Payment
  - Workload

# And The Future Holds.....

## Measure Expansion!



Measure sets expected to “evolve rapidly”

- Efficiency measures
- Outcome measures
- Emergency care measures
- Care coordination measures
- Patient safety measures
- Structural measures

# Challenges to P4P Systems



## **CHALLENGES WITH MEASURES**

- Outcomes vs Process? (Ideal vs practical)
- Focused vs widely representative
- Can measures be dynamic and reflect EBM/best practice
- Will measures incentivize vs inhibit progress (stifle innovation)

## **CHALLENGES WITH PAYMENT**

- Sufficient \$ to make it worthwhile
- Sufficient % of payer mix to make worthwhile
- New money vs budget neutral

## **CHALLENGES WITH PROVIDERS**

- Risk-adjusting outcomes for payment
- Gaming the system: turning away the sicker patients

# How will P4P impact your practice?



## How can you prepare for P4P?

# P4P and Health Systems Pharmacy: Areas of Focus



- The Hospital Strategic Plan for P4P
- The Pharmacy Strategic Plan for P4P
- Measure Performance
- Data-guided Care

# Hospital Strategic Plan for P4P



- Who is addressing P4P at your workplace?
  - Identify key players: QI, PI, Finance, Admin, special committees
- What is the strategic plan for P4P?
  - What plans will you be participating with?
  - What will be priority areas?
  - How will resources be allocated?
- Is Pharmacy represented at the P4P table?
  - # of measures that are medication-related
  - Highly educated staff that can drive improvement

# Pharmacy Strategic Plan for P4P



- Align pharmacy dept goals with institutional targets
- Reevaluate practice model to assure you are patient-centric, outcomes-focused and efficient.
- Tailor staff roles and daily activities to achieve targets
- Where possible, assign accountability to staff for performance measures
- Place online staff into focused performance/QI design teams

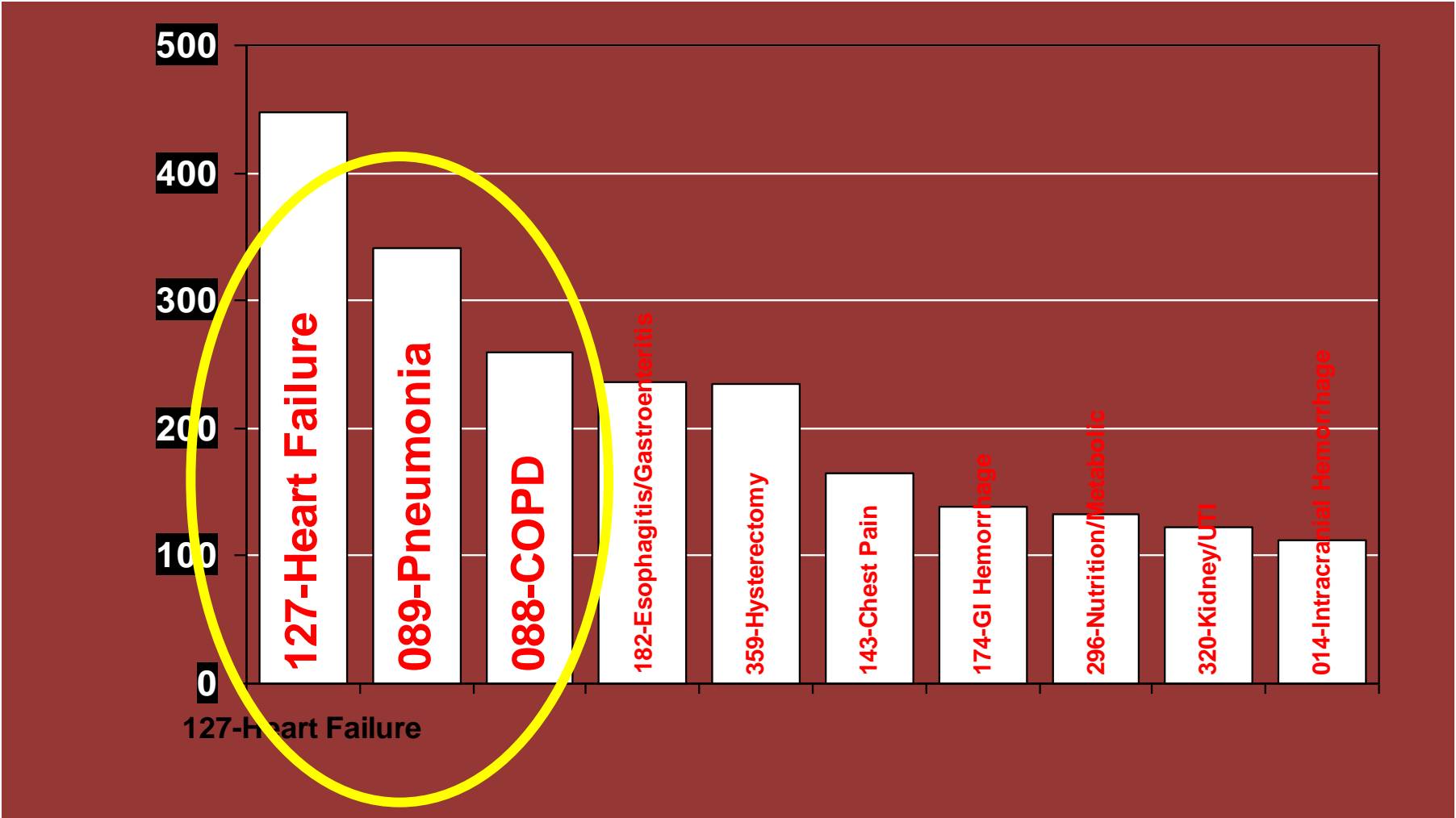
# P4P Measure Performance



*How is your hospital currently performing on RHQDAPU measures?*

- Where are there gaps or deficiencies in care?
- Which of these can be impacted by Pharmacy?
- Are these priority areas?
- What specific actions can you take to address?

# CMS Top Medical/ Surgical DRGs 2010



# P4P Measures: New Opportunities



## Importance of HCAHPS (Hospital Patient Satisfaction Survey)

- Are your pharmacists interacting with your patients?
- Provision of information on medications (along with the discharge med list) is part of the survey.
- Inline with ASHP 2015, develop process to assure each patient sees the pharmacist at least once. Consider provision of key medication information for all or targeted patients.
- Develop pharmacy info flyer for all patients that explains value of pharmacists and services provided. Market your value!

# P4P Measures: New Opportunities



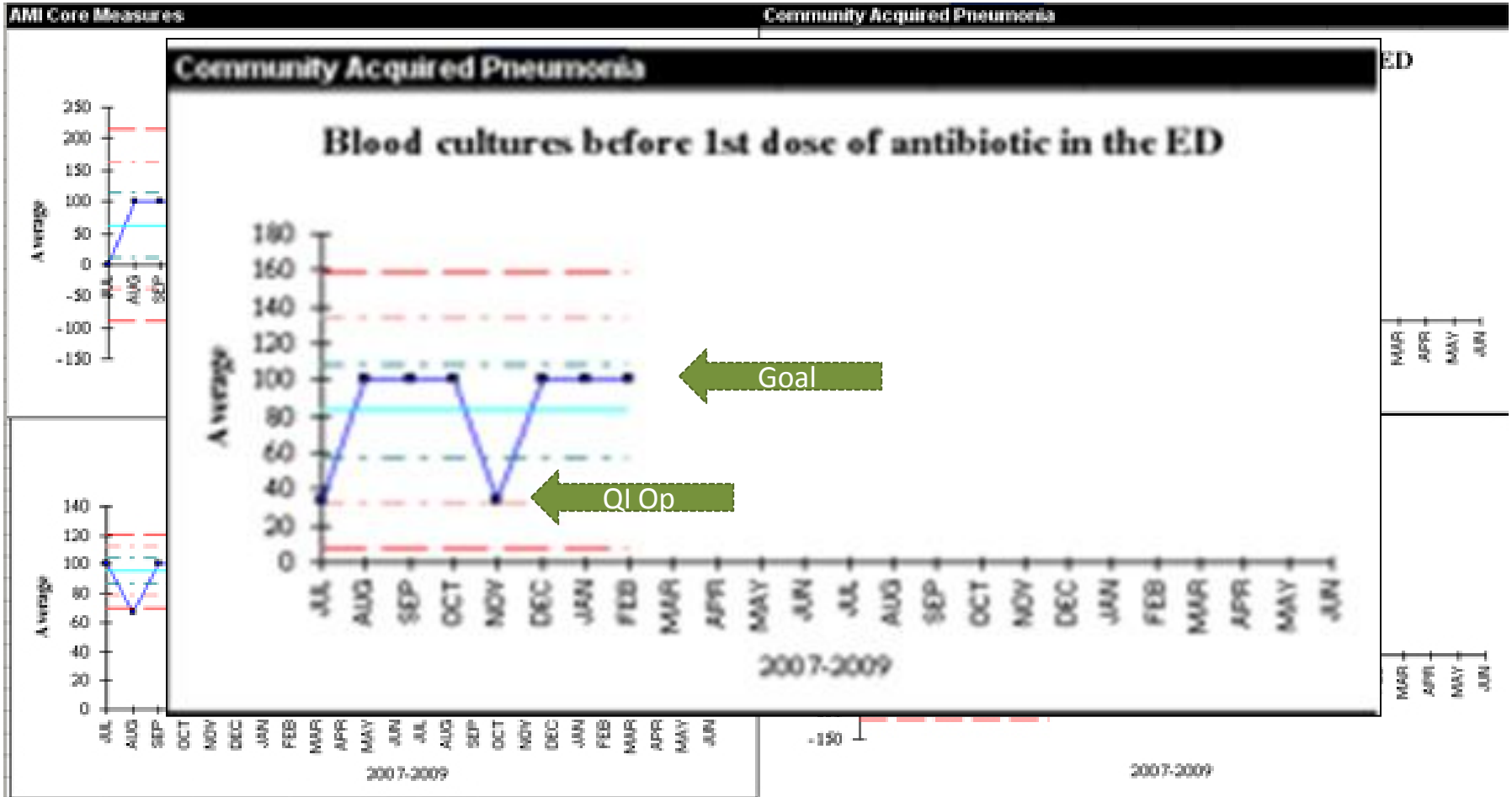
## Focus on Readmissions/Transitions in Care

- CMS will continue to tighten payments on readmissions.
- Focus on interventions both during stay and post-discharge that prevent readmits for key DRGs.
- Consider pharmacy interventions that can improve outcomes:
  - Medication education/counseling
  - Adherence tools & counseling
  - Post-discharge medication follow-up calls or appointments
  - Medication reconciliation
  - Coordination of care for chronic conditions, anticoagulation, etc.

# Use Data to Drive Improvement

- Maximize use of departmental &/or institutional databases for generation of timely reports
  - Real-time surveillance data for identifying improvement opportunities should drive staff actions
  - Reminders or flagging systems for staff communication
  - Create dashboards to show timely performance data
- Pharmacy IT should be prioritized to these goals.
- Institutions should post or present performance data for key measures (CORE, TJC, Leapfrog, etc) in highly-visible areas and at meetings to increase staff awareness.

# CORE Measures Dashboards: Performance tracking and improvement tool



# Rules-driven Surveillance Data

## Sentri7®

Dashboard Lists Patients Admin

Pharmacists | Pharmacists #2 | Renal Dosing | Antibiotics #1 | Antibiotics #2 | Antibiotics #3 | **CMS Core Measures** | Anticoagulation | Other Clinical Data | Pain | Nutrition Services | PICC Services

### Core Measure - MI and No ACE/ARB (5)

Patient Id	Name	Location	Events in Last 7 Days	Diagnosis	Admit Date
3096 - 01		3096 - 01	INT - Antibiotic - Streamlining, Closed, 05/21/2010	ACUTE ALLERGIC REACTION,EARLY...	5/20/2010 12:00:00 AM
3178 - 01		3178 - 01		ATYPICAL CHEST PAIN	5/22/2010 12:00:00 AM
2189 - 01		2189 - 01		STABLE ANGINA	5/23/2010 12:00:00 AM
NONE, 2181 - 01		NONE, 2181 - 01	INT - Anticoagulation - Warfarin Dosage, Open, Due: 05/23/2010 INT - Renal dose change - Cefepime, Closed, 05/21/2010 INT - Antibiotic - Positive Blood Cultures, Open, Due: 05/23/2010 INT - Anticoagulation - Warfarin Dosage, Closed, 05/18/2010	DEHYDRATION,MUSCULOSKELETAL	5/7/2010 1:14:00 PM, 5/13/20...
3181 - 01		3181 - 01	INT - IV-to-PO - Pantoprazole, Closed, 05/23/2010 INT - Pharmacokinetic consult, Open, Due: 05/23/2010	ACUTE RESPIRATORY FAILURE	5/14/2010 6:54:00 PM

### Core Measure - MI and No Aspirin (2)

Patient Id	Name	Location	Events in Last 7 Days	Admit Date
NONE, 7004 - 02		NONE, 7004 - 02	INT - Anticoagulation - Warfarin	5/14/2010 12:00:00 AM, 5/14/20...
2189 - 01		2189 - 01		5/23/2010 12:00:00 AM

### Core Measure - MI and No Beta Blocker (4)

Patient Id	Name	Location	Events in Last 7 Days	Admit Date
3096 - 01		3096 - 01	INT - Antibiotic - Streamlining, Closed, 05/21/2010	ACUTE ALLERGIC REACTION,EARLY... 5/20/2010 12:00:00 AM
2189 - 01		2189 - 01		5/23/2010 12:00:00 AM
NONE, 2181 - 01		NONE, 2181 - 01	INT - Anticoagulation - Warfarin Dosage, Open, Due: 05/23/2010 INT - Renal dose change - Cefepime, Closed, 05/21/2010 INT - Antibiotic - Positive Blood Cultures, Open, Due: 05/23/2010 INT - Anticoagulation - Warfarin Dosage, Closed, 05/18/2010	DEHYDRATION,MUSCULOSKELETAL 5/7/2010 1:14:00 PM, 5/13/20...
3181 - 01		3181 - 01	INT - IV-to-PO - Pantoprazole, Closed, 05/23/2010 INT - Pharmacokinetic consult, Open, Due: 05/23/2010	ACUTE RESPIRATORY FAILURE 5/14/2010 6:54:00 PM

### On Heparin/LMWH with No Baseline Labs Ordered (1)

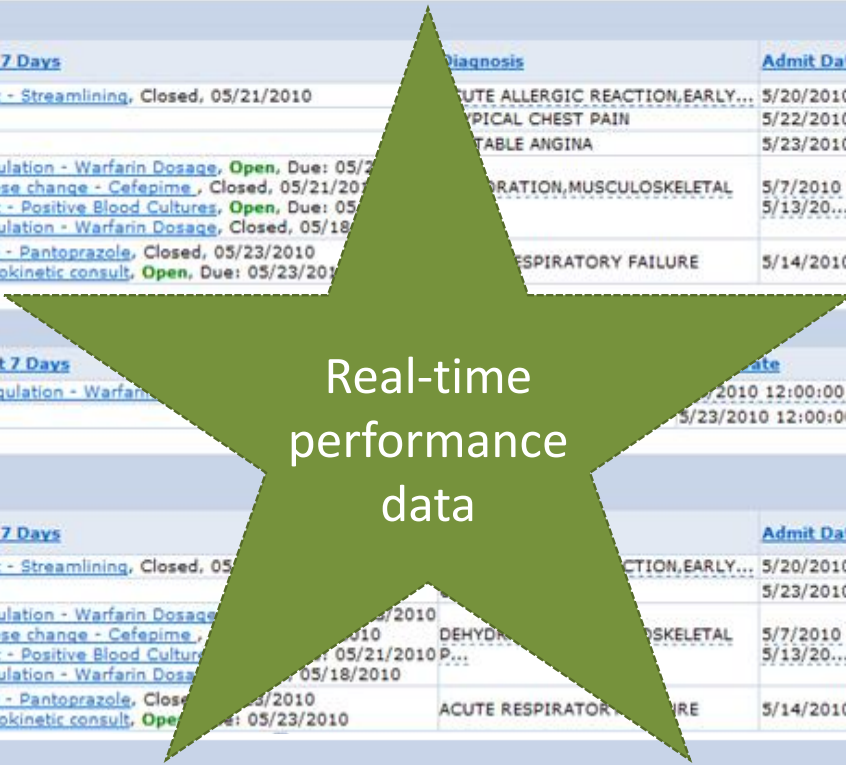
Patient Id	Name	Location	Events in Last 7 Days	PITPTI	PLT	Drug Matches
XY08364	Doe, Jane B	120 - 01		↓ 28	↑ 153	HEPARIN SODIUM

**Suggested Action:**  
Per NPSG3E, Baseline labs (aPTT and Platelets) should be available prior to initiating therapy with Heparin or LMWHs. These patients are in non-compliance of the NPSG. Contact prescriber, get labs ordered and document in Quantifi as non-compliant.

### Pharmacy to Dose Heparin/LMWH - Daily Monitoring (1)


Patient Id	Name	Location	Events in Last 7 Days	Drug Matches
XY08364	Doe, Jane B	120 - 01		HEPARIN SODIUM

**Suggested Action:**  
Continue Daily Monitoring and document ongoing dosing and lab values in Quantifi Follow Up.



# Evolution of Payment Reform

## Past and Emerging Models of Accountability in Provider Payments



Supporting Better Performance		Paying for Better Performance		Paying for Higher Value	
<b>Pay for reporting.</b> Payment for reporting on specific measures of care. Data primarily claims-based.	<b>Payment for coordination.</b> Case management fee based on practice capabilities to support preventive and chronic disease care (e.g., medical home, interoperable HIT capacity).	<b>Pay for performance.</b> Provider fees tied to one or more objective measures of performance (e.g., guideline-based payment, nonpayment for preventable complications).	<b>Episode-based payments.</b> Case payment for a particular procedure or condition(s) based on quality and cost.	<b>Shared savings with quality improvement.</b> Providers share in savings due to better care coordination and disease management.	<b>Partial or full capitation with quality improvement.</b> Systems of care assume responsibility for patients across providers and settings over time.

# P4P Reference Sites



- **AHRQ Pay-for-Performance Resources**  
<http://www.ahrq.gov/QUAL/pay4per.htm>
- **CMS Pay-for-Performance Initiatives**  
<http://www.cms.hhs.gov/apps/media/press/release.asp?counter=1343>
- **Premier HQID project info**  
[http://www.cms.hhs.gov/HospitalQualityInits/35\\_hospitalpremier.asp](http://www.cms.hhs.gov/HospitalQualityInits/35_hospitalpremier.asp)
- **Hospital Value Index:**  
Rankings for over 4,500 hospitals  
<http://hospitalvalueindex.com/>

# Thanks for your participation!



**FEEL FREE TO CONTACT ME FOR FURTHER QUESTIONS...**

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# Questions and Discussion

