Physicians: Medicare Formula Is Priority in Reform

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WASHINGTON — Congress should fix Medicare's payment formula before taking on any new reforms to pay physicians on the basis of quality, medical organizations testified at a hearing of the House Ways and Means health subcommittee.

If impending cuts to the fee schedule go into effect, "physicians will be hard pressed to undertake quality initiatives such as information technology," testified Nancy H. Nielsen, M.D., trustee to the American Medical Association.

President Bush's budget request for fiscal year 2006 includes a scheduled 5.2% payment cut for physician services under Medicare. Actuaries have estimated that physician payments could decline by more than 30% through 2012, unless modifications are made to the sustainable growth rate (SGR), a component in the physician pay formula that determines each year's update.

Going ahead with pay-for-performance initiatives without changing the Medicare formula to stave off the 5.2% payment cut 'is unacceptable.'

Although the AMA has engaged in its own evidence-based, quality improvement measures, "it is critical to replace the flawed physician payment formula to allow quality initiatives to flourish," Dr. Nielsen said.

Other medical organizations offered similar pleas in testimony and in statements to the subcommittee.

Going ahead with pay-for-performance initiatives but not changing the formula to stave off the 5.2% cut "is unacceptable," Jerome B. Connolly, senior government relations representative with the American Academy of Family Physicians, told this newspaper.

At the hearing, pay-for-performance proposals were heavily touted as a viable payment alternative by witnesses and panel members alike. "We fundamentally have to rethink how we pay our doctors," said Subcommittee Chair Nancy L. Johnson (R-Conn.).

Some physicians perform better than others in the quality of care they deliver, Glenn M. Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC), testified.

The SGR system "fails to create appropriate incentives to improve performance," he said. MedPAC in its March report to Congress recommended a quality incentive payment system for physicians under Medicare, using various types of information technology to manage patients.

Such an approach would establish exclusive performance standards and award physicians accordingly, while establishing standards to improve quality, he said.

Rep. Pete Stark (D-Calif.), the panel's ranking member, countered that he was "reluctant to get into the quality issue." As far as reforming payments, "I think it's up to the doctors to regulate themselves."

Any type of payment system that rewards providers by improving patient care and outcomes must not be punitive or used as a control for physician volume, said William F. Gee, M.D., a urologist from Lexington, Ky., who testified on behalf of the Alliance for Specialty Medicine.

Measures should also be specialty specific, he continued. "In some areas, particularly surgery, it can be difficult to keep quality measures up to date enough to be perceived as relevant."

In addition, the reporting of quality or efficiency indicators and health outcomes data could be administratively prohibitive to many physicians, especially those in small practices that don't have electronic health records, Dr. Gee testified.

There is some evidence that pay for performance can work, at least in the private sector. Since the implementation of three major pay-for-performance contracts with Partners Healthcare System in Boston, "we have steadily improved in targeted areas," such as diabetes care, Thomas H. Lee, M.D., network president for the health care system, testified.

The rate of rise in pharmacy spending under these contracts averaged about 5% in 2004, which is lower than the national average of 9%.

The contracts cover the care of over 500,000 primary care patients and a number of patients referred to specialists. ■