Opinion

BY RICHARD P. MILLS, MD, MPH

P4P—Is It a Tidal Wave or Just Another High Tide?

The water level is rising fast in Washington, D.C., that much we know. Pay for performance (P4P) is the latest craze among the geniuses in our nation's capitol who pass laws affecting medicine. My theory is that the acronym contains a number because the bureaucrats had run out of unique letter combinations. Alphabet soup has become alphanumeric soup.

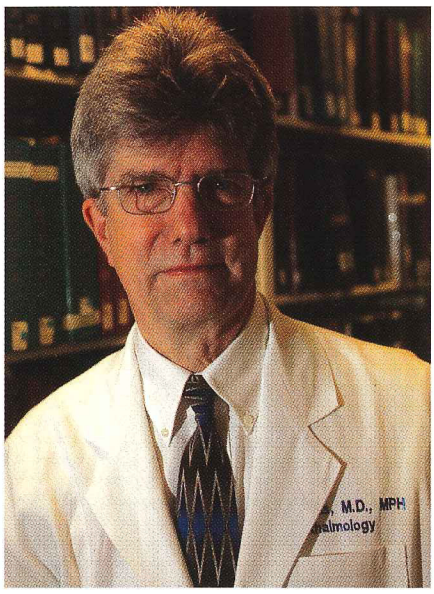
If you are like me, you wonder where P4P came from. The Institute of Medicine report *Crossing the Quality Chasm* (2001) recommended that purchasers reward improvement by aligning documented quality to payment incentives. Taking up the gauntlet, Medicare's Payment Advisory Commission decided in 2004 to recommend that Medicare begin to link payment to quality. As the debate in Congress continues about a fix to the flawed Sustainable Growth Rate formula that projects an annual 5 percent cut in physician reimbursement over the next six years, physicians are being asked to agree to P4P as the price for fixing the automatic annual cuts. So far, MedPAC recommends differential pay for performance in the 1 percent to 2 percent range; private sector experience with P4P demonstrates that it takes at least a 5 percent differential to engage physicians.

While P4P ought to be quality driven, it is sounding a lot like it will be financially driven, a way to save money. P4P ought to increase payments for fulfilling performance requirements, but it is likely only to reduce payments for physicians who don't. Fairness should dictate that equal access to P4P be available to all physicians, but actually it is likely that the best access will be to those with sophisticated information technology systems, like big multispecialty clinics. Ideally, P4P should not alter the clinical patient mix, but actually it may cause doctors to refer high-risk cases elsewhere so their quality data look pristine. Finally, the performance measures will not be outcome-based (how your patients did), but instead process-based (did you order appropriate tests?).

Needless to say, there is a big scramble among medical associations to propose performance measures that their members can use to obtain the higher payment rate. It's not a simple process. First of all, the measures must be evidence-based, broadly understood and accepted. Then, the measures must be submitted to the AMA's Physician Consortium for Performance Improvement for approval, and then to the National Quality Forum, prior to action by Medicare. At least the Academy is ahead of the curve, because its *Preferred Practice Patterns* suggest performance measures that will fulfill the criteria. Nevertheless, there remains a lot of work to be done on a short timeline, for which the Academy is gearing up. "No ophthalmologist left behind," is the goal.

The AMA has released a series of five principles it believes should be respected by P4P: 1) ensure quality of care; 2) foster the physician-patient relationship; 3) offer voluntary physician participation; 4) use accurate data and fair reporting; and 5) provide fair and equitable program incentives.

The last time the water rose this fast was during the managed care fad, and it sure looked like a tidal wave. It turned out not to be, of course. It was just a high tide, but I remember fleeing to high ground all the same. This time, let's flee to the high ground of insisting that improved patient care is the basis for P4P.



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