No. 03
Friday January 19, 2007

Analysis & Perspective

Physician Payment

Medicare Expands Pay-for-Performance Demonstration Projects

Slavkin is an attorney in the Orlando, Fla., office of Foley & Lardner LLP. He can be reached at (407) 423-7656, or Rslavkin@foley.com.

As any human resources director will tell you, an effective way to motivate employees to improve their productivity is to create a bonus structure. Such is the logic behind Medicare's pay-for-performance (P4P) programs.

However, the goal with P4P is not greater productivity, but increased quality of health care.

Pay for performance already is widely used by private health insurers. Critics long have stated that Medicare beneficiaries do not receive the highest possible quality of care; the program's payment system, they state, encourages volume of care rather than efficiency and quality.

In fact, former Senate Finance Committee Chairman Charles E. Grassley (R-Iowa) has stated that the current Medicare system rewards for quantity by paying physicians for treating complications that result from their own mistakes.[1]

To address the concern that the Medicare system does not foster quality of care, the Centers for Medicare & Medicaid Services has implemented several P4P incentive demonstration projects, which, if successful, likely will become part of Medicare's reimbursement infrastructure.

Premier Hospital Demonstration

One such program is the Premier Hospital Quality Incentive Demonstration project. In this program, 300 inpatient facilities enrolled in the program report quality measures that are based on clinical evidence and industry-recognized metrics. CMS has been careful to structure the clinical quality measures based on guidance

from recognized industry entities such as the American Hospital Association, the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, and the Agency for Healthcare Research and Quality.

The 34 measures developed based on these groups' recommendations are utilized for the hospitals to report on five clinical conditions. These conditions are: (1) acute myocardial infarction; (2) coronary artery bypass graft; (3) heart failure; (4) community acquired pneumonia; and (5) hip and knee replacement.

If any of the 300 participating inpatient facilities are able to demonstrate improvements in quality of care in the five clinical conditions utilizing the 34 quality measures established, the facilities are eligible for up to a 2 percent increase in payment from Medicare.

Expanded Pilot Projects

In late 2006, the government took a bold step forward in expanding its pilot P4P projects.

The Tax Relief and Health Care Act of 2006 (Pub. L. No. 109-432), approved by the 109th Congress on Dec. 8-9, 2006, and signed into law by President Bush on Dec. 20, 2006, maintains physician Medicare reimbursement at the current levels for 2007. It also provides for a 1.5 percent increase in reimbursement to those physicians who agree to report data on certain quality of care measures.

Under the terms of Pub. L. No. 109-432, beginning July 1 and ending Dec. 31, 2007, physicians voluntarily may report the quality measures that are identified at the 2007 Physician Quality Measures on the CMS Web site. CMS has posted the 2007 Physician Volunteer Reporting Program Physician Quality Measures effective Jan. 1, 2007.

There are 66 quality measures developed in a manner similar to the 34 measures identified in the Premier Hospital Quality Incentive Demonstration, including, but not limited to, measures regarding the treatment of patients with coronary artery disease, patients with cataracts, patients with diabetes, patients who are stroke victims and in rehabilitation, patients with melanoma, patients with osteoporosis, and patients with oncological conditions.

For each of the 66 quality measures, there are data reporting requirements such as information regarding how often physicians prescribe medications to heart attack patients, and how they manage diabetic patients and patients with hypertension.

Reporting Metrics

These reporting metrics also are provided on the CMS Web site. During the initial "pilot" period of July 1-Dec. 31, 2007, CMS will announce a proposed set of quality reporting measures for 2008. The draft measures are due no later than Aug. 15, with the final set of measures being announced Nov. 15, for implementation for the entire calendar year 2008.

Beginning July 1, 2007, physicians participating in the initial program will qualify for the bonus if they report to the government data on certain quality of care. The Congressional Budget Office (CBO) estimates the physicians who report quality information will receive approximately $300 million in bonus payments in 2007.

CBO stated in its final analysis of Pub. L. No. 109-432, that physicians who account for about two-thirds of Medicare spending for doctors will qualify for bonus payments.[2]

There has been significant criticism on Capitol Hill of the idea of government intervention on the issue of physician quality standards in medical care. Rep. Henry A. Waxman (D-Calif.), the new chairman of the House Oversight and Government Reform Committee, said, "I am very skeptical of pay for performance. I am not sure we can measure quality and performance that well."[3]

Also, Rep. Fortney "Pete" Stark (D-Calif.), incoming chairman of the House Ways and Means Subcommittee on Health and a noted proponent of regulation of physician activity, stated that doctors are supposed to provide quality care as part of providing medical services and should not receive extra payment for doing so.

Stark further stated that he believes that federal officials do not have the ability, understanding, training, or the knowledge to establish appropriate quality-of-care standards.[4] There appears to be an overriding concern from critics that bureaucrats should not be controlling quality of care in a medical practice.

Additional Criticism

Criticism of P4P programs is not just limited to lawmakers. Robert Moffitt, the director of health policy studies at the Heritage Foundation, is quoted as saying, "Doctors will be financially pressured to comply with government guidelines and standards. The integrity and independence of the medical profession could be compromised."[5] A

Also, an article in the Oct. 12, 2005, edition of the *Journal of the Medical Association* assessed the effectiveness of P4P mechanisms in health plans by reviewing administrative reports of physician groups in California and the Pacific Northwest.

The article's authors evaluated an experiment with P4P by reviewing administrative reports regarding physician group quality from a large health plan (the intervention group comprised of California physician groups) and a similar comparison group (physician groups in the Pacific Northwest).

Quality improvement reports were reviewed from October 2001 through April 2004. The data reviewed by the authors revealed that in this instance, P4P largely rewards those physicians with higher quality performance at the baseline--those physicians who provide higher quality service to begin with are more likely to reap the rewards of the program.

The article concluded by stating that P4P mechanisms may produce few gains in quality for the money spent.[6]

As colorful as the criticism has been regarding P4P, at this time there is only sparse evidence of the efficacy or lack thereof of a P4P program in Medicare.

Given the intense focus by legislators, as well as physician, hospital, long-term care, and managed care advocacy groups, all data regarding the effectiveness of P4P undoubtedly will be scrutinized down to a microscopic level.

The next 12-to-24 months likely will provide answers as to the future of P4P in Medicare and in the U.S. health care system.

---

[1] Robert Pear, "Medicare, in a Different Tack, Moves to Link Doctors' Payments to Performance," *The New York Times,* Dec. 12, 2006.

[2] The CBO also stated that the maintenance of current reimbursement levels for physicians in 2007 would increase Medicare spending by $1.8 billion overall this year.

[3] Robert Pear, "Medicare, in a Different Tack, Moves to Link Doctors' Payments to Performance," *The New York Times,* Dec. 12, 2006.

[4] *Id.*

[5] *Id.*

[6] Early Experience with Pay for Performance, *JAMA, Vol. 294, No. 14, Oct. 12, 2005, p. 1788-1793*

ISSN 1521-4699