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The implications of "pay-for-performance" reimbursement for Otolaryngology – Head and Neck Surgery

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ABSTRACT

Objective: To introduce otolaryngologists to outcomes-linked reimbursement ("pay-for-performance"), identify clinical practice implications and recommend changes for successful transition from the traditional "pay-for-effort" reimbursement model.

Study design: Policy review

Results: Payers are actively linking reimbursement to quality. Since the Institute of Medicine issued its report on medical errors in 1999, there has been much public and private concern over patient safety. In an effort to base health care payment on quality, "pay-for-performance" programs reward or penalize hospitals and physicians for their ability to maintain standards of care established by payers and regulatory groups. More than 100 such programs are operational in the United States today. This reimbursement model relies on detailed documentation in specific patient care areas to facilitate evaluation of outcomes for purposes of determining reimbursement. Since performance criteria for reimbursement have not yet been proposed within Otolaryngology-Head and Neck Surgery, otolaryngologists must be involved to ensure the adoption of reasonable goals and development of reasonable systems for documentation.

Conclusion: "Pay-for-performance" reimbursement is increasingly common in the current era of outcomes-based medicine. It will assume an even greater role over the next 3 years and will directly affect most otolaryngologists.

INTRODUCTION

Over 20 years ago, when the influence of managed care on the practice of medicine was relatively weak, Starr[1] described the history of medicine as "…a tale of social and economic conflict over the emergence of new hierarchies of power and authority, new markets, and new conditions of belief and experience". He observed that power is rooted in dependence. Unfortunately, physicians were still feeling independent – and, thus, empowered - when this work was published. As a result, physicians overestimated both their power and the strength of their resources compared to those of corporate America.

Physicians allowed themselves to become commoditized (the state in which competitors are differentiated from each other only by their cost), and reimbursement dropped dramatically as they competed for patients in a reverse auction for payer contracts. Patient flow was increased to maintain revenue streams with efforts such as expanded scopes of practice and incorporation of alternative medicine into formerly traditional practices. Few physicians questioned the quality of the care they provided, and fewer still found or made the time to explore formal quality improvement in their practices or their hospitals.

Meanwhile, the quality assurance movement was gaining momentum. Egdahl and Gertman[2] cited "…close to 1000 studies…to assess the level of quality of care delivered". They presented "…ample information to support the contention that simple, routine tasks are not performed well in the American medical care system". They concluded, perhaps prematurely, that the need for "…better practice habits" was a primary cause.

Whatever the reasons, and poor practice habits are certainly among them, routine things are still not done well enough often enough in the American medical care system. And the cost of suboptimal care is staggering. Once this became obvious to those who pay for the bulk of American healthcare, they rapidly used market power to shift control of healthcare dollars from the supply side (physicians) to the demand side (those who pay physicians). The power to direct patient flow has shifted from physicians to employers, who provide a reported 63% of American health insurance at an average cost of $6,966 per employee in 2003.[3]

Strong investor demand for shareholder return has placed new emphasis on the contribution of healthcare costs to the prices of all goods and services. Compounding this are what, to physicians, are disproportionately large compensation packages (linked to shareholder return) for corporate executives.

The insurance industry dramatically underscores the growing influence of shareholder demand and executive compensation throughout corporate America on reimbursement for healthcare. A typical large healthcare insurer[4] defines its executive compensation philosophy as "…focus[ing] executives on increasing shareholder value by awarding them stock-based compensation directly linked to improvements in Company earnings and stock price". Clear evidence of the success of this approach is found in their reporting "…lower than expected healthcare cost[s for the company]" for 2004 ($1.89B) in comparison with 2002 ($3B) and 2003 ($2.2B), a 14% drop despite a reported increase in national healthcare expenditure[5] from a reported $1.6B in 2002 to $1.8B in 2004. The president of this insurer earned $3M in 2004, up from $2.3M in 2002 (a 30% increase in two years). The CEO earned a reported $18.2M in 2003 and $22M in 2004 (a 21%

increase in one year). Comparison with physician income over the same period is invited.

Reducing employee healthcare costs has become a national priority for corporate America. Initial reliance on the promises of managed care proved fruitless as physicians and hospitals learned to work around the roadblocks set before them. Many recent articles and books have dramatized the cost of medical errors, providing the impetus for another strategic shift in health care cost containment: paying for performance.

DISCUSSION

In 1999, the Institute of Medicine (IOM) published it report, *To Err is Human*,[6] raising public awareness of medical errors and sparking a revolution in quality of care efforts. The report estimated that as many as 98,000 people die annually in the United States as a result of preventable medical mistakes.

One recommendation of the report was that large purchasers of health care use their power to affect the behaviors of health care providers by creating financial incentives to ensure the safety of patients. Almost immediately, large employer coalitions began to form to address that charge. This initiated a trend towards performance-rewarding reimbursement that continues to progress at a very rapid pace. This movement gained support after the IOM's next report, *Crossing the Quality Chasm*,[7] included the recommendation of alignment of payment policies with quality improvement in its suggested redesign of our nation's healthcare system. Meanwhile, a separate study by HealthGrades, Inc. in 2004 garnered national media attention by raising concern that the number of annual deaths due to medical errors was actually double the IOM's

estimate.[8] A 2004 survey of members of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) demonstrates that our specialty is not immune to error-making.[9]

Pay-for-performance (P4P) is based on rewarding health care providers for the quality of their care with financial or other incentives. Traditionally, physician reimbursement has reflected the type and quantity of care without measures of quality. While most healthcare providers would like to claim that they only provide the highest quality care, the reports by IOM and HealthGrades forces that into question. In addition, the rates at which medical knowledge and technology advance make it increasingly difficult for a physician to stay current with changing standards of care.

Two common P4P reimbursement models are the threshold and tiering systems.[10,11] In the threshold approach, a physician would be rewarded by meeting a quota of requisite processes or outcomes. Alternatively, in the tiering approach, providers would be ranked according to their achievements with the top performers being rewarded. In this approach, providers do not know the requirements to receive the bonus, because they do not know where they rank amongst their competition.

Proponents of P4P argue that it is an innovative way to improve the quality of patient care while also lowering healthcare costs. Many concerns exist, however, that patient care may actually suffer under a P4P model. Some argue that if physicians are scored based on the compliance of their patients, it may drive doctors to avoid treating noncompliant patients to protect their income and reputation.[12] The same is true for the more ill and complicated patients.[10]

The most notable early initiatives driving P4P include The Leapfrog Group, the Integrated Healthcare Association (IHA), and Bridges to Excellence (BTE). The Leapfrog Group formed in 1998 when a group of large employers banded together to use their purchasing power to have an influence on the quality and affordability of the healthcare for their employees.[13] They used the 1999 IOM report as their initial focus and officially launched the The Leapfrog Group in 2000. The groups growing consortium of over 170 companies including AT&T, Ford, Exxon, and Microsoft provide health benefits to more than 36 million Americans. The Leapfrog Group has identified hospital quality and safety practices that are the focus of its hospital recognitions and rewards, and Leapfrog members have agreed to base their purchase of health care on principles that encourage provider quality. The hospital quality and safety practices, which include computer physician order entry, evidence-based hospital referral, and staffing in the intensive care unit by critical care physicians, have all been independently proven to reduce errors and mortality.

The IHA is a consortium that includes California's seven major health plans and other large corporations.[14] The IHA introduced a tiering P4P system in 2003. The measurement set for performance is categorized into 3 major groups: clinical indicators, patient satisfaction, and information technology (IT) investment. IHA paid over $50 million in "performance" payments last year.

Similar to IHA is the national BTE coalition, which works in partnership with The Leapfrog Group. BTE is a threshold based P4P that pays bonuses to physicians who reach specified quality targets in diabetes management and cardiac care.[15] Physicians are

also rewarded if they institute certain systems for improving care, such as an electronic health record (EHR) or patient registries.

Following the initiative of these groups, the Center for Medicare and Medicaid Services (CMS) announced in February of this year that it planned a demonstration project of P4P. This pilot effort, which began in April, involves 10 large medical groups throughout the country. In March, the Medicare Payment Advisory Commission (MedPAC) annual report to Congress suggested that Medicare should begin paying all physicians differently based on how they perform. This summer, separate bills were introduced before the United States Senate and House of Representatives that could result in all Medicare payments being linked to yet-to-be-determined federal quality measures.

The American Medical Association (AMA) has approached the P4P boom with trepidation. There is concern that the true goal of these reimbursement systems is really based on cost, not quality.[10] The worry stems from the theory that P4P programs are nothing more than new window dressings for withhold programs that harm patient care by creating exclusive panels and limiting services.[16] One supposed P4P model that underscores these concerns is the UnitedHealth Performance pilot program in Missouri. In this program physicians are designated "performance" physicians by passing quality and efficiency screens. These physicians are differentially marked in the physician directory to encourage patients to preferentially choose them. Rather than being incentive driven, however, the patients in this program are discouraged from seeking care from the UnitedHealth Group participating physicians who were not awarded "performance" status by being required to pay 100 percent of the cost if they chose to do

so. This has garnered intense criticism for creating obstacles to continuity of care and breaking the patient-physician relationship.

To address such concerns, the AMA formulated a set of guidelines to be used to assess whether P4P programs are fair and ethical.[17] They announced the five principles one day after MedPAC released its annual report to Congress. The principles require that P4P programs ensure quality of care, foster the patient-physician relationship, offer voluntary physician participation, use accurate and fair reporting, and provide fair and equitable incentives. They specified that the incentives must be paid for by new funds.

Meanwhile, the Ambulatory Care Quality Alliance (AQA), formed last year by the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the federal Agency for Healthcare Research and Quality, worked to establish clinical performance measures for the ambulatory care setting. They developed 26 criteria with the hope that they be used as uniform measures across health plans and, as a result, reduce treatment standard inconsistencies and administrative burden for physicians who deal with multiple payers.[18] In August, the National Quality Forum, who had been charged by Congress with establishing the measures upon which Medicare payments would be based, adopted 36 quality standards for the outpatient setting.[19]

A major focus of the P4P revolution is the widespread adoption of IT in the form of an EHR to track and report patient data. Almost six years after the IOM's report on medical errors, some argue that the time has come for its universal use.[15,20] The Leapfrog Group cites that computer physician order entry has been shown to reduce serious prescribing errors in hospitals by more than 50%.[13] BTE offers bonuses for an EHR,[15]

while the IHA weighs 20% of its P4P measures on investment in IT.[14] Obviously, such investments can result in considerable upfront costs. The AMA feels that P4P programs should minimize such financial and technological barriers to physician participation and hopes to avoid the development and requirement of health plan specific IT capabilities.[14] Concerns that the reporting requirements of the current Congressional proposals regarding a CMS P4P system will inevitably force participating physicians to make the IT investment may be eased by the recent announcement that CMS will offer Vista, the EHR developed by the Veterans Health Administration (VA), free of charge.

It is not yet evident how drastically the movement towards P4P will affect our healthcare reimbursement system, but it is clear that a change is imminent. According to a recent survey, 29 of the nation's 51 Blues plans have launched a total of 37 P4P programs in 32 states.[21] Both the Senate and the House of Representatives are considering bills concerning value-based purchasing, another name for P4P, for Medicare and Medicaid. Although the bills are similar, significant differences exist that can have a pronounced effect on CMS reimbursement rates.[22] For example, the Medicare Value Purchasing Act of 2005, which was introduced in the Senate, does not commit new money for the performance "bonuses." Instead, funding of the rewards would result in reduction of the standard reimbursement rates. Furthermore, participation would essentially be mandatory since physicians who are unable to report quality data would see an automatic 2% reduction in their Medicare update. In addition, the bill does not address the troubled current CMS reimbursement system, which is scheduled to result in further reductions in the upcoming years. It fails to meet the AMA's principles that call for voluntary participation and the use of new funds. The more recently introduced

Medicare Value-Based Purchasing for Physicians' Services Act of 2005 being considered in the House, on the other hand, would commit new money to the system and abandon the current CMS physician reimbursement formula. Also, it would be voluntary, which would put it further in line with the AMA's principles. Finally, the bill explicitly calls for physician specialists themselves to provide recommendations on how the government should rate their quality of care. Although there are still concerns with the legislation, it is an improvement in comparison to the Senate bill.

The effect that the P4P movement will have on specialists is even less clear. Most of the currently defined measurements have been designed for primary care. In fact, of the 26 measurements established by the AQA, only 3 (documentation of tobacco use, smoking cessation advice, and streptococcal testing for children with pharyngitis) are clearly and directly useful for performance evaluation of most otolaryngologists. Specialists cannot be rated on performance without the establishment of standards on which to judge them. Some are skeptical that appropriate standards can even be established for our specialty. A recent poll posted on the website of the AAO-HNS found that 97% of respondents did not think it was possible for health plans to have the right kind of information to accurately identify which physicians meet a high-quality profile.[23]

RECOMMENDATIONS

Whether you are skeptical or optimistic, P4P is expanding, and there are things that can be done to prepare for its spread to Otolaryngology – Head and Neck Surgery. As individual physicians, otolaryngologists can embrace efforts to improve patient care by practicing evidence-based medicine and maintaining appropriate documentation to

enable outcomes reporting. Adoption of an EHR should facilitate these efforts, and would better prepare a practice for a change to a reward-based reimbursement system. Although current P4P efforts have focused predominantly on primary care, there are initiatives to improve surgical care. Familiarity with these projects is important, since it is likely that any P4P program directed at surgical fields would be modeled after these efforts. The Surgical Care Improvement Project (SCIP) is a national quality partnership started by CMS and the Center for Disease Control and Prevention to reduce post-operative complications.[24] Its main targets are surgical site infections, adverse cardiac events, venous thromboembolism, and postoperative pneumonia. The American College of Surgeons' National Surgical Quality Improvement Program (NSQIP) is modeled after the VA program of the same name that resulted in a 27% decline in postoperative mortality and a 45% drop in postoperative morbidity in the government sector.[25] It is important to note that the NSQIP is a risk-adjusted model, which should counter any perceived disincentive for physicians to treat complicated patients. In 2002, the IOM named the NSQIP "the best in the nation" for measuring and reporting surgical quality and outcomes. Knowledge of these initiatives will help otolaryngologists prepare for interventions applicable to all surgical specialties, but there are no performance guidelines designed specifically for Otolaryngology – Head and Neck Surgery. As a group, the AAO-HNS must define specialty-specific measures that can accurately identify quality patient care within our field. The government is already indicating that it may look to specialty groups for advice on such standards,[22] and the AAO-HNS must be prepared to seize that opportunity. Only physicians have the knowledge and experience

to ensure that such measures actually reflect enhanced patient care and provide the proper quality-based incentives.

CONCLUSIONS:

Rewarding for quality care is a popular reimbursement trend that is expanding at a rapid pace. Congress is considering legislation that would link Medicare payments to quality measures, and P4P programs will inevitably spread to our specialty. Otolaryngologists can prepare by practicing evidence-based medicine, investing in EHR systems, and establishing specialty-specific quality care measures.

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TABLE 1		
YEAR	MONTH	ACTION
1999		IOM publishes “To Err is Human”
2000		Leapfrog Group is launched
2003		Integrated Health Association introduces large-scale P4P in California
2004		HealthGrades issues its first report on medical errors
	February	CMS announces a P4P demonstration project
	March	Medicare Payment Advisory Committee recommends P4P to Congress for all physicians
	March	AMA proposes principles of fairness for P4P programs
	April	CMS demonstration project begins for 10 large medical groups
	June	American Quality Alliance releases 26 clinical performance measures for ambulatory care
	July	Separate House and Senate bills are introduced linking Medicare payment to federal performance measures
	August	National Quality Forum adopts quality standards proposed as a Medicare basis for payment

Table 2:
Potential drawbacks of P4P:
1. Small group practices may not have large enough sample sizes to meet performance criteria of individual insurers
2. Incentives based on patient compliance could lead to physicians avoiding the care of non-compliant patients.
3. Incentives based on patient outcomes could lead to physicians avoiding the care of the complicated patients
4. Reporting requirements could result in increase practice costs
5. Funding for “rewards” could result in decreased reimbursement for “non-performers”
6. Performance measures may not accurately judge physician quality
7. Performance standards have not been set for specialty practices

Table 3:
AMA's five principles to evaluate a pay-for-performance program.
A P4P must:
1. Ensure quality of care.
2. Foster the patient-physicial relpationship
3. Offer voluntary physician participation
4. Use accurate and fair reporting
5. Provide fair and equitable incentives.

Table 4: Ambulatory Care Quality Alliance's 26 performance measures

PREVENTION MEASURES
1. Breast Cancer Screening
Percentage of women who had a mammogram during the measurement year or year prior to the measurement year.
2. Colorectal Cancer Screening
The percentage of adults who had an appropriate screening for colorectal cancer.
One or more of the following:
FOBT – during measurement year;
Flexible sigmoidoscopy - during the measurement year or the four years
prior to the measurement year;
DCBE – during the measurement year or the four years prior;
Colonoscopy – during the measurement or nine years prior.
3. Cervical Cancer Screening
Percentage of women who had one or more Pap tests during the measurement year or the two prior years.
4. Tobacco Use
Percentage of patients who were queried about tobacco use one or more
times during the two-year measurement period.
5. Advising Smokers to Quit
Percentage of patients who received advice to quit smoking.
6. Influenza Vaccination
Percentage of patients [50-64] who received an influenza vaccination.
7. Pneumonia Vaccination
Percentage of patients who ever received a pneumococcal vaccine.
CORONARY ARTERY DISEASE (CAD)
8. Drug Therapy for Lowering LDL Cholesterol
Percentage of patients with CAD who were prescribed a lipid-lowering
therapy (based on current ACC/AHA guidelines).
9. Beta-Blocker Treatment after Heart Attack
Percentage of patients hospitalized with acute myocardial infarction (AMI)
who received an ambulatory prescription for beta-blocker therapy (within 7
days discharge).
10. Beta-Blocker Therapy – Post MI
Percentage patients hospitalized with AMI who received persistent beta-blocker treatment (6 months after discharge).
HEART FAILURE
11. ACE Inhibitor /ARB
Therapy# Percentage of patients with heart failure who also have LVSD who were prescribed ACE inhibitor or ARB therapy.
12. LVF Assessment
Percentage of patients with heart failure with quantitative or qualitative
results of LVF assessment recorded.
4 Diabetes
13. HbA1C Management
Percentage of patients with diabetes with one or more A1C test(s) conducted during the

measurement year.
14. HbA1C Management Control
Percentage of patients with diabetes with most recent A1C level greater than
9.0% (poor control).
15. Blood Pressure Management
Percentage of patients with diabetes who had their blood pressure
documented in the past year less than 140/90 mm Hg.
16. Lipid Measurement
Percentage of patients with diabetes with at least one Low Density Lipoprotein cholesterol (LDL-C) test (or ALL component tests).
17. LDL Cholesterol Level (<130mg/dL) Percentage of patients with diabetes with most recent LDL-C less than 100 mg/dL or less than 130 mg/dL.
18. Eye Exam*
Percentage of patients who received a retinal or dilated eye exam by an eye
care professional (optometrist or ophthalmologist) during the reporting year
or during the prior year if patient is at low risk for retinopathy.
A patient is considered low risk if all three of the following criteria are met:
(1) the patient is not taking insulin; (2) has an A1C less than 8.0%; and (3)
has no evidence of retinopathy in the prior year.
ASTHMA
19. Use of Appropriate Medications for People w/ Asthma*
Percentage of individuals who were identified as having persistent asthma
during the year prior to the measurement year and who were appropriately
prescribed asthma medications (e.g. inhaled corticosteroids) during the
measurement year
20. Asthma: Pharmacologic Therapy#
Percentage of all individuals with mild, moderate, or severe persistent
asthma who were prescribed either the preferred long-term control
medication (inhaled corticosteroid) or an acceptable alternative treatment.
DEPRESSION
21. Antidepressant
Medication Acute Phase: Percentage of adults who were diagnosed with a new episode of depression and treated with an antidepressant medication and remained on
Management* an antidepressant drug during the entire 84-day (12-week) Acute Treatment
Phase.
22. Antidepressant Medication Management* Continuation Phase: Percentage of adults who were diagnosed with a new episode of depression and treated with an antidepressant medication and remained on an antidepressant drug for at least 180 days (6 months).
PRENATAL CARE
23. Screening for Human Immunodeficiency Virus#
Percentage of patients who were screened for HIV infection during the first
or second prenatal visit.
24. Anti-D Immune Globulin
Percentage of D (Rh) negative, unsensitized patients who received anti-D immune globulin at 26-30 weeks gestation.

QUALITY MEASURES ADDRESSING OVERUSE OR MISUSE
25. Appropriate Treatment for Children with Upper Respiratory Infection (URI)*
Percentage of patients who were given a diagnosis of URI and were not
dispensed an antibiotic prescription on or 3 days after the episode date.
26. Appropriate Testing for Children with Pharyngitis*
Percentage of patients who were diagnosed with pharyngitis, prescribed an
antibiotic and who received a group A streptococcus test for the episode.

Table 5:
Recommendations for Otolaryngologists:
1. Practice evidence-based medicine
2. Improve documentation and reporting capabilities by investing in an electronic health record
3. Establish specialty-specific quality care measures