National Hospital Pay for Performance Programs- Payment Models

Hospital Quality Alliance (Medicare with AHA, AMA and others)- Existing Funds Model

- Almost all USA hospitals participate
- Pay for reporting model currently; results publicly reported on *Hospital Compare*.
- Hospital submits data on 21 measures- AMI, HF, PN, SIP. New measures will be added in future program years. Hospital copies and submits 5 medical records per quarter for validation
- Validation is 80% or higher
- Hospital receives annual market basket increase from CMS
    - 0.4% FY 2005
    - 2.0 %FY 2006

Premier/CMS demonstration project- Direct Investment Model for first Two Years

- 266 hospitals in 38 states
- Hospital submits data – 33 measure set partially overlaps with CMS core measures but includes additional measures including mortality measures.
- Hospital copies and submits 7 medical records per quarter for validation
- Validation is 80% or higher
- Hospital composite score is in 1st or 2nd decile per diagnosis-related measure set, i.e., AMI, HF, PN, SIP
- 1st decile = 2% additional reimbursement (bonus) for all Medicare cases in that diagnosis population
- 2nd decile = 1% additional reimbursement (bonus) for all Medicare cases in that diagnosis population
- In 3rd year of demo, hospitals with composite score in 9th decile pay a penalty of 1% and 2% for the 10th decile
- Pay for performance hospitals showed greater improvement (2.6-4.1%) in all composite measures of quality as compared with a control group of hospitals with only public reporting of quality measures. [1]
- In second year, $8.7 million in bonuses paid to 115 hospitals. Bonuses averaged $71, 960 per year and ranged from $914 to $847, 227.

Leapfrog "Hospital Rewards" proprietary program- Direct Investment Model for First Year, then Generated Savings Model

- Program licensed and tailored by insurer, large employer, health plan
- Hospital submits data on any of the following diagnosis-related measures: Coronary artery bypass graft (CABG), Percutaneous coronary intervention (PCI); Acute myocardial infarction (AMI); Community acquired pneumonia (CAP); and Deliveries/newborn care. Mortality data are included.

[1] PK Lindenauer et al, "Public Reporting and Pay for Performance in Hospital Quality Improvement," NEJM, Feb 1, 2007, Vol 356, pgs. 486-96.

- Hospital provides efficiency data –severity-adjusted average length of stay broken down by routine care and specialty care days, and short-term readmission rate to the same facility.
- Hospitals receive a rolled-up or composite quality score and resource or efficiency score for each diagnosis-related area.
- Program licensees can tailor rewards and incentives to local market area. Rewards can be both financial and non-financial, such as public recognition. Each diagnostic area can be rewarded separately. Health plan members may be incentivized to select hospitals with high quality and efficiency scores which may lead to increased market share for these institutions.
- Program design allows for new money for rewards in the first year. In subsequent years, savings generated from improved quality and resource-use efficiency are expected to finance rewards.
- New program –program licensee experience not known.

Various regional health plan and insurer programs- generally Existing Funds model

- Hospitals submit data on a variety of nationally endorsed measures depending on the local plan, including JCAHO and CMS core measures, Leapfrog hospital survey measures, AHRQ quality measures, Institute for Safe Medication Practices medication survey.
- Validation of data not generally performed. Hospital self-reporting is usual approach to data collection.
- Weighting and scoring approach is generally transparent and based on assignment of a percentage score to selected measures or measure sets. Composite score is achieved by adding up the percentages assigned to the measure sets or categories.. Risk adjustment and complex statistical analysis not generally done.
- Rewards and incentives may be financial or non-financial and are built into contract language. Financial rewards may be in the form of bonuses, percentage of inpatient payment, tiered bonuses or variable cost-sharing. Non-financial rewards include public recognition, CME credit for physicians and technical support for HIT. Amount budgeted for annual financial rewards depends on the insurer or plan sponsoring the pay for performance program and generally does not represent new money.