AMA Pay-for-Performance Agreement Stirs Debate

BY JENNIFER LUBELL
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Specialty organizations are concerned that the American Medical Association is unilaterally setting performance goals that doctors will not be able to meet.

A recent agreement between the AMA and leaders in Congress outlines an ambitious 2-year time line for establishing performance measures, "to improve voluntary quality reporting to congressional leadership," Duane M. Cady, AMA chair, said in a statement.

Dr. Cady signed the pact at the end of last year, although the details weren't publicly disclosed until several months later. The terms were outlined in a Feb. 7 memorandum from Dr. Michael Maves, AMA vice-president, to the state medical associations and national specialty societies.

The plan was cosigned by Sen. Charles E. Grassley (R-Iowa), chair of the Senate Finance Committee; Rep. Bill Thomas (R-Calif.), chair of the House Ways and Means Committee; and Rep. Nathan Deal (R-Ga.), chair of the House Energy and Commerce subcommittee on health.

If the plan goes through, physician groups will work with the Centers for Medicare and Medicaid Services to agree on a starter set of evidence-based quality measures for a broad group of specialties, with the goal of developing approximately 140 physician measures covering 34 clinical topics by the end of 2006.

The AMA has been working on these quality initiatives for some time, Dr. Cady said. "For the past 5 years, the AMA has convened the Physician Consortium for Performance Improvement, which includes more than 70 national medical specialty and state medical societies." To date, the consortium has developed more than 90 evidence-based performance measures.

The consortium has not yet tested the physician measures; it has been working with several groups to do so, including the Ambulatory Care Quality Alliance, said Dr. Nancy Nielsen, speaker of the AMA's House of Delegates, at a press briefing. The alliance is receiving funding from the Agency for Health Research and Quality and the CMS to test 26 measures at six clinical sites, beginning May 1. Those measures include some developed by the consortium.

The pilot is crucial, because it will bring to the surface any "unintended consequences," Dr. Nielsen said. Then, in 2007, doctors who report on three to five quality measures would see increased payments from Medicare. By the end of next year, physician groups should have developed performance measures "to cover a majority of Medicare spending for physician services," the agreement said.

Other initiatives, such as working on methods to report quality data and implementing additional reforms to address payment and quality objectives, also were outlined in the agreement.

Dr. Cady said nothing in the agreement with the congressional leaders should be a surprise. "It involved only [those] commitments we had previously outlined to our specialty society colleagues."

Yet some of the members of the consortium said they had no advance notice of the AMA's plans to sign this pact.

The American College of Cardiology said in a statement it was concerned about the closed process that led to the pact, but it was "also acutely aware of the political realities woven into the legislative process.

"Cardiology is fortunate in that it has performance measures developed for its specialty. The challenge will be in bringing medicine together to … draw these measures into a pay-for-performance model that facilitates true quality improvement and better patient outcomes," said an ACC spokeswoman. She also cautioned that Congress must remain flexible and mindful of the realities of physician practice in relation to the timing and costs associated with the implementation of any model.

The real problem isn't about advocacy or the workings of the consortium. It's about meeting deadlines on clinical measures, Cynthia A. Brown, director of advocacy and health policy at the American College of Surgeons, said in an interview. "Not everyone is ready for [pay for performance]." Many primary care quality measures have been written, but it's a different story for subspecialties, "because their measures haven't even been developed yet."

With this latest agreement, subspecialties now feel pressured to find their own groups of doctors to propose measures to run through the consortium's process by year's end, she added.

"This is a dust-up about nothing," Dr. Nielsen said at the press briefing, adding that the specialty societies had been included on the performance measure development from the start. The initial measures won't cover all the specialties, but it was necessary to show Congress that the profession was serious about quality improvement by geting something started quickly, she asserted.

Dr. Maves noted that physician concerns about the CMS's initial draft of the physician voluntary reporting program had been interpreted on Capitol Hill as a sign of opposition to quality reporting.

Indeed, the American College of Physicians wants to move even more quickly than the AMA on measure development, voluntary reporting, and pay for performance, Robert B. Doherty, the college's senior vice president for governmental affairs and public policy, said in an interview.

From the CMS's perspective, there's no reason why the AMA's agreement should not work in tandem with the physician voluntary reporting program, Peter Ashkenaz, CMS spokesman, said in an interview.

The program isn't about developing measures, it's about testing systems "on how well we can use the existing claims-based system to capture the data from the measures," he said. The agency is testing the system on a voluntary basis to make sure it can function in a manner that works for both providers and the Medicare program, and ultimately for the beneficiaries when CMS reports the data. "Making sure we have a robust set of measures to populate this program or any follow-up program that Congress may design is the critical part of the AMA's deal with the Congress."

"We need to show Congress that the profession is committed to quality measurement and reporting," said Mr. Doherty. ■

GUEST EDITORIAL

The Perils of Pay for Performance

The concept of quality improvement in medical practice is laudable, but the "pay-for-performance" method—in which physicians are financially rewarded for reaching certain goals set by panels of "experts"—is particularly offensive to our professional identity.

BY FAITH FITZGERALD, M.D.

Are we, like cabbies or waiters, to be tipped for the very service that we are bound by our doctor-patient covenant to achieve? Are we, like car salesmen, to be put on commission?

The collaboration in setting such goals as evidence of quality by our collective societies in medicine—the American Medical Association, the American College of Physicians, the American Board of Internal Medicine, and others—is an act of desperation born of the steadily decreasing value given by third-party payers to doctors who craft their care by applying time-consuming assessment and judgment to individual patients.

Will we not, if we accept this, again generate a rush of laboratory studies, medication prescriptions, and screening protocols for all patients within a given diagnostic cohort ("the diabetic," "the hypertensive," "the person over 50"), rather than decide what is appropriate for the single patient who sits before us? Experience says we will, if only to eke out enough money to continue caring for people in the face of diminishing recompense that barely covers overhead in many practices. This is iniquitous, and is yet another capitulation to the fallacy that the art and science of medicine is a business like any other.

There are, I think, two major dangers inherent in pay-for-performance schemes. The first is evident to those old enough in the profession to have witnessed the multiple cataclysmic reversals of "expert" judgments in medicine and science. Hormone therapy for all menopausal women, prostate-specific antigen screening for all men of a certain age and family background, calcium supplements for osteoporosis, CA 125 screening, the latest diet, and—coming soon, I'm fairly sure—revisions of the now astonishingly broad category of people who should be on statins all flash upon the stage of medicine as initially wonderful, then useless or, worse, detrimental.

When we fall in with these epileptiform enthusiasms aimed at advancing the well-being of our patients, we are sometimes sorry in retrospect for the harm we caused, but are comforted by the thought that we were doing the best we could with the knowledge of the time. Shall we have the same solace if we make these decisions, not because we think they are right, but for money? Should we penalize and discourage doctors who are skeptical? It is, after all, from their ranks that the corrections come.

Second—and to me most erosive of our professional identity—is the very concept of pay for performance for doctors, especially when we collaborate in creating the concept: Pay for performance embodies the tacit assumption that if we are not delivering, it is because we are not being paid enough. We send a message to patients, then: "We'll give you our very best care if it profits us, but not otherwise. It is not ignorance, fatigue, a system failure, or even an individual physician's flaw that leads to substandard practice, but rather a mutually agreed-upon group avarice."

Even if adherence to laudable goals supported by the best current data and opinion is effectuated through pay for performance—and studies suggest it is, at least at first—this is a shameful fact, and not one to be reinforced, but rather acknowledged by the profession, carefully studied as to why it is so, and then—when possible—remedied.

I would encourage all proud physicians and their representative groups to refuse cooperation with those who would institute pay for performance. It corrodes the concept of self-governance and correction that is part of the definition of professional. It would be unnecessary were it not for our ongoing capitulation to the directives of external agencies for cheap, algorithmic, rapid-throughput, one-size-for-all medical care with diminishing returns for increasing mandates.

Goals for error-free best care should, of course, be sought and disseminated; this is inarguably the duty of physicians. We must not accept gratuities for doing our duty. ■

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