

Physicians Cry Foul!

The Feds Want to Link P4P to Medicare Payment Updates

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There is so much chatter about Pay for Performance that some have characterized it as a rising tsunami. There are multiple gorillas driving this: the Leapfrog Group, National Quality Forum, the Institute of Medicine, JCAHO, Centers for Medicare and Medicaid Services and MedPAC, and the National Committee on Quality Assurance.

To address legitimate concerns about quality, P4P arose as an approach to port the performance incentive paradigms employed in other industries to Medicine. However, in its present iteration as discussed by the Congress, P4P seems largely to be about saving money for Medicare. The Administration, Senator Frist, and House leaders all believe that instituting P4P will benefit Medicare, and they appear determined to link P4P with Medicare rates for physicians.

Regarding this Medicare payment update, first the Senate passed a budget reconciliation package providing a 1 percent increase in Medicare rates for physicians, coupled with onerous P4P provisions. Later the House version of the budget package appeared, but it was silent on Medicare: it contained no provisions to address the Sustainable Growth Rate-engendered Medicare payment update of (-) 4.4 percent for 2006. Washington sources reported that the House leadership had decided for political reasons not to have any amendments on Medicare, effectively preventing some undesirable potential amendments, such as placing the whole issue of Medicare Part D (this is the new and extremely complex Medicare prescription drug coverage program) on the table for discussion. However, because the Senate bill did deal with the impending Medicare cuts but not changes to Part D, the issue of physician payment was on the table when the two chambers met in joint conference committee.

On December 19, the House passed S.1932, the Deficit Control Act of 2005, which freezes Medicare physician conversion factors at 2005 rates through 2006. On December 21, the Senate passed its own version of the reconciliation bill. The House must approve this later version, so that one bill can be presented to the President for his signature. However, the House has recessed for the holidays and is expected to reconvene in late January 2006. If no action

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is taken before January 1, the Medicare cuts may go into effect, although the Congress can retroactively fix this when it reconvenes. There is no P4P in either version of S.1932.

Congress has responded to vigorous lobbying by the ASA and AMA, as well as other physician groups, not to mandate P4P in this bill. Some might characterize this as a significant early political victory concerning P4P. The battle will surely continue in the second session of this Congress, but because next year is an election year, continued pressure on legislators may stave it off longer as we continue to press vigorously to educate and to present coherent alternatives.

It is worth noting that the AMA has been strident in its declaration that it will not accept P4P in Medicare without abolition of the SGR, and that P4P must

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be about “new money,” not just distribution of money between doctors. However, Congress has been equally clear that there will be no “new” money. Therefore, it appears certain that substantial educational initiatives, intense lobbying, and major expenditure of political capital will be needed for physicians to persuade legislators to scrap the version of P4P that they seem to have in mind.

On the ASA front, to participate in the new Medicare Physician Voluntary Reporting Program, the ASA submitted three performance measures to CMS, but only one of these was chosen by CMS for inclusion in the 36 adopted: timely administration of preoperative antibiotic prophylaxis. Considerable effort was expended by the ASA in developing and in refining additional measures via discussions with CMS staff—maintenance of normothermia and comprehensive planning for chronic pain management—which, without explanation, were not chosen. Many other specialties had a similar experience, and there has been considerable angst produced by these developments. Clearly, there are many aspects of the timely preoperative antibiotic prophylaxis measure that are not controllable by anesthesiologists, and therefore a team approach will be required. Moreover, in many practice settings, this area has already been “staked out” by hospitals and some surgeons, so how this will play out for our specialty may be problematic. It appears at this early stage that some physicians may already be “more

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equal than others.” Given our dismal history with Medicare—the institution of RVRBS in 1992 which threw our Medicare payments into the dumpster, and the Budget Reconciliation Act of 1997 which gave all physicians the SGR—suspicions that we are about to be unjustly abused once again seem close to becoming predictions.

In the current issue of *The Physician Executive*, a publication of the American College of Physician Executives, there is a special report on P4P (November-December 2005). Two of the five interesting articles are “The Dark Side of P4P” and “Is P4P Ethical?” In the first article, a highly respected gastroenterologist in St. Louis missed a United Health Care performance measure by a statistically insignificant amount (0.4 percent), but suffered loss of a preferred designation and hence dramatically increased co-pays for his patients. Backlash from patients and doctors was intense, and the insurer suspended the P4P program. However, the damage to physician-patient relationships had occurred and was irretrievable.

In the second article, Dr. Richard Thompson, who teaches ethics at Missouri State University, discusses how the devil in the details of a P4P program will determine whether or not it is even ethical to institute a payment scheme which intends to establish inequality in pay between individuals or groups working in the same area of an organization. Concerning Medicare P4P, he gives seven examples of how something theoretically ethical can be rendered unethical by how it is implemented.

If the avowed purpose of P4P is quality but in actual fact it is about efficiency, then this becomes an unethical matter, because “word speak” (that is, using one word when what is actually meant is the opposite, like in George Orwell's 1984 wherein “slavery is freedom”) is being used to enhance public relations or to serve political purposes. If equal opportunity to earn P4P is not accessible to all doctors, then P4P is unethical. If results are rewarded but are not actually caused by the rewarded individual or hospital, then that is unethical. If P4P uses criteria to reduce certain medical services, then P4P is unethical. If performance criteria are unachievable, the carrot always just out of reach, then that is unethical. If basic pay is reduced by the P4P plan, and average performance is penalized rather than superior performance rewarded, then P4P is unethical. And finally, if the feds state that they wish to reward “effective performance that improves quality care,” but actually seek to use P4P “as a bribe, a control tool, where payers can micromanage both patients and hospitals,” then P4P is unethical.

To summarize, the inappropriate linkage of Medicare payment updates to P4P is blowing strong from government central; the AMA and the ASA continue to

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demonstrate the effectiveness of grassroots lobbying activities; Congress has somehow managed to keep the balls in the air; the ASA has angst about how the new Medicare Physician Voluntary Reporting Program is getting started; there is unequivocal documentation of the disruption of physicians practices by P4P in the private sector; and there are serious concerns about whether P4P as contemplated by Congress is even ethical.

There is now apparently an opportunity to reframe the debate on P4P, and we must get to work on this immediately. If P4P is eventually instituted in a way that is clearly unethical, then perhaps there may be aspects of it that are possibly or even clearly illegal. If so, and pending this determination, perhaps its implementation could be enjoined by the courts. In the meantime, we must focus on education, lobbying, and raising political capital. At this juncture, it appears to be truly an "up" date. Let's run with it.

CMA/CSA Legislative Day April 4, 2006

The CMA is hosting its annual Legislative Day in Sacramento on Tuesday, April 4. As in recent years, the CSA will be a joint sponsor and have tables reserved for CSA members.

CSA members are urged to attend the meeting, which includes updates of this year's important legislative issues and speakers from the legislature and/or state agencies. The afternoon is open to visit your legislators and attend any hearings of interest. Appointments should be made well in advance of the meeting.

The CSA reimburses 14-day advance coach airfare or mileage and parking fees to CSA members who attend and sit with the CSA delegation (as opposed to sitting with your county medical society). If you plan to attend, let us know so we will have an accurate count for reserving CSA tables. Contact by phone at (800) 345-3691, fax at (650) 345-3269 or e-mail to bbaldwin@csahq.org.