Understanding pay for performance

by

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Currently, the Medicare physician fee schedule awards payments to providers for services delivered, regardless of the quality of care. At the advocacy and health policy levels, the dysfunctional aspects of the current Medicare physician payment system are well understood by policymakers in Congress and in the Administration. And, increasingly, these policymakers are looking at business models in the private sector for solutions. As a result, leaders in this arena are actively trying to identify mechanisms where the concepts of competition, payment incentives, efficiency, and effectiveness can be incorporated into the Medicare system

Messages from Capitol Hill and the Administration are clear: Medicare intends to follow the lead established by private health plans and business coalitions to evolve into a system where payment is based on providing services effectively and efficiently (rather than paying according to how many services are provided). Hospitals, nursing homes, home health agencies, and end-stage renal disease facilities are all engaged, and they are submitting relatively simple performance data that are benchmarked and publicly reported. There are limited demonstration projects involving physicians as well.

With all this in mind, a task force of the College's Health Policy Steering Committee has been examining the issue of pay-for-performance (P4P)—also known in legislative parlance as "value-based purchasing for physicians"—in depth, in an effort to understand its implications for surgeons and their patients and to prepare the College for participation in shaping the payment systems of the future.

Problems in search of a solution

The U.S. health care system continues to suffer from staggering increases in the cost of care despite efforts to solve this problem. While expenses are rising, some regions of the country are experiencing inexplicable differences in access, quality, and cost of care. Well-insured patients have relatively simple access to costly, high-quality disease prevention and detection services, whereas those who are uninsured struggle to obtain care, see limited health care dollars applied to their conditions, and lack proper disease detection and prevention.

To control costs, this system inadvertently creates obstacles to improved patient health. These hurdles can take the form of access barriers, administrative burdens, and payment reductions. In other words, the U.S. health care system holds down costs by making it more difficult to obtain care.

This system also stifles innovation. When a new treatment is developed, payors cringe at the thought of the additional associated costs. In fact, many simply refuse to adopt new technologies or drugs without overwhelming evidence of patient benefits. As a result, it reportedly takes an average of 17 years for new innovations to be transformed from clinical trials to standards of care. In any other industry, new innovations are embraced for the value they bring to our lives.

It is no wonder that patients, payors, and corporations are beginning to question whether the U.S. model for health care delivery truly fits patient needs. What if the focus changed from a system of restricting costs—and care—to one with incentives to reward high-quality care? What if the U.S. created a model to encourage value, which could be measured and rewarded, in the delivery of care? Some describe this as a P4P insurance model.

Promise of P4P

Michael E. Porter and Elizabeth Olmsted Teisberg recently directly addressed some of the apparent peculiarities in the U.S. health care system in a *Harvard Business Review* article.[1] The authors reported that the problem in health care rests in the system's narrow focus on delivering care in an environment of "zero-sum competition." In other words, our society has wrongfully valued health care to reduce or avoid costs, has relied on costly legal recourse when health care fails, and has created choices between health *plans* rather than health *care*. As a result, incentives for competitive solutions are perverse and follow the wrong direction for solving the health care crisis.

In considering changes to the U.S. health care model, it must first be determined if competitive health care is based on quality or cost. If it is supposed that health care is a commodity, where all the sellers (providers) essentially produce the same product (such as is the case in the automobile fuel industry), then surgeons and other providers should be viewed as commodities and compete on cost rather than quality.

Evidence suggests, however, that health care is not a commodity and that competition should be

based on quality. For example, Porter and Teisberg point out that the Texas Heart Institute (THI) has one-third to one-half the cost per cardiac operation than other institutions. THI reduces expenses while dealing with more complex patients, providing treatment with the newest innovations, and delivering the best outcomes. Furthermore, the authors cite Birkmeyer et al, who demonstrate improved mortality rates in patients at high-volume institutions and patients of high-volume surgeons.[2] The authors conclude that health care is not a commodity; rather, it is a service that greatly varies in quality, outcomes, processes, and safety.

For surgeons, the zero-sum competition model has been particularly disastrous. This is the environment that led to the establishment of the sustainable growth rate cost-containment system that has prevented Medicare physician payments from keeping pace with the cost of providing care. It also is the foundation of Medicare's resource-based relative value scale physician payment system, in which any effort to appropriately value and reimburse for any group of health care services must come at the expense of other services.

Porter and Teisberg say it is time to define a more competitive market for health care—one that opens up the opportunity for quality, service, process, and outcome enhancements. They suggest that health care incentives must be redefined to create value through competition, including rewarding increased value rather than shifting costs, publishing information on providers' experience and outcomes, and creating open access to improve consumer choice.

Payors and patients take notice

Payors continue to fine-tune the current care model in an effort to curtail rising costs. They have long toyed with past incentive systems to rein in costs and these efforts have failed repeatedly. Now payors hope to limit costs through various new demands on quality with additional payments tied to improved care.

Quality and safety initiatives gained a spot on center stage when payors and the public took notice of two reports by the Institute of Medicine: *To Err Is Human: Building a Safer Health System*,[3] and *Crossing the Quality Chasm: A New Health System for the 21st Century*.[4] Since the release of these reports, the health care industry has received notice it must establish open safety standards and quality reports. Beyond the industry's response, the general public has new knowledge about quality and safety in medicine.

Mark McClellan, MD, PhD, Administrator of the Centers for Medicare & Medicaid Services (CMS), has made clear his intention to expand P4P programs for physicians and other providers—which typically suggests that the remainder of the health care insurers will follow.

As one of many examples, CMS has created a three-year demonstration project in 10 large physician group practices that aims to assess quality performance and improvement while focusing on the following costly, chronic illnesses: congestive heart failure, coronary artery disease, diabetes mellitus, hypertension, vaccines (influenza and pneumococcal pneumonia), and cancer screening (breast and colon).

The demonstration project follows several hospital projects that provide financial rewards for quality reporting, including Hospital Quality Initiative, Premier Hospital Quality Incentive Demonstration, Medicare Coordinated Care Demonstration, and Medicare Care Management for High-Cost Beneficiaries Demonstration, in addition to programs applicable to other provider groups such as nursing homes, home health agencies, and end-stage renal disease facilities.

CMS' quality improvement organizations (QIOs) are partnering with physicians and hospitals on a broad array of quality and safety outcomes and processes—the foundation of P4P. In fact, in their new contract cycle, the QIOs will be working with hospitals and physicians to implement the goals established by the Surgical Care Improvement Project (SCIP), a national quality partnership sponsored by CMS, and a variety of other federal agencies and provider groups, including the College (see page 15 for list of participating organizations). SCIP's goal is to reduce postoperative mortality and morbidity by 25 percent over five years by focusing on the following four broad target areas:

- *Surgical site infections,* which account for 14 to 16 percent of all hospital-acquired infections and are a common complication of care. By implementing projects to reduce surgical site infections, hospitals could achieve a savings of $3,152 and a reduction in extended length of stay by seven days for each patient who develops an infection.

• *Adverse cardiac events,* which are complications of surgery occurring in 2 to 5 percent of patients undergoing noncardiac surgery and as many as 34 percent of patients undergoing vascular surgery. Certain perioperative cardiac events, such as myocardial infarction, are associated with a mortality rate of 40 to 70 percent per event, prolonged hospitalization, and higher costs.

• *Deep vein thrombosis* and *pulmonary embolism*, which occur after approximately 25 percent and 7 percent, respectively, of all major surgical procedures performed without prophylaxis. More than 50 percent of major orthopaedic procedures are complicated by deep vein thrombosis, and up to 30 percent by pulmonary embolism, if prophylactic treatment is not instituted.

• *Postoperative pneumonia,* which has been associated with high fatality rates, according to the Centers for Disease Control and Prevention (as cited on the SCIP Web site). Postoperative pneumonia occurs in 9 to 40 percent of patients and has an associated mortality rate of 30 to 46 percent. A conservative estimate of the potential savings of the reduced hospitalization resulting from postoperative pneumonia is $22,000 to $28,000 per patient per admission.

Making physician P4P real

In order for P4P to come to life, the key component(s) of a P4P payment system begin with reliable physician clinical performance assessments (PCPA). To pay for performance, there must be a physician-endorsed, patient-valued performance assessment. If the system is not patient-valued, then clinical performance will measure parameters that do not enhance care and the program will simply become an exercise tied to financial incentives rather than patient well being. Ultimately, the medical community will bring forth pressures that dissolve patient confidence and so lead to the collapse of the system.

Landon et al tried to assess the current state of PCPA.[5] The authors have outlined the current prospects and barriers to PCPA. The true goal of PCPA is the ability to assess physician competency. Obstacles to implementing physician performance measurement systems include the following: lack of evidence-based measures, such as representation, feasibility and cost, and ensured increase in value of care, for many specialties; challenges in defending thresholds for acceptable care; sample size consideration; process, or outcomes, or both; and using appropriate statistical models. The authors note that lack of evidence-based measures reflects the fact that many specialties have not defined measures to assess clinical performance. The limited measures that do exist may not be risk-adjusted, outcome-based, evidence-driven process metrics of proven value.

Indeed, despite the fact that surgeons continue to advance evidence-based care, surgical specialists and the research and processes they have developed have largely been omitted from recent debates on ways to report and measure health care quality in a Medicare P4P program. Instead, the focus has been principally on public health and primary care services and on processes that are relatively simple to measure through ambulatory service claims.

It is important to highlight key distinctions between surgical quality improvement and preventive and chronic care quality measures. For example, surgery is more episodic and less focused on chronic disease management, preventive services, and screening. In surgery, the ultimate outcome produced by a specific intervention is much more immediate and clear than disease-management strategies that may span many years. As a result, surgery lends itself much more readily to rigorous clinical outcome measurements. And, whereas generalist physicians typically see approximately the same wide array of patients, surgeons tend to have more focused areas of practice that make

SCIP Steering Committee organizations

Agency for Healthcare Research and Quality
American College of Surgeons
American Hospital Association
American Society of Anesthesiologists
Association of periOperative Registered Nurses
Centers for Disease Control and Prevention
Centers for Medicare & Medicaid Services
Department of Veterans Affairs
Institute for Healthcare Improvement
Joint Commission on Accreditation of Healthcare Organizations

it difficult to apply broad quality measurements. Administrative records other than the operative report—such as claims records—provide much less useful information about processes of care because of the way surgery is packaged and billed. Finally, successful patient management in a primary care setting generally results in increased use of preventive services. In surgery, "more" rarely means "better" care. For surgery, the best measures focus on elaborate decision-making processes that call for direct action to determine the right procedures, at the right time, for the right patient. Surgical quality initiatives limit acute complications and provide immediate cost savings, with enhanced outcomes and improved operational efficiencies through process development.

Obviously, then, as policymakers begin to pursue development of P4P, surgical participation is vital.

Even if current proposed measures are accepted, Landon et al question how to decide P4P in terms of the quality delivered. What level of compliance defines quality? What patient-specific parameters provide exceptions or alterations to the metric? What happens when surgeons do not comply because patients are under the auspices of new clinical protocols? Who will set the thresholds for compliance (for example, 5% or 95%)?

Physician groups respond

In May 2005, the Ambulatory Care Quality Alliance announced its endorsement of a recommended "starter set" of 26 clinical performance measures for ambulatory care that could be used as the basis of a P4P system. This alliance of stakeholder organizations—initially convened by the American Academy of Family Physicians, American College of Physicians, America's Health Insurance Plans, and the Agency for Healthcare Research and Quality—considered and selected measures based on clinical importance; validity, feasibility, and relevance to physician performance; and relevance to consumers and purchasers. The starter set addresses the following priority areas: prevention, coronary artery disease, heart failure, diabetes, asthma, depression, prenatal care, and overuse or misuse of antibiotics. Within these areas, individual measures tend to focus on monitoring patients for chronic conditions and improved adherence to screening guidelines.

Following are Web sites that provide more information on programs and organizations mentioned in this article.

- For more information on all CMS quality programs, visit *http://www.cms.hhs.gov/quality/*.
- For more information on the SCIP program, visit *http://www.medqic.org/scip/*.
- For more information on the Ambulatory Care Quality Alliance, visit *http://www.ahrq.gov/qual/qualix.htm*.
- For more information on the ACS NSQIP, visit *https://acsnsqip.org/content/main/default.asp*.
- For more information on the STS National Database, visit *http://www.sts.org/sections/stsnationaldatabase/*.
- For more information on the ACS Maine Chapter's colorectal diseases project, visit *http://www.maine-acs.org/outcomegroup.htm*.

Surgeons tend to views outcomes reporting as being most familiar and perhaps more valid than process measures. Various outcomes—infection rates, postoperative myocardial infarctions, and so forth—are currently tracked in hospitals. In order for outcomes to have reasonable measures of quality and competency, however, the care must be risk-adjusted for individual patients. Risk adjustment demands large volumes of data and full-time employees hired to collect those data. And, as with process standards, specialty organizations representing the profession involved would need to assign thresholds for appropriate P4P compliance.

Currently, the College has followed the lead established by the Veterans Affairs Health System and has established the National Surgical Quality Improvement Program (NSQIP) outcomes program with numerous participating facilities. The program has risk-adjusted components and it is robust with data. The outcomes parameters are identified for a range of procedures. The surgical profession's support for the NSQIP program, developed by surgeons, appears likely.

The Society of Thoracic Surgeons (STS) offers outcomes programs in the areas of adult cardiac, general thoracic, and congenital surgery. By committing to collecting outcomes data to the STS National Database, thoracic surgeons are committing to improving the quality of care that their patients receive. Since 1994, more than 40 publications have been based on studies of the STS National Databases. These studies have been published in a variety of professional journals and textbooks. Furthermore, the STS National Database has recently served as the basis for a federally funded national quality improvement randomized trial, as well as research in targeted areas of cardiac surgery.

Process programs are less well developed. Currently, the ACS has supported a pilot program in conjunction with its Maine Chapter that focuses on several processes in colon and rectal surgery that are evidenced-based and defined by consensus panel. Prospective data collection and reporting of compliance with the processes are compared with the outcomes, without risk adjustment. The quality or value of care is determined by the level of compliance achieved by the individual surgeon and hospital. Currently, the thresholds for quality are undetermined.

Summary

Dr. McClellan has stated his intention to implement some kind of physician P4P initiative by 2006. Similarly, congressional leaders with jurisdiction over Medicare have said quite plainly that any proposal to reform the physician payment update system will likely be linked to some kind of performance measurement and incentives.

What is less clear at this point is the blueprint that will guide the development of physician P4P. The number of individuals and practices involved, combined with the specialized nature of the services each provides and the limited technological and staff resources available to most of them, defies efforts to identify implementation of simple, yet meaningful, across-the-board performance measures of the sort that have been applied to hospitals and nursing homes. For physicians, the picture is further complicated by the sustainable growth rate system and budget neutrality rules that will impose payment reductions on some physicians (even those whose quality is not questioned) in order to offset any incentive payments made to others for whom performance measures have been established. For these reasons, many specialty societies—particularly some surgical specialty societies—are viewing the P4P concept with skepticism.

Of course, the lack of specific direction from policymakers also offers opportunities. Essentially, physicians (for the moment) are free to design their own measures and systems. And, given the current price tag of $155 billion over 10 years, which has dampened congressional enthusiasm for eliminating the sustainable growth rate system, P4P could open the door to meaningful Medicare payment changes that are desperately needed. Ω

References

1. Porter ME, Teisberg EO. Redefining competition in health care. *Harv Bus Rev*. 2004;82(6):64-76,136.
2. Birkmeyer JD, Skinner JS, Wennberg DE. Will volume-based referral strategies reduce costs or just save lives? *Health Aff*. 2002;21(5):234-241.
3. Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC: National Academy of Sciences; 2000.
4. Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: Institute of Medicine, National Academy of Sciences; 2001.
5. Landon BE, Normand SL, Blumenthal D, Daley J. Physician clinical performance assessment: prospects and barriers. *JAMA*. 2003;290(9):1183-1189.

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