Elements of Pay-for-Performance in Healthcare

The HIMSS Quality, Cost, Safety Committee developed this fact sheet to inform providers about the infrastructure needed for a successful pay-for-performance (P4P) initiative.

This fact sheet includes:

- What is pay-for-performance?
- Attribution: Who is the healthcare provider that is responsible for the patient?
- Measures: Using technology to bring us to the next level of care.
- Submission of data.
- Appeals.
- Summary.

What is Pay-for-Performance (P4P)?

The impetus behind P4P is to improve the quality of patient care by aligning financial incentives with cost effective quality improvement. The goal of P4P is to reimburse providers based on performance of quality and efficiency measures that result in improved outcomes vs. current reimbursement methods that reward patient care volume rather than improved care.

There are many aspects to P4P. Three elements critical for any meaningful program are attribution, measurement and evaluation that results in a reward. How these elements are arranged will determine the success of any program. Physicians and other stakeholders need to be clear on the data collected and the incentives provided. A well designed plan will give the results it was designed to give.

**Attribution**

Attribution is assigning the right patient to the right physician and more importantly the right practice. This is the key to identifying who is ultimately responsible for the care of the patient. The correct identification of the responsible provider will make the patient and the provider more responsible for the care. The primary care physician can be designated by the insurance plan or the patient. When the physician is not designated, the primary care physician can be attributed as follows:

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1) The physician or practice that sees the patient more than two times in a year. If more than one physician sees the patient twice then attribution should be to the physician that orders the most preventive medicine screening tests.

2) A sub-specialty physician can be the primary physician for a patient when the patient’s primary diagnosis is in that field (i.e., chronic renal failure to the nephrologist).

**Measures**

The advent of widespread technology adoption allows for the collection of data in ways that healthcare has not seen before. We must guard against the collection of data because we can. This is not valuable. The data collected needs to be evidence based and meaningful. The data needs to be actionable to improve care. Practices also need to be able to collect measures that are relevant to their patients. The sample size of the data needs to be statistically relevant.

The sample has to be reasonable for the physician to be graded. For example with a sample size of three, if you miss one out of three charts you are at 66-percent compliance. The sample size for grading needs to be at least 30 records for that indicator.

We need to use technology to collect measures that are new, dynamic and leverage the technology. For example, averaging blood-pressure readings to obtain the mean average pressure may be more relevant than collecting a blood pressure reading from the last office visit and using that to result to measure quality. We might use telephonic blood-pressure monitoring of the patient at home as the basis for treatment.

The definition of the indicators needs to be clear, precise and consistent. Measures need to be standardized across all payers, so that apples are compared to apples. It is not possible for physicians in small practices to be able to make significant changes in practice if every insurance company, health organization and the government uses different measures or defines measures differently.

The CPT codes for each measure needs to be defined and agree with current coding practices and reimbursement policies.

The timing of data collected needs to be defined so that the scoring is fair. For example, for a new diabetic patient to a practice, the practice should not be held accountable for the HgA1c after one visit. There also needs to be some measure of patient accountability in the process as well. The data needs to be timely; reviewing data that is six months old is not as effective as reviewing data that is a month old. Data review needs to occur in the moment not in the distant past. The process of data collection should be dynamic. New measures should be added annually based on community need and eliminated when least there is at least 95 percent or better compliance with an indicators.
**Submission of Data**

Data can be collected from billing information, but we need to acknowledge that this is notoriously inaccurate. We should move to a system that extracts accurate data from the EHR. As adoption of technology in small practices and hospitals accelerates under the government's meaningful use program, Physicians that have an EHR should be allowed to submit their data from their EHR. Data needs to be available by population, insurance, regional and practice size/type. Barriers to performance need to be identified not only from the physician perspective but also from the community and plan perspective.

**Evaluation**

In the first year, all physicians should be paid for participation. Participation should be defined as data collection and analysis of a practice’s processes. Poor quality patient outcomes are often a result of poor processes.

Practices where the initial evaluation of measures is below the national, state or local average should be compensated on the rate of improvement, not on an absolute score. The greatest improvement in healthcare will come from raising the quality of the practices that are not currently optimized for quality.

Practices where the initial evaluation of measures is above the national, state or local average should be compensated on those absolute scores that are statistically relevant. Measures should be change or rotate as practices advance.

Data that is reported should be statistically significant. Practices should be grouped into categories based on size, scope and geography. This enables practices that have the same resources be evaluated against each other. You cannot evaluate a rural solo practices against an urban university group practice. These comparisons are not meaningful to effect change.

**Appeals**

If there is a dispute on data, there should be a mechanism for the physicians to submit their proof and have it resolved. This proof can be a paper audit or the submission of EMR data on the practice.

**Summary**

As healthcare costs continue to rise, the concept of value-based purchasing of healthcare is becoming more relevant. Health IT will be at the heart of this concept. The system needs to
reward providers for good outcomes of patients not the volume of patients seen. As the economics of practice change, the number of solo practices will decline. The medical home model of care delivery will change the responsibility for the patient’s care from a single responsible provider to care delivered by groups of providers. The correct attribution of care will be essential for identifying where in the system problems exist and how corrective actions will be applied.