

Pay for Performance

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Learning Objectives

Upon completion of this presentation, learners should be better able:

- Identify incentives for achieving a Medical Home Designation
- Appraise different types of Pay for Performance (P4P) initiatives in which your practice might elect to participate
- Assess obstacles and opportunities associated with the implementation of P4P reimbursement in your practice.



Pre-test Questions

What activity is not considered as Pay for Performance?

1. Adoption of an Electronic Health Record
2. Electronic prescribing
3. Medical Visits
4. Qualifying as a Medical Home



Pre-test Questions

Do you see most of your patients as a?

1. Staff provider
2. Private provider



Pre-test Questions

Are you receiving pay for performance?

1. Yes
2. No



P4P Definition

Features common to most definitions include an insurer or health system awarding a periodic bonus to clinicians or practice that reach particular quality goals.

Source: P4P Research Clearinghouse



P4P Decisions

	<ul style="list-style-type: none"> •Provides Certainty for providers •Payers are uncertain of costs 	<ul style="list-style-type: none"> •Less provider control •Payers may have more certainty
<ul style="list-style-type: none"> • Low achievers have stronger incentives to improve quality but high achievers are “punished” • Rewards may go to providers whose performance does not meet quality standards 	Rewards provider with X percent improvement in mammogram rate	Rewards provider with mammogram rate improvement in top X percent
<ul style="list-style-type: none"> •Rewards superior providers, but without motivating improvement •Incentives may be out of reach for low providers 	Rewards provider with X mammogram rate	Rewards provider with mammogram rate in top X percent

Source: Paying for quality: Understanding and assessing physician pay-for-performance initiatives, The Synthesis Project, Policy Brief No. 13, December 2007 The Robert Wood Johnson Foundation



Available P4P Programs

- Patient Centered Medical Home
- Electronic Health Record and Meaningful Use
- Physician Quality Reporting Initiative
- Electronic Prescribing Incentive Program



Patient Centered Medical Home

- National Committee for Quality Assurance (NCQA)
- National HIV/AIDS Strategy for the United States
- Health Homes for Enrollees with Chronic Conditions – (CMS)



NCQA: Patient Centered Medical Home

1. Enhance Access and Continuity 6 Standards
2. Identify and Manage Patient Populations 27 Elements
149 Factors
3. Plan and Manage Care
4. Provide Self-Care and Community Support
5. Track and Coordinate Care
6. Measure and Improve Performance

2010 Levels	Points
Level 3	75-100
Level 2	50-74
Level 3	25-49
Not Recognized	0-24

Source: NCQA PCMH 2011 Scoring Summary



New York State PCMH Incentive

Fee-for-service add-on incentive payment amounts for providers achieving patient-centered medical home recognition are as follows:

Setting	Level I	Level II	Level III
Article 28 Clinic	\$5.50	\$11.25	\$16.25
Office-based practitioners	\$7.00	\$14.35	\$21.25

Medicaid Managed Care Plans can alternatively pay a per member per month add-on incentive payment of \$2.38 for providers achieving patient-centered medical home recognition.

Source: New York State Medicaid Update December 2009



National HIV/AIDS Strategy

To support the provision of quality care for people living with HIV, it is important to reduce barriers that impede access to services.

The concept of a medical home is a model for the provision of coordinated, person-centered care for individuals with chronic or prolonged illnesses requiring regular medical monitoring, care management, and treatment.

The Ryan White HIV/AIDS Program has supported the development of medical homes for people living with HIV and has experience to share, which can be valuable to other providers including community health centers and private physicians in their provision of HIV care. (page 27)

Source: National HIV/AIDS Strategy for the United States



CMS: - Health Homes for Medicaid Enrollees with Chronic Condition

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

Source: CMS State Medicaid Directors Letter 2010



Medicare EHR Incentives

	First Calendar Year in which the EP receives an Incentive Payment				
Calendar Year	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 [*] and later
2011	\$18,000				
2012	\$12,000	\$18,000			
2013	\$8,000	\$12,000	\$15,000		
2014	\$4,000	\$8,000	\$12,000	\$12,000	
2015 [*]	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016		\$2,000	\$4,000	\$4,000	\$0
Total	\$44,000	\$44,000	\$39,000	\$24,000	\$0

^{*} Providers not satisfying the Meaningful Use Criteria will have their Medicare fee schedule amounts are reduced by 1% in 2015, 2% in 2016 and 3% in 2017 and between 3%-5% in subsequent years.

Source: Primary Care Information Project



Medicaid EHR Incentives

Payment Amount for Year:	First Year Medicaid EP Qualifies to Receive Payment 2011	First Year Medicaid EP Qualifies to Receive Payment 2012	First Year Medicaid EP Qualifies to Receive Payment 2013	First Year Medicaid EP Qualifies to Receive Payment 2014	First Year Medicaid EP Qualifies to Receive Payment 2015	First Year Medicaid EP Qualifies to Receive Payment 2016
2011	\$21,250	-	-	-	-	-
2012	\$8,500	\$21,250	-	-	-	-
2013	\$8,500	\$8,500	\$21,250	-	-	-
2014	\$8,500	\$8,500	\$8,500	\$21,250	-	-
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	-
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	-	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	-	-	\$8,500	\$8,500	\$8,500	\$8,500
2019	-	-	-	\$8,500	\$8,500	\$8,500
2020	-	-	-	-	\$8,500	\$8,500
2021	-	-	-	-	-	\$8,500
TOTAL Possible Incentive Payments	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Source: Primary Care Information Project



CMS (PQRI)

Physician Quality Reporting Initiative

- To participate in 2011
 1. Report on information on 190 quality measures or measures groups to CMS on Medicare Part B claims
 2. To a qualified PQR registry
 3. Or to CMS via a qualified EHR
- **Incentives** (beginning in 2015 penalties for non-compliance)
 1. 1.0% of their total estimated Medicare Part B allowed charges during that reporting period.
 2. An additional .5% submit data on quality measures for a 12-month reporting period and participate in a Maintenance of Certification Program.

Source: Centers for Medicare and Medicaid



CMS (eRx)

Electronic Prescribing Incentive Program

- To participate in 2010
 1. Report use of a qualified eRx system by submitting one eRx measure to CMS on Medicare part B claims
 2. To a qualified registry or via a qualified EHR.
 3. At least 10% of prescriber's Medicare Part B covered services must be made up of codes that appear in the denominator of the eRx measure.
- Incentive
 - 2.0% if submitted 25 unique prescribing events

Source: Centers for Medicare and Medicaid



P4P Obstacles

- Reliance on claims which may not be timely or complete
- Incentive payment not available to the practice or provider
- Incentives are too low to offset change in practice
- EHR implementation is generic and delayed
- There is no payer for the uninsured patient.



Opportunities

- States offer Regional Extension Centers to assist providers in adoption of EHRs
- Health Care Reform expands Medicaid eligibility
- The Triple Aim
- Accountable Care Organizations
- Pay for Performance for Patients



Accountable Care Organization

Structure:

An organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.

Shared Savings:

For each 12-month period, participating ACOs that meet specified quality performance standards will be eligible to receive a share (a percentage, and any limits to be determined by the Secretary) of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount.

Source: Centers for Medicare and Medicaid



The Triple Aim

- Population Health
- Improved care experience
- Reduced and/or controlled per capita cost

Source: Berwick, DM, Nolan, TW, Whittington, J. The triple aim: care, health, and cost. *Health Affairs*. 2008 May-Jun;27(3): 759-69



Steps to a Healthier Life

- Annual self health assessment
- Quarterly Visits to Primary Care Provider
- Timely refill of prescriptions
- Use of Patient Portal
- Cancer Screening

Source: NewYork-Presbyterian System SelectHealth



Post-test Question

Who does not pay for performance?

1. Centers for Medicare and Medicaid System
2. Ryan White Treatment Modernization Act
3. State Medicaid
4. Health Maintenance Organizations (HMOs)

Post-test Questions

What is your role in choosing an EHR?

1. I have no input.
2. I am the decision maker.
3. I have some input.



Post-test Questions

What is your role in deciding to apply for Medical Home Designation?

1. I have no input.
2. I am the decision maker.
3. I have some input.



References and Resources

Online listing of many of these references and additional resources

<http://sqworl.com/7xjtnx>

Satin, D.J. & Miles, J. Pay for Performance Research Clearinghouse, <http://student.med.umn.edu/p4p-new/>

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National Center for Quality Assurance, Patient-Centered Medical Home, <http://www.ncqa.org/tabid/631/Default.aspx>

National Center for Quality Assurance, PCMH 2011 Content and Scoring Summary, <http://www.ncqa.org/LinkClick.aspx?fileticket=AHJ2EF4pH6Y%3d&tabid=631&mid=2435&forcedownload=true>

New York State Medicaid Update December 2009 V. 25, #16, http://www.nyhealth.gov/health_care/medicaid/program/update/2009/2009-12spec.htm

Centers for Medicare and Medicaid Services, State Medicaid Directors Letter, Health Homes for Enrollees Chronic with Chronic Conditions, November 16, 2010, <http://www.cms.gov/smdl/downloads/SMD10024.pdf>

Primary Care Information Project, New York City Department of Health and Mental Hygiene, <http://www.nyc.gov/html/doh/html/pcip/meaningful-use.shtml>

Centers for Medicare and Medicaid Services, Physician Quality Reporting System, <http://www.cms.gov/pqri/> ,
E-Prescribing Incentive Program, <http://www.cms.gov/ERXIncentive/>, Medicare Accountable Care Organizations, <http://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf>

National HIV/AIDS Strategy for the United States, <http://aids.gov/federal-resources/policies/national-hiv-aids-strategy/>

Institute for Healthcare Improvement, The Triple Aim, <http://www.ihl.org/IHI/Programs/StrategicInitiatives/TripleAim.htm?TabId=0>

Berwick, DM, Nolan, TW, Whittington, J. The triple aim: care, health, and cost. Health Affairs. 2008 May-Jun;27(3): 759-69 <http://content.healthaffairs.org/content/27/3/759.long>

U.S. Department of Health & Human Services, The Office of the National Coordinator Regional Extension Centers, <http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&mode=2>

