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Medicare and pay for performance

Curbside Consult

ROBERT SLAVKIN

Q: *What are some of the pros and cons associated with Medicare pay for performance and how is the quality of health care affected under this program?*

A: Pay for performance is already widely used by private health insurance, and in the private sector generally to provide an incentive for employees to increase productivity. The goal of pay for performance in Medicare, however, is to increase quality of care.

Critics have long 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, Chuck Grassley (R-Iowa), former Senate finance committee chair, has stated that the current Medicare system rewards for quantity by paying physicians for treating complications that result from their own mistakes.

In late 2006, the government took a bold step forward in expanding its pilot projects for pay for performance. Under the Tax Relief and Health Care Act of 2006, PL 109-402, physician Medicare reimbursement is maintained at the current levels for 2007, and also provides for a 1.5 percent increase in reimbursement to those physicians who agree to report data on certain quality of care measures. Beginning July 1 and ending Dec. 31, 2007, physicians may voluntarily report the quality measures that are identified on the CMS Website. Physicians participating in the program will qualify for the bonus if they report to the government data based on these quality measures.

The Congressional Budget Office ("CBO") estimates the physicians who report quality information will receive approximately $300 million in bonus payments in 2007.

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. Pete Stark (D-Calif.), 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. Rep. Stark further stated he believes that federal officials do not have the ability, understanding, training or the knowledge to establish an appropriate quality of care standards.

Criticism of pay for performance 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."

Also, an article in the Oct. 12, 2005 edition of the *Journal of the AmericanMedical Association* assessed the effectiveness of pay for performance mechanisms in health plans by reviewing administrative reports of physician groups in California and the Pacific Northwest. The data reviewed revealed that in this instance, pay for performance 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 concludes by stating that pay for performance mechanisms may produce few gains in quality for the money spent.

As colorful as the criticism has been, at this time there is only sparse evidence of the efficacy or lack thereof of a pay for performance 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 pay for performance will undoubtedly be scrutinized down to a microscopic level.

The next 12 to 24 months will likely provide answers as to the future of pay for performance in Medicare and in the American health-care system.

Robert Slavkin is an attorney at Foley & Lardner in Orlando; 407-244-7135; rslavkin@foley.com.