

Innovations in Government Programs: P4P, Chronic Care, and Basic Payment Policy

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Some Concepts and Definitions

- P4P uses marginal dollars to reward specific behavior – now, mostly 1° and 2° prevention (HEDIS) and patient experience (CAHPS)
- P4P has actually been around a couple of decades – with different focus and names
 - US Healthcare capitation had bonuses and withholds for costs, convenience of hours, etc.
- P4P is not value-based purchasing, which is a much broader concept in which P4P is one tool



Why Do It?

- Quality overall is mediocre, so pay for providers to do better – professionals do respond to financial incentives
- The available, validated measures of quality do address important deficiencies in the process of care for important conditions, e.g. diabetes



Why Do It (cont.)

- In face of resistance to change, start somewhere
- Response to P4P might change provider culture to spillover into other areas to improve quality, costs, etc.
 - P4P is an important deviation from payment that is directly related to underlying costs for group of providers
- If everyone is doing (or at least talking) about it, there must be something here.



Concerns About P4P

- There is scant evidence of effectiveness
- Focuses on marginal few percent, and ignores the base payments – is the tail wagging the dog?
- Overemphasis on what is measurable – is this the “searching for the lost key under the light” phenomenon?
- Can’t easily address overuse and misuse quality dimensions, much less costs. So, a *quid pro quo* for replacing the SGR with P4P makes little sense



Concerns About P4P (cont.)

- Pay extra for what should be an expectation?
- May reward capacity to report more than true performance
- Reinforces tiering of providers – the relatively rich get richer
 - Can address by also paying for improvement and by using other types of measures that are less technically clinical? But hard politically



The Policy Dilemma

- On the one hand, a lot of probably productive behavior is going into P4P (there are many worse ways to occupy people's time), but it may be a diversion from need for more important reforms
- Resolution? – Make clear that P4P is to be used opportunistically – for specific conditions and providers and relatively few measures – not as broad-based, complex initiative; and not as a substitute for the expenditure controls



Chronic Care Pilots/Demos

- Some are important as intermediate approaches between full practice redesign (the Wagner chronic care model) and third-party disease management, which is a strategy that bypasses physicians
- A concern – some assume CMS would replicate the demos, rather than incorporate the lessons into basic payment policy



The Basic Problem with RBRVS

Relative values do not reflect relative value

They are, at best, an approximation of underlying resource costs, not an attempt to determine what services beneficiaries and the program need

And, what purports to be an objective process is, despite good intentions, inherently subjective and political



A Missing Concept - Strengthening PCPs in Medicare

- Increasingly, face-to-face visits do not encompass the work of primary/principal care for patients with chronic conditions (i.e., most beneficiaries)
- Yet, FFS payments cannot easily adapt to the range of services that comprise good care management, including non-physician care management, team conferences, consulting other physicians, harnessing community resources, etc.



FFS Payment Codes Have a Bias for Face-to-Face Encounters

There are reasons:

- Relatively high transaction costs associated with frequent, low dollar activities
- Program integrity concerns and the problems that come with more oversight
- Moral hazard – too easy to justify additional services when no natural barriers to demand



Medicare Should Test “Retainer” Payments For A Medical Home

- Per Person Per Month payment, but avoiding some mistakes of primary care capitation –
 - Payments need to be risk adjusted
 - Pppm payments need to include more than just actuarial equivalence of the value of PCP FFS payments, including care coordination
 - No formal downstream risk – but could do P4P
 - “Soft” patient lock-in to a medical home
 - Practices need to qualify for this payment approach, e.g. by having and using an EMR

