

# PAYING FOR QUALITY:

## Making policy and practice work for patients

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Since the Institute of Medicine (IOM) published *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001)<sup>1</sup> and *Leadership by Example: Coordinating Government Roles in Improving Healthcare Quality* (2002),<sup>2</sup> the conversation among health care policymakers has shifted. Whereas the focus previously was on patient safety efforts, prevention of errors, and their application to public health programs, the emphasis now includes the implementation of quality improvement (QI) processes and outcome measures across the health care system. Following the route established by these IOM reports—as well as through efforts at the National Quality Forum (NQF) and private sector entities such as the Leapfrog Group—the QI conversation has progressed beyond the theoretical academic applications of the late 1990s and early 2000s to the practical, more tangible world of health policy and health care delivery through the work of the Medicare Payment Advisory Commission (MedPAC), the Centers for Medicare & Medicaid Services (CMS), and, most noticeably, the U.S. Congress.

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In his testimony before the U.S. Senate Committee on Finance in July, Mark Miller, executive director of MedPAC, stated, “MedPAC has concluded that Medicare is ready to implement pay for performance [P4P] as a national program and that differentiating among providers based on quality is an important first step toward purchasing the best care for beneficiaries and assuring the future of the program.”<sup>3</sup> Miller was restating the broad recommendations of the March 2005 MedPAC *Report to the Congress*,<sup>4</sup> in which the commission specifically recommended that Congress establish quality incentive payment policies for physicians and other providers. In light of these recommendations, Congress has responded by holding hearings on how such a payment system might be implemented.<sup>5</sup> Furthermore, given the challenges posed by the sustainable growth rate (SGR) methodology for calculating Medicare physician payments (which, left in its current form, will cut physician payments between 4 and 5% per year for the next six years), congressional discussions have focused largely on how the SGR might be replaced by a physician P4P system.

### ***Congress moves ahead on legislation***

Following the issuance of MedPAC’s March report, conversations between policymakers and physician stakeholders, such as the College, began to focus in earnest on possible forms of legislation that would establish a comprehensive P4P system under Medicare. On June 30, Sens. Charles Grassley (R-IA) and Max Baucus (D-MT)—Chair and Ranking Member of the Senate Finance Committee, respectively—were the first to introduce legislation, the Medicare Value Purchasing Act of 2005 (S. 1356).<sup>6</sup> Similarly, Rep. Nancy Johnson (R-CT), Chair of the House Ways and Means Subcommittee on Health, introduced the Medicare Value-Based Purchasing for Physicians’ Services Act of 2005 (H.R. 3617) on July 29.<sup>7</sup> Both bills would establish a process for setting quality measures and both would create financial incentives for physicians to report on particular measures effective in 2007.

According to their authors, both S. 1356 and H.R. 3617 envision a consultative process between the physician community and CMS in establishing those measures; however, H.R. 3617 more clearly establishes a process for physician organizations

and specialty societies to submit specific measures each year to a consensus-based entity, such as the NQF. That entity, in turn, would make recommendations to CMS regarding specific quality measures for inclusion in the P4P system, and CMS would then publish its proposed measures for review and comment before final implementation each year. H.R. 3617 would establish a phased approach to P4P, starting with the required reporting of particular processes in 2007 and phasing into full P4P in 2009. Under H.R. 3617, those physicians who report required data in 2007 and 2008, and those who meet the measure requirements in 2009 and future years, would receive a payment increase equivalent to the Medicare Economic Index (MEI), which measures the annual increase in physicians’ practice costs. Physicians who do not meet the requirements will receive a payment increase of MEI less 1 percent.

Similar to H.R. 3617, S. 1356 would set up a phased approach to P4P, starting with the reporting of data in 2007; but unlike the House bill, S. 1356 would implement full P4P in 2008. The penalties for failure to report data or to meet performance thresholds also would be greater under S. 1356: Physicians not submitting data in 2007 would receive the payment update provided under law less 2 percent, and starting in 2008, physicians not meeting quality thresholds would receive the payment update less 1 percent. The amount subtracted for physicians who do not reach thresholds would increase incrementally each year to a full 2 percent reduction in 2012.

Although all of these differences are significant, the most marked difference between the bills is that H.R. 3617 would repeal the SGR and replace it with payment updates that guarantee increases for all physicians in 2006 and almost certainly would guarantee increases regardless of their quality measure status for all physicians in 2007 and beyond. Because S. 1356 leaves the SGR in place, it would merely add P4P to the already broken physician payment structure.

### ***CMS sets the stage***

Although much attention is currently (and rightfully) being paid to these congressional efforts, it is important to note that CMS has been setting the stage for P4P for several years. In November 2001, Tommy Thompson, then-Secretary

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of the U.S. Department of Health and Human Services, announced the CMS Quality Initiative, which began with the Nursing Home Quality Initiative (NHQI). Through a collaborative effort with NQF and nursing home stakeholders, CMS developed quality measures for the facilities that were included in a pilot project that commenced in April 2002. In November 2002, the NHQI was launched in nursing homes nationally. In 2003, this initiative was extended to include home health agencies through the Home Health Quality Initiative and hospitals through the Hospital Quality Initiative (HQI); in 2004, it was extended to dialysis facilities that treat end-stage renal disease patients and the Physician Focused Quality Initiative, which at present is focused largely on primary care demonstration projects.<sup>8</sup>

Consistent with the logical progression of the NHQI, CMS has turned its focus this year toward quality measures for physicians. Although CMS' authority for development of these broad quality measures is uncertain, and no formal physician P4P measures have been proposed as of press time, CMS has forged ahead in communications with the physician community about possible measures for inclusion in a physician P4P program; whether the program would be of national scope or initially limited to a pilot program remains to be determined.

With respect to surgery, draft measures circulated by CMS staff are based largely on the College's collaboration with CMS, the Centers for Disease Control and Prevention, and other partners through the Surgical Care Improvement Project (SCIP),<sup>9</sup> and include measures to prevent postoperative complications, such as surgical site infection, adverse cardiac events, and postoperative pneumonia. However, while the College has been closely involved in the development of the SCIP criteria, to date these measures have been largely hospital-based. Concerns have been raised within the profession about the application of hospital-based surgical measures to surgeons, who see a more narrow scope of patients. In response, the College and the surgical specialties are working to ensure that any surgical measures, whether implemented in a demonstration project or more broadly, appropriately account for the risk associated with particular patients and particular conditions.

### ***Hospitals: A model for surgical P4P?***

Beyond the College's efforts within SCIP, the HQI approach taken by CMS—and, to a lesser extent, Congress—should serve as a helpful guide for surgery and the physician community as a whole when considering the possibilities of physician P4P—partly because of the considerable interaction that physicians and hospitals have in caring for patients, and partly because of similar political realities that hospitals faced when quality reporting requirements were first linked to their payment under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).<sup>10</sup>

Over the past year, the course adopted by the HQI, which provided for a collaborative process between CMS and the Hospital Quality Alliance (HQA), is one that CMS and congressional policymakers and physician stakeholders have used as a model for developing a physician P4P program. The HQA is a public/private effort that includes a wide range of organizations and supporters, including the American Hospital Association, the Federation of American Hospitals, the American Medical Association, the Agency for Healthcare Research and Quality (AHRQ), CMS, NQF, the Joint Commission on the Accreditation of Healthcare Organizations, consumer groups, and labor representatives. Through HQA, a starter set of 10 basic quality measures were developed, and under the MMA, those hospitals that report on the starter set measures are guaranteed a full inflationary update for fiscal years 2005, 2006, and 2007; for those same years, those hospitals not reporting data have their payment update reduced by 0.4 percent. In addition, the public is able to compare various hospitals on up to 17 measures via the CMS Hospital Compare Web site (<http://www.hospitalcompare.hhs.gov/>); similar quality comparison Web sites exist for the nursing home and home health efforts.

Under the HQI, CMS has also been exploring P4P in the hospital setting through the Premier Hospital Quality Incentive Demonstration,<sup>11</sup> a three-year study that began in October 2003. It includes 274 hospitals nationwide and studies linking hospital payments with quality measures in the following five clinical areas: (1) acute myocardial infarction, (2) congestive heart failure, (3) coronary artery bypass graft, (4) hip and

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knee replacement, and (5) community-acquired pneumonia. Hospitals performing in the top 10 percent for a given diagnosis receive a 2 percent bonus for payments for the measured condition, and hospitals in the second 10 percent receive a 1 percent bonus. In the third year of the demonstration, hospitals not reaching baseline thresholds for performance improvement will have adjusted payments; the baseline will be set by hospitals performing in the ninth and tenth deciles in the first year. Specifically, in year three, hospitals performing below the ninth decile threshold from the first year for a given condition will receive a 1 percent reduction of payments for the diagnosis; those below the tenth decile will receive a 2 percent reduction in payments. Although these established baselines would set penalties for hospitals not meeting these thresholds, CMS and Premier have stated their belief that all participating hospitals will exceed these thresholds and not be financially penalized.<sup>12</sup>

In May of this year, CMS and Premier released data regarding hospital quality under the demonstration's first year, during which the median composite performance scores for all participating hospitals increased by 7.5 percent.<sup>12</sup> Although there was improvement in all five clinical areas, the most significant improvements were realized in care provided to heart failure and pneumonia patients. In addition, an initial finding of particular interest that should be no surprise to the surgical community is that a key component to hospital QI is actively engaging the staff physicians in the QI effort. In the case of several measures—for example, the administration of prophylactic antibiotics, which is consistent with SCIP measures supported by the College and circulated by CMS staff for possible inclusion in surgical P4P—the surgeon is ultimately responsible for ensuring that care is delivered to the patient. So long as physician QI efforts remain consistent with the HQI model and the Premier demonstration, surgeons can be encouraged about policymakers' desire to establish a consultative process, which uses process measures that surgery has helped develop and that most surgeons are already implementing on behalf of their patients.

From a political perspective, there are similarities between the situation facing the physician community today and the one the hospital

community was experiencing at the time of the MMA's enactment. In light of the March 2003 MedPAC *Report to the Congress*,<sup>13</sup> hospitals were recommended to receive less than a full inflationary update for inpatient services in 2004; instead of the full inflationary increase of 3.5 percent, MedPAC recommended that inpatient payments to hospitals increase by 3.1 percent. With Congress prepared to act on MedPAC's recommendations, the hospital community, in exchange for a full inflationary update, agreed to initial data reporting on quality measures. As mentioned previously, those hospitals not reporting data receive an inflationary update minus 0.4 percent. As in the case of hospitals two years ago, policymakers are again using Medicare payment formulas to enact their QI goals. However, whereas hospitals stood to receive lower payment increases than previously expected, physicians stand to have their Medicare payments actually cut in January 2006. In spite of this notable difference, though, by engaging policymakers now, the physician community is laying a foundation for physician P4P under Medicare that can be based on a consultative partnership between CMS and the physician community, much like the process in place for hospitals. For surgery, this means building on the success of SCIP and applying its lessons to the surgeon as well as the hospital, in addition to building on broader QI efforts such as the College's leadership in the National Surgical Quality Improvement Program (NSQIP).<sup>14</sup>

### ***Physician P4P efforts under way***

Beyond hospital P4P efforts, it is also important for surgery to look at other efforts to link payment to quality of physician services that are already under way. In 2004, CMS launched the Physician Focused Quality Initiative. Under the initiative, initial efforts to establish payment incentives for improved quality have included multiple demonstration projects, such as the following:

- *Doctor's Office Quality (DOQ) Project*: DOQ is a one-year demonstration administered by Medicare quality improvement organizations (QIOs) in Iowa, California, and New York; DOQ includes clinical measures on chronic disease and preventive care services and an evaluation survey of patient experiences.
- *DOQ Information Technology (IT)*: DOQ-IT

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is a two-year demonstration led by the California QIO, Lumetra, which will include up to five states and is designed to promote the use of electronic health records in small- to medium-sized physicians' offices in the delivery of the chronic care and preventive services measured by DOQ.

- *VistA—office electronic health records:* CMS is working with the Veterans Health Administration (VHA) to configure VistA, the VHA's electronic health records technology, to promote adoption of this program in private physician office settings across the U.S. Among its applications, VistA's technology will assist in disease management and in interfacing practice management and billing systems.

- *Medicare Physician Group Practice Demonstration:* This three-year demonstration includes 10 large group physician practices and evaluates them on the care management they provide to chronically ill, high-risk Medicare beneficiaries by measuring the effectiveness of the disease management and preventive services they provide. Payment awards to practices will be based on their success in improving quality and avoiding high-cost complications.

- *Medicare Care Management Performance Demonstration:* This three-year demonstration, which is limited to four sites, promotes the use of IT by physicians in managing the care of chronically ill patients. Those physicians meeting certain standards for quality improvement set by CMS will be eligible for bonus payments. The demonstration must be budget neutral.

In addition to these efforts, which were highlighted in the September *Bulletin*,<sup>15</sup> the Ambulatory Care Quality Alliance (AQA) released a proposed starter set of 26 measures for use in the primary care setting earlier this year.

Surgery's efforts have not gone unnoticed by CMS and the College receives frequent mention by CMS leaders, such as Mark McClellan, MD, PhD, CMS Administrator, and Herb Kuhn, Director of the Center for Medicare Management, when discussing the success of SCIP.<sup>16-17</sup> In addition, as mentioned previously, surgery, along with a wider range of specialties, appears to be likely to be included in some type of CMS-led P4P effort in the near future. Even though CMS' authority to implement measures to link payment to quality for all physician payments


under Medicare is questionable, the agency, under Section 646 of the MMA, was mandated to establish a five-year, budget-neutral demonstration program to examine factors that lead to QI in patient care. From recent conversations with CMS staff, barring congressional action, the most likely scenario would be a demonstration project under Section 646 for a broad range of physician services, including surgery. Although the details of any such effort remain to be determined, it is likely that any demonstration for surgery would bear similarities to some of the examples highlighted, in which payments are linked to particular processes and best practices, improved quality outcomes, and actual savings to the Medicare program.

### ***Surgery's leadership in QI***

As the prospect of linking payment to quality for physician services moves increasingly closer to reality, surgery must determine what role it will play. Although the clearly defined efforts of CMS have focused on QI in primary care, the College has arguably been a pioneer in the QI effort, essentially setting the stage for surgical P4P through its efforts with SCIP and NSQIP. Likewise, health policy leaders in Congress are preparing to expand CMS authority so that commitment might be realized.

In addition to the partnership at SCIP and NSQIP, the College, along with the surgical specialties, continues to be an active participant in the Physician Consortium for Performance Improvement, which has served a vital role in the review and approval of evidence-based quality measures that recognize the best clinical practices across physician services. In the near future, the consortium is expected to complete its work on measures for perioperative cardiac risk assessment. As Congress and CMS consider how to pay for quality, the College will continue its history of commitment to QI through its collaborations with the physician community, CMS, VHA, and quality organizations, such as AHRQ and NQF, and through its internal efforts in the Division of Research and Optimal Care. Through these ongoing efforts, and through the Division of Advocacy and Health Policy, the College is working to ensure that any quality measures for surgery are based on such efforts and are linked

to better outcomes for patients.

While paying for quality performance may be a relatively new concept to Medicare, for more than 90 years the College and its Fellows have set the standard for quality outcomes and improvement in surgery. Since the College's founding in 1913, its chief mission has been to ensure the highest quality in surgical care for patients. Practically, this mission has been most noticeably realized in the educational, professional, and ethical standards associated with College Fellowship. Consistent with the requirements of Fellowship, the College has also realized that promoting the highest-quality surgical care means educating Fellows about advances in practice and technology that stand to improve the quality of surgical outcomes for patients. In linking reimbursement to quality, policymakers' success or failure will ultimately be determined by their ability to align payments with such advances rather than hindering them. While we proceed cautiously, the College sees hope in paying for quality—hope for better outcomes for patients and hope for the recognition that Fellows deserve. 

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