Pay for Performance Stirs Ethical Concerns

BY MARY ELLEN SCHNEIDER
New York Bureau

SAN DIEGO — Pay-for-performance programs must be designed to avoid putting some of the most vulnerable patient populations at risk, officials with the American College of Physicians warned at the organization's annual meeting.

Although pay for performance has the potential to improve medical care, it could also endanger the physician-patient relationship, the financial stability of the health care system, and the elderly and the chronically ill, said Dr. Frederick E. Turton, chair of ACP's Ethics, Professionalism and Human Rights Committee.

ACP is preparing to publish a position paper on the issue of ethics in pay for performance. The paper focuses on what the programs should accomplish, what physicians should do if participating in them, and the potential unintended consequences of these programs.

For example, ACP officials are concerned about programs that base their incentives on meeting strict clinical targets, such as a specific hemoglobin A_{1c} level, because that might prompt physicians to select patients based on their ability to meet that target. Instead, programs that focus on improvement on a measure might be more appropriate, Dr. Turton said at a press briefing. Other unintended consequences include the potential for gaming the system by physicians, and an increase in unnecessary care and costs.

The programs also have the potential to encourage physicians to perform to the measure, rather than evaluating the individual needs of the patients, Dr. Alan R. Nelson, a member of the Institute of Medicine's study committee on pay for performance. And quality measures may not lead to reductions in cost, in fact, in the short term, it will probably increase use of services and cost, he said.

Limited data are available about pay-for-performance ethical concerns, in part because these programs are so new and researchers need more time to study their effects, said Dr. Matthew K. Wynia, director of the Institute for Ethics of the American Medical Association. The programs are also variable, complex, and are often proprietary and confidential, making them hard to study. And pay for performance is generally not well understood by either patients or physicians at this point.

The limited data in the literature has provided mixed results on pay for performance. One study compared the performance of California physicians enrolled in a pay-for-performance program with the performance of physicians in the Pacific Northwest who were not enrolled. It assessed outcomes on cervical cancer screening, mammography, and hemoglobin A_{1c} testing. The California physicians achieved greater quality improvement only in cervical cancer screening. The authors found there was little gain in quality, and the financial rewards were given mainly to those who had a higher performance at baseline (JAMA 2005;294:1788-93).

In another study, 207 hospitals in a Medicare-sponsored pay-for-performance demonstration showed greater improvement in a composite of 10 quality measures, compared with 406 hospitals involved in voluntary public reporting only. In pay-for-performance hospitals, those with the worst baseline quality performance improved the most; those with the highest baseline quality improved least (N. Engl. J. Med. 2007;356:486-96). ■

Physicians Want Registry Data As Basis for Quality Reporting

BY ALICIA AULT
Associate Editor, Practice Trends

BALTIMORE — Outcomes registries, not claims data, should be the base for the Physician Quality Reporting Initiative next year, physicians and their representatives said at a forum held in May by the Centers for Medicare and Medicaid Services.

CMS officials said they are gathering comments on how to evolve from claims-based information to a registry model, to prevent duplicative efforts to collect data and to encourage quality improvement. The agency's final recommendations will be published in the Federal Register in mid-August as a proposed set of 2008 reportable measures, agency officials said.

A Department of Health and Human Services spokeswoman said that more than 600 people participated in the forum via conference call. The initiative was mandated as part of the Tax Relief and Health Care Act of 2006. Beginning in July, physicians can take part in the initiative by reporting on specialty-specific measures. This year, CMS has listed 74 measures (posted at www.cms.hhs.gov/PQRI).

To participate, physicians submit data on those measures through December on at least 80% of their cases. Those who participate will get a bonus lump-sum payout of 1.5% of claims submitted, some time in mid-2008.

Many physicians already report on such measures to specialty societies.

The longest-running registry is maintained by the Society of Thoracic Surgeons. The 17-year-old registry contains more than 3 million records, Dr. Jeffrey Rich of the STS said at the forum. He noting that registries allow for the collection of clinical data on patient outcomes, which is more useful for quality improvement.

STS suggested that outcomes measures should be vetted through groups such as the American Medical Association's Physician Consortium for Performance Improvement and the AQA (formerly the Ambulatory Care Quality Alliance).

Measures that cut across disciplines should be harmonized, preferably by the National Quality Forum, Dr. Rich said. In addition, input standards should be established to ensure that the data cover all patients, not just a random sample, and finally, registries should be subject to validation and an audit mechanism, he noted.

CMS also heard about the registries of the American Osteopathic Association, the Wisconsin Collaborative for Healthcare Quality, users of GE Healthcare's electronic medical records, the American Medical Group Management Association, and the American Society of Plastic Surgeons.

Jean Harris of the American College of Surgeons said that organization is exploring registry development through the Surgical Quality Alliance. The American Board of Neurological Surgery has developed 15 procedure-specific outcomes measures that are available online, said Dr. Robert Harbaugh of the American Association of Neurological Surgeons.

In 2006, the American Board of Internal Medicine began requiring internists to begin using Practice Improvement Modules (PIMs) in order to maintain certification. With PIMs, physicians enter medical data about patients, and then receive reports back from ABIM, which they are supposed to analyze and use to develop a self-improvement plan.

The American College of Physicians was due to make a statement at the forum, but a representative on the conference call said the group decided it was not ready to share its thoughts on registries and PQRI. ■