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EDITORIAL COMMENTARY

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

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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. Because 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.

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 with 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

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became obvious to those who pay for the bulk of American health care, they rapidly used market power to shift control of health care 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 health care 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 health care. A typical large health care 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 ($1.89 billion) in comparison with 2002 ($3 billion) and 2003 ($2.2 billion), a 14% drop despite a reported increase in national health care expenditure[5] from a reported $1.6 billion in 2002 to $1.8 billion in 2004. The president of this insurer earned $3 million in 2004, up from $2.3 million in 2002 (a 30% increase in 2 years). The CEO earned a reported $18.2 million in 2003 and $22 million in 2004 (a 21% increase in 1 year). Comparison with physician income over the same period is invited.

Reducing employee health care 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 its 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 toward 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 health care system. Meanwhile, a separate study by HealthGrades, Inc in 2004 garnered national media attention by raising concern that the number of annual deaths caused by 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) shows 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. Although most health care providers would like to claim that they only provide the highest quality care, the reports by IOM and HealthGrades force 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 among their competition.

Proponents of P4P argue that it is an innovative way to improve the quality of patient care while also lowering health care costs. Many concerns exist, however, that patient care may actually suffer under a P4P model (Table 1). 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) (Table 2). 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 health care 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