Pay for Performance: Why It's Coming and Where It's Going

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Medicine in general, and anesthesiology in particular, nationally, and especially in California, have been under assault by insurers and government alike. The stated premise has been to "enforce" quality, to protect patients, and to minimize waste, but the reality of all of these machinations seems to me to be otherwise. Our system of medicine has, without question, become increasingly dysfunctional, but it is not physicians simply trying to practice their profession who have made it so. Many physicians, perhaps seduced or "captured" by various forces, have been made to dance to the dysrhythmias which wash over them, and regrettably we have observed some few physician adminstrators act with considerably more sanguine motivations. However, in actual fact, it seems instead that the incentives which payers have attempted to exploit to effect control economically over what doctors do in their professional and personal relationships with patients are at the root responsible for the devolution which we are witnessing. The law of unintended consequences has run rampant over our profession.

Health care costs have spiraled out of control, driven there by technologic advances, patients insisting that they get the very latest and the very best, lawyers enforcing these expectations, profits extracted by the stock market, a changing age demographic, and subjecting even those patients certain to succumb to their illnesses to all manner of fruitless expenditure of resources. Moreover, the web of HMOs, IPAs ("I Paid Already"), capitation and closed networks have conspicuously incentivized primary care physicians to become gatekeepers providing minimalist care.

Medicine is becoming increasingly unaffordable for many middle class Americans, to say nothing of the uninsured, and so the great social debate is increasingly framed by money: what it costs, who pays for it, how to get it for less and how to get more value for what is spent. It is within this framework that the concept of Pay for Performance (P4P) has arisen. Those paying substantially for health care services, both private sector and governmental, have determined that they might boost the pace of quality enhancement and reduce their costs through P4P. Unlike the capitalistic ideal in which prices of goods and services are reflective of difference in quality, in medicine it is apparent that excellent and substandard service often cost the same.

Dr. Alexander Hannenberg, ASA Vice President for Professional Affairs, laid out the pieces of the P4P puzzle at the 2005 ASA Legislative Conference in Washington, D.C. There is a $144 billion payment gap now between what physicians are being paid as determined by the Medicare Sustainable Growth Rate (SGR) formula and what they

"should" be paid based on a more reasonable measure of inflationary growth such as the Medical Economic Index (MEI) (see AMA graph on page 54, "The Un-Sustainable Growth Rate 2006 through 2013," AMA March 2005). The federal budget deficit is more than $500 billion. Medicare insolvency is predicted within 11 to 12 years. Last year there was a $70 billion "bailout" by Congress of physician Medicare reimbursements to avoid dramatic payment reductions to conform to the SGR formula.

Moreover, the Institute of Medicine (IOM) has articulated a "quality chasm" of 100,000 excess deaths yearly from medical mistakes. In 2001 the IOM published Crossing the Quality Chasm,[1] a report which developed six fundamental principles for a 21st century American health care system: health care should be Safe, Timely, Effective, Efficient, Equitable, and Patient-centered (STEEEP). This evolved into the "Bridges to Excellence" (BTE) initiative, a not-for-profit corporation of large employer groups and health plans, which now pays qualifying physicians financial bonuses in three separate programs (Diabetes Care Link, Cardiac Care Link, and Physician Office Link) for specific quality-improvement activities. Employers pay these incentive rewards (P4P) and realize demonstrated savings in health care costs.

This process of P4P to use monetary incentives to drive health care improvement has been embraced by a variety of national organizations such as the Leapfrog Group, National Quality Forum (NQF), IOM, JCAHO, Centers for Medicare and Medicaid Services (CMS) and MedPAC,[3] and National Committee on Quality Assurance (NCQA). The politically correct mantra has become: "No outcome, no income." In fact, institutional rate increases for Medicare from 2001 to 2004 are now based 75 percent on documented performance measures. Primary care physicians have seen monetary incentives to stimulate screening eye exams, hemoglobin A1c measurement, counseling concerning smoking cessation, beta blocker therapy post myocardial infarction, screening mammograms, pap smears, and patient satisfaction surveys. P4P incentives for specialists are in their infancy.

So how might anesthesiology be affected by P4P? Perioperative anesthetic care has become significantly safer in the past 25 years, and our specialty has been the acknowledged leader and driver of patient safety initiatives, reducing anesthetic mortality from 1:10,000 to 1:250,000. Our patients have been the beneficiaries of the functions of closed claims studies, the Anesthesia Patient Safety Foundation (ASPF), drugs with improved pharmacologic profiles, safer anesthesia machines, expanded patient monitoring, and a series of carefully constructed ASA Standards, Practice Parameters, and Guidelines. The ASA Committee on Performance and Outcomes Measurement is exploring how preoperative care strategies might be designed to improve outcomes such as surgical infection rate, cardiac complications, and postoperative pneumonia. It has been suggested by ASA's *Karin Bierstein, J.D., M.P.H., Assistant Director of Governmental Affairs (Regulatory)*, that perhaps documentation of adherence to ASA's high quality evidence-based practice parameters might become a basis for "rewards." Hannenberg spoke of a wide variety of potential proposals for

P4P measures in anesthesiology: maintenance of perioperative normothermia, perioperative glucose control, optimal timing of preoperative antibiotic prophylaxis, prevention of ventilator-associated pneumonia, beta blockers for cardio-protection, and prevention of DVT. In this issue of the *CSA Bulletin*, Wallace argues for implementing a program to reduce perioperative cardiac risk by using beta-blockers and/or clonidine. This might be adopted as a best practice or protocol, and some percent of documented adherence to its recommendations might be one kind of example of how P4P might be employed by anesthesiologists.

Another chasm is now developing between primary care and specialist physicians. Public reporting of Performance Data, so called "publicity for performance,"[4] has been instituted both by CMS Hospital Compare and California Report Card on Medical Group Quality. So far, the CMS data reports three hospital measure sets concerning myocardial infarction, congestive heart failure, and pneumonia, while the California Office of the Patient Advocate maintains a web site posting data comparing how large medical group practices fare in certain Health Plan Employer Data and Information Set (HEDIS) and patient satisfaction areas. Surgeons, however, feel that a small set of numbers do not capture "quality," and that patients, employers, and health plans might be easily misinformed by taking data at face value. Some surgeons are even becoming reluctant to take on difficult and high-risk patients for fear of marring their performance data, and hence, risking future problems with contracts or patient self-selection. Cardiovascular surgeons anecdotally report that they are already beginning to limit their practices in certain areas and feel that patients are beginning to be denied care, a kind of negatively incentivized rationing of resources in high risk cases.

Dr. Hannenberg, nevertheless, makes the case that P4P is much more of an opportunity than a threat for anesthesiologists.[5] He argues that P4P is separate and distinct from the battle to fix the flawed SGR formula, which we must continue to do, alongside all specialties. He argues that we must not decline to engage in P4P for the wrong reasons, as a protest against Medicare's inadequacies, because to do so would result in a missed opportunity to use payer incentives to improve our practices through further use of evidence-based medicine and, hence, to strengthen our specialty. He seems right, of course, in a certain pure and academic way, but instead of some intellectualized "carrot and stick" incentivization, my view is that what we truly need to improve quality is for payers and/or the government to provide physicians, or more properly collectives of specialist physician analysts, with the resources to collect and analyze data, just as the ASA Closed Claims Project has already done and continues to do.

Moreover, this P4P incentivization arrives at a time when the perspective of our specialty has been shaped by the illogical manner in which we have been brutalized in reimbursement since the advent of RBRVS in 1992, our reimbursement being now 38 percent of commercial rates compared to the 80 percent average of other specialties. We are the one specialty that has championed quality and produced data to prove

this with our record of safety. If P4P is becoming such a trumpet call, why has CMS not looked at what anesthesiologists have done over the past 25 years and corrected the flawed RBRVS conversion factors and the unfair reimbursement rules suffered by academic anesthesiologists? That would be the kind of P4P that anesthesiologists could understand. Contemporaneously in California we are fighting balance billing prohibitions backed by insurers, HMO administrators and primary care physicians; Workers Compensation rates based upon a 120 percent multiple of Medicare; silent PPOs; egregiously inadequate Medi-Cal rates; and markedly increased intensity of services required in the distilled patient populations at hospitals.

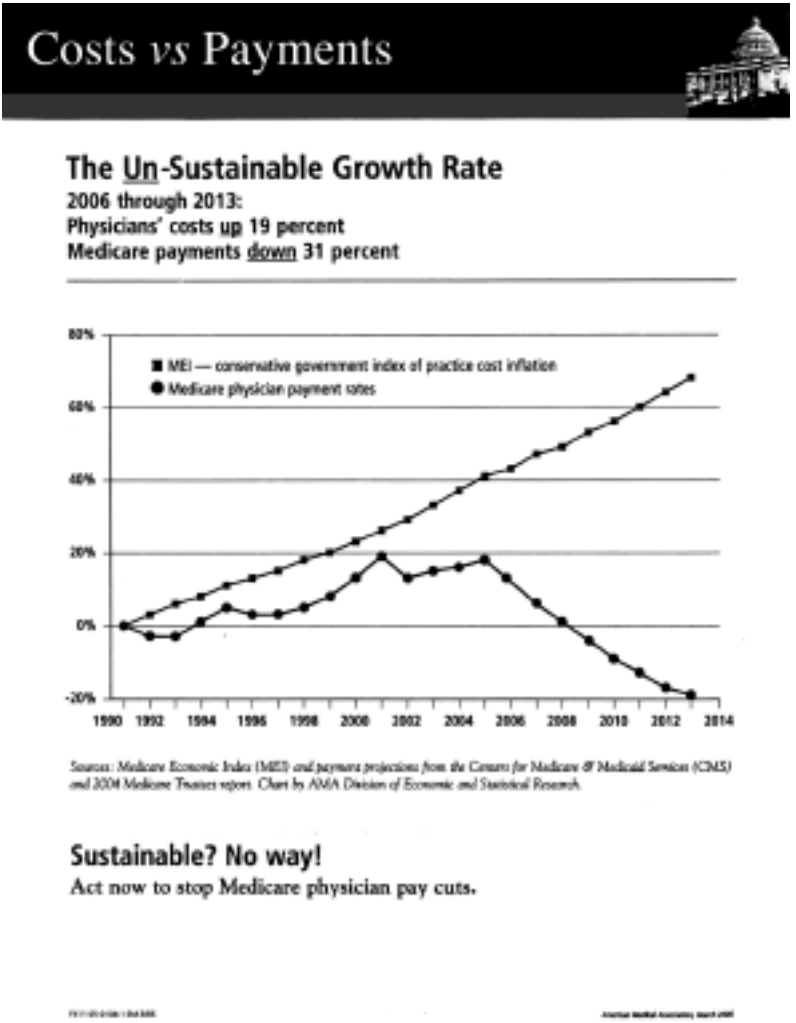
Now arrives what I see as a nebulous proposal for us, maybe one that might reclaim some money from the gap between Medicare SGR and MEI rates, if we demonstrate some "performance." It just all seems to me like "déjà vu all over again": a well-intentioned theory by those not engaged in what we actually do for a living to incentivize our "efficiencies," and which can be so easily perverted by those with economic incentives antithetical to our interests and well-being. I see this as an elaborate scheme to pay us less for our professional services, another iteration of the law of unintended consequences. Moreover, as has been demonstrated repeatedly, our state and national professional medical organizations to which the legislature and Congress look for guidance, the CMA and AMA, develop agendas that not infrequently are driven overwhelmingly by primary care physicians, often to the detriment of specialists.

So what are we to do? P4P is still in its infancy in our specialty. If it develops that P4P involves "new" money (that is money beyond that needed to "fix" SGR, bringing reimbursements more in line with MEI), we must exhibit wisdom and ensure that, at least in our specialty, we write the yardsticks and ensure that "performance" is measured as process, not as some finished product or outcome. As we know all too well, even the best process, carefully applied, can produce an adverse outcome in any one individual case, but appropriate process, over time and over volume of services, ought logically to produce an aggregate better outcome. Nonetheless, even this "optimal outcome" is subject to a variety of perturbations and influences beyond our control. We must, despite our reservations, work with our leaders to construct measures appropriate to enhancing what we do to make P4P—which some see as an unstoppable train—work for us. If, on the other hand, P4P evolves in such a way that it becomes clear that all that is in play is a redistribution of "funding gap" monies, then we will all have to consider our options and politcal actions.

As my former representative, Christopher Cox, the new Chair of the Securities and Exchange Commission, told a few of us who visited him in Washington in May, "The reason you physicians cannot change anything [concerning Medicare reimbursement] is because you are too polite, too docile, too professional. If you really want to change something, you will have to act out of character for you and really make some noise to get some attention." This seems like sage advice, indeed, from a nine-term Congressman. To be sure, we ought to watch how P4P develops in our specialty. In

the meantime, we should deliberately prepare for the time when it might be appropriate to follow Representative Cox's advice.

If you would like a copy of the article with the references, please contact the CSA office at (800) 345-3691 or csahq@csahq.org.



from "The Un-Sustainable Growth Rate 2006 through 2013," *AMA* March 2005
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