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Accountability – the next reality for physicians (Broccolo, Fischer, & McDermott, June 9, 2006)

The summary of the Physician Legal Issues Conference presentation on Accountability was written to describe both the history and current status of Pay for Performance (P4P) programs in America. The authors attempted to provide an effective history and context for discussion. Although they fail to accomplish that, the reader is left with a sense that P4P is immature as a method to improve quality, not yet effective, but headed in the right direction. This paper will address some of the limitations of the history and context the authors provide, the misapplication of the IOM report in the development of P4P, and consider some of the reasons the private and public programs are challenged based on these issues. The goal of this paper is to offer a useful reassessment of the structure they describe and a discussion on how these problems might be addressed in the future, including some potential for changes that might avoid antitrust problems.

Limitations of history – Medicine as a business

Since the dawn of medicine there has been a fee for the service that healers have given to their fellow man. This was very straightforward as a fee-for-service arrangement until the advent of 3rd party payers. Insurance was first developed around the time of the American Civil War, but didn't reach the status of 3rd party payer until employment based insurance began to proliferate in the 1940's. Since then the concept of a risky medical population has almost become more the lingo of insurance actuaries than physicians. There is no doubt that the benefit of mitigating short term risk by participating in an insurance pool makes a lot of sense – provided the process is cooperative, transparent and managed by a non-profit organization. This brief description of the ideal, when compared to the present state of for profit insurance in America, creates one of the most substantial arguments against the further development of P4P in isolation. The system consists of 5 major players –Patients (consumer) and/or Payers (first party), providers (2nd party), insurers (3rd party), and Regulators. Trying to squeeze one segment of the system (the providers) when the rest of the system remains out of control will not provide the desired solution.

The consumer/1st-party-payer separation issue is in itself a significant area of controversy because of the inconsistent division of power that results. The ability of consumers and/or 1st party payers to affect the system (perhaps the major control of a 'free market' healthcare economy) is significantly compromised in the current system. Consumers have also been taught to be impatient with respect to outcomes in healthcare (many time inappropriately). Insurers have a superficial incentive to improve the quality of healthcare since it is peripheral to their primary business (making money by investing funds 1st party payers deposit). Regulators are challenged by their political base to be utilitarian. Their goal is generally to choose the option available that will maximize the happiness of as many as

possible. As Dr. Waymack pointed out in his lecture (Mark H. Waymack, 2011), the utilitarian approach often lacks dignity and conflicts with ordinary moral intuitions about rights and justice. There is also a challenge to avoid deontological morality because of our nominal separation of church and state. If P4P becomes a driver for quality improvement, providers who are already having a hard time realizing the value of their education from a philosophical standpoint might be pushed to focus even more attention from caring about what they document for patients health benefit to documentation to prevent loss. Unless someone is able to demonstrate a causal relationship between cost and quality, this will remain non sequitur. Although each of these 5 players has problems of their own, an often unconsidered element of the system that is out of control is the vendors who can create products and charge for them based on development cost instead of what the system can afford.

The IOM report

The 2001 IOM report entitled "Crossing the Quality Chasm" advised that Healthcare should strive to be safe, effective, patient centered, timely, efficient, and equitable. Although it is reasonable to include financing, it should not be the most dominant force when considering methods to achieve these criteria. The IOM understood this when they advised aligning payment policies with quality improvement rather than advising the development of payment policies to improve quality of healthcare. Certainly there should not be a barrier to the development of systems that improve quality within the payment system, but it cannot be the primary driver. Although Broccolo and Fischer describe monetary and efficiency measures of quality, Goodman (Goodman, 1998) note this approach to be shortsighted. I would further state that driving changes in Healthcare by focusing on finances takes attention away from the target criteria. And in the process it exacerbates the money problem. For this reason, the focus needs to be on developing a more effective culture of quality in healthcare.

Even disregarding the arguments above, the given historical context of this approach is incomplete. Failure to recognize the full context creates an inadequate base for any system, especially P4P, and therefore it cannot stabilize or improve the system. The authors state that P4P arose "out of the movement towards consumer driven health care" as an effort to "improve the quality and reduce the cost of health care". This is a mash-up of the desire to meet the criteria of the IOM report and reports that patients are not satisfied with the business of medicine (not the practice of medicine). Patients are often dissatisfied with the limited time they get to spend with their provider for the amount of money they are paying and complexity of the system, but most patients feel satisfied with the actual care they receive. Patients hear concerns about outcomes based on research being done, but don't have a personal sense of what that means. Creating these distinctions is not so important if you are just looking for a surrogate measure by which you can grade care and provide a reward. They are critically important if the desire is to create a healthy population and have patients satisfied with their care.

The report goes on to state that "quality is not improving because current payment methodologies do not create incentives to improve quality". If money were the only factor affecting the development of quality, this might be possible. But there are many ethical, social and legal factors affecting the development of systems that promote quality care. This is no more evident that in the process of defining quality itself. Many of the measures used as

surrogate markers of quality do not fulfill the definitions that are created, and the definitions created don't always match the evidence. When the authors report that "capitated payments encourage underutilization" and "fee for service payments encourage overutilization" they are not providing examples of how quality can be drawn from financing, but rather that the measurement of quality is independent of the measurement of money.

Current Programs

Of the private programs that had been developed at the time of this presentation, the non-profit consortium Bridges to Excellence (BTE) seems to have been the most comprehensive and effective. Integrated Healthcare Association (IHA) did not show benefit with its more limited approach, and Leapfrog is focused on the hospital side only. The United Health Care (UHC) model seems to be similar to the IHA model. The key to the more likely effectiveness of BTE and Leapfrog is the focus on the non-financial aspects of development. This keeps a balance within the system. Leapfrog was not offering remuneration for performance, but rather allowing participation – promoting team work and collaboration. To date these programs seem to have reaped what they have sown. A review of 128 studies of P4P programs in 2009 found that "P4P effects can be judged to be encouraging or disappointing, depending on the primary mission of the P4P program: supporting minimal quality standards and/or boosting quality improvement." (Pieter Van Herck, 2010), but it has been shown that larger incentives yield larger participation. (Francois S. de Brantes & and B. Guy D'Andrea, 2009) Money can get people to participate, but to what end?

In the evaluation of public models, such as the Physician Group Practice Demonstration Project under Medicare, the goal was to reduce costs by comparing an 'unmanaged' community of patients with those of an intervention group. This creates a focused look at the behavior of providers without considering the milieu in which they work. The expectation is that physicians are willing and able to control the factors which affect the cost of care. Additionally, the data sources – Medicare enrollment files and National Claims History files represent a difficult to use and skewed dataset (Research DataAssistance Center, 2009). This can lead to misleading and incomplete information. The intent was to use this data to identify similar populations, but if the cohort is not comparable, the outcomes will be as well. The plan was set up so that if more than a 2% cost savings occurred, 80% of that savings would to go to the provider. There is no evidence that this would result in better care, just less expenditure. It would leave it entirely up to the provider to decide how to manage a population of patients– without the support of evidence, teamwork, negotiation, patient education regarding expectations, or any feedback regarding outcomes or efficacy.

As an alternative to focusing on outcomes, MedPac wanted "implementation of systematic processes to improve care management", and payment based on "ability to produce information related to quality" rather than solely on the purchase of IT. This is clearly the beginning of what we now refer to as 'Meaningful Use'. As a future element, yet to be defined, Meaningful use is intended to take the results of this information request and develop methods that will promote higher quality healthcare. Stage II criteria are in the process of being solicited today. A part of this process will need to be the feedback of useful information to providers that is timely, specific, useful and effective.

Structuring problems with P4P

The authors appropriately offer a discussion, oriented toward P4P, of the factors that are important in the development of systems in general. Developing principles, incentives, measurement tools and data sets that provide for good function are necessary for any system. Guiding principles would include short and long term goals with the intent of P4P to reward quality improvements. Obviously this is a significant challenge if there is no consistent definable relationship between quality and money spent. Voluntary compliance with P4P is of lesser significance if chance is the major factor in success, and public reporting public reporting of no more value than keeping track of daily numbers winners.

The incentives for P4P were described using 3 key factors: type, significance, and source. Whether they are presented as a positive (bonus) or negative (penalty), monetary incentives fail to provide the necessary feedback to improve the system. Probably the most important point of this critique is that all of this work on P4P boils down to a single number – the amount of money to be put back into the practice – but that single number has no real attachment to the goal (is nonspecific), is often weeks or months delayed (not timely), offers no method for change (not useful) and has not been shown to be helpful (ineffective). That doesn't mean that providers ignore the number, which means that whatever their response it is not likely to move them in the direction they desire or necessarily toward improved quality. And as the IOM noted, this process needs to support the development of effective feedback mechanisms for quality development, but cannot do so on its own.

The article further discussed tiered programs of incentives with achievement thresholds, pools of providers and standards of care. In essence expecting peer pressure and cooperation between discordant and sometime competing groups with limited communication along with fear of antitrust to be effective tools for development. There are also issues with non-monetary compensation as the borders of legality and ethical standards are approached in order to give the cooperative provider a competitive or business advantage. These compensation mechanisms include patient channeling (possible collusion, bribery), exemptions from referral or authorization requirements (blacklisting, obstruction of commerce, discrimination), public reporting (liable if inaccurate or misleading, market suppressing), funding for HIT (conflict of interest – currently under Safe Harbor), and Quality grants (kickbacks). Except for perhaps the grants for quality, none of these mechanisms support the development of quality directly, but rather attempt to coerce the provider by money or market pressure to glean the required numbers from their practice. There is no incentive to improve teamwork or create a culture of quality.

The authors also discussed the significance of incentives, noting that there has to be a reasonable return on investment for the provider due to the increased reporting requirements (time and money). Additionally there have to be controls to limit the risk of inappropriate incentives for utilization, and the incentive criteria must be achievable in the current system. Having unrealistic goals and financial loss would surely be a cause of failure. This would also be true for a system that focuses on culture change and teamwork. The cost of developing these systems needs to be 'covered' in order for the incentive to be effective.

Well described in the article were the high level measures of quality improvement including patient safety, clinical effectiveness, utilization and cost, and patient satisfaction. Patient safety has not been well managed in the history of American healthcare. Although there is a trend toward the development of less 'tort-uous' methods, penalty systems remain

the standard approach to improving safety. This severely limits the ability of failures to be used as learning opportunities. Using clinical effectiveness as a measure is challenging at best due to the limited amount of evidence we have to base effectiveness on. It remains true that many patients get better in spite of medical attention rather than because of it. Probably the greatest attention has been paid to utilization and cost management. These are readily measurable but they are not related to quality. They are descriptive of the cost of care, and when used in conjunction with quality measures give a rough determination of cost effectiveness. Patient satisfaction has been a measure considered to be the epitome of market feedback. But especially when considered in conjunction of those providers who get sued, it is evident that it is more useful as a measure of time spent with patient and listening rather than quality of care.

Structural elements can be useful components of a program to promote quality, such as EHR and CPOE. Having electronically aggregatable data will clearly make much of the task of getting the information needed for P4P easier. It is unclear whether this will affect the balance of effective quality measures to be more toward process or outcome. A key issue presented is that of providers being unsure about being accountable for measures that are not in their control. A regulatory development since this article was presented is the concept of Accountable Care Organizations (ACO's). This method of accountability tries to bring the issues of teamwork and culture into a business model that allows the competing and sometimes discordant practices within a community to effectively allow providers to trust that the measures are under their control. The actual structure of ACO's is not well defined, and the distinctions between them and an HMO/PPO/PHO are somewhat academic. The key point is that a group of providers takes responsibility for a population of patients and tries to get a handle on how to do that most efficiently and effectively.

As is well known to any researcher, data will make or break any project. Setting up the measures to be able to answer the question at hand, getting a comprehensive data set, and assuring you are getting data integrity and consistency are essential elements. The larger then number of participating centers and study leaders, the greater the likelihood of incomplete, inaccurate, and 'dirty' data. An additional bias is created by the intent of the study. It has been note that people are 'sicker' in places where there is more attention to detail. People who moved from low medical intensity areas to high intensity areas mysteriously got sicker (i.e. had more testing and increased numbers of diagnosis and medication/treatments) (Song Y, 2010 Jul 1). Those who went from high to low intensity areas were more fortunate – they were less sick – as evidenced by less testing, less diagnosis and less treatment. Strangely enough, the rate of death and disability was not significantly different in these two populations. Which of these providers should get the better reward?

Of the legal issues discussed by the authors – Anti-trust, Fraud & Abuse, Self-referral, Tax exemption, Privacy and HIPAA – changes in the way groups of providers are able to negotiate with groups of payers (insurance companies), and vendors seem likely to create the greatest number of ethical options for limiting the cost of medicine in the future. Currently providers must be careful about how they work together to create the product and the price for the services they provide. In the past an attempt was made to determine the 'real' value of physician services with the development of Relative Value Units (RUV's). The social and financial impact of this academic exercise was quickly recognized by organized medicine and

the political system was used to prevent the system from being implemented in its original form. The original intent was to create an effective comparison of the cognitive skills in medicine to the procedural skills. Traditionally procedures, for which a beginning and end are clearly defined, have been reimbursed at a much higher rate than cognitive skills, for which the beginning and end are not defined. Although this system may not ever be able to meet its original goal, it might be used to allow physicians to create standardized products, with a standard value. Once this is developed by the physician organizations, the each business can negotiate its price with the payers. Individual providers can vary its additions to the base product and develop systems to improve the quality of the base product which will allow the payer to more effectively compare the service and price. The value gained for the system is standardization while maintaining competitiveness.

Summary

The Federal Strategic Action Plan for 2006 -2009 had a goal of Achieving a Transformed and Modernized Healthcare System for the 21st Century. To do so the stated objectives were to develop a skilled, committed and highly motivated workforce; accurate and predictable payments; high-value health care; confident, Informed consumers (transparency); and collaborative partnerships. The concept being offered for high value is currently modeled in P4P based on quality and cost measurement. But the issues discussed here, and as emphasized in the philosophy that 'culture beats strategy' (Pieterson), emphasize the need to allow changes in health care reimbursement such as P4P to support but not drive the development of systems that create and maintain high quality care.

What options are there for the future? Each element of concern voiced in this paper has maintained a common theme. The IOM report is on target, but the way to achieve those goals is to place P4P back into a supporting role and focus on the culture of medicine. In order to help move the drivers of quality toward patient centered care, working to develop a model of medicine that promotes self care and patience with healing, public utility model insurance pools (e.g. electric company), team culture development for providers beginning in medical school and extending into practice, and more evidence upon which to base appropriate medical care (increased funding for research with newly developing patient data sources). If there is feedback based on quality measures, the information from the measures can go back to the providers, and the funding should be returned to the system. Initial savings should be returned to funding for training and public education. After that has stabilized earnings should be returned to research. And when sustained savings are achieved earnings can be returned to providers and insurance utilities.

A big driver for people to go into healthcare, especially in recent years as the economy has faltered elsewhere, is the guarantee of work and the high incomes. Incomes are likely to remain high (although there should be some paring down of the disparity between procedural and cognitive specialties) but the potential for individual entrepreneurship with substantial variation in income will likely go away. In our current economic situation every person, group and business needs to be bringing forth what they can forego instead of the reasons why their interests should avoid the chopping block. This is an opportunity for healthcare to step up, offer a long term solution that can begin to help us eventually answer tougher questions. Despite all this work we will have yet to answer the question of when to stop providing care for patients. How much can we afford to pay to sustain life and relieve suffering? With our

healthcare system fragmented, unbalanced and blundering forward out of control we cannot hope to come to a satisfactory answer. Teamwork, information, and a new culture of evidence based development will hopefully put our society in a position to seriously consider this problem.

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