Medicare Advisers Examine Pay for Performance

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WASHINGTON — The Medicare Payment Advisory Commission is considering redistributing 1%-2% of Medicare physician payments to physicians who demonstrate quality based on certain performance measures.

But what measures to use, how to obtain the quality information, and whether to base payments on performance by individual physicians or group practices are still up in the air. Linking an even greater portion of physician pay to quality might be necessary to make the plan viable, commission member Arnold Milstein, M.D., said at a recent commission meeting.

Private-sector experiences indicate that in order for physicians to put a high priority on quality measures, payments need to be more than 10%, Dr. Milstein said, compared with the current 5%-10% on the table from insurers.

"I also agree that we should put more and more of the payment at risk," said Ralph W. Muller, a MedPAC member and CEO of the University of Pennsylvania Health System.

Over 3-5 years, Medicare should increase the amount of the payment that is at risk, he said.

"We've now seen 30 years of evidence that the payment system drives behavior more powerfully than almost everything else. So if you want quality to be a bigger part of the agenda, as we are suggesting it should be, then more and more of the payment system in fact has to be tied to quality," Mr. Muller said.

But taking 1%-2% of Medicare physician payment and redistributing it based on quality may have a much bigger impact than larger payments from private insurers because of the larger average share of Medicare patients in many physician practices, said Glenn Hackbarth, MedPAC chairman and an independent consultant from Bend, Ore. "The 1%-2% is a starting point," Mr. Hackbarth said, "not necessary an end point."

It would be better to start out at a lower level of payments as Medicare officials figure out the best measures to use, but keep the door open to increasing the amount of payments linked to quality over time, he said.

But Mary Frank, M.D., president of the American Academy of Family Physicians, cautioned that to make pay for performance work, Medicare officials can't just redistribute the payments. Additional funding will be needed to provide real financial

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DR. MILSTEIN

incentives, but over time, the system will gain because improvements in quality and efficiency will decrease costs, she said in an interview with this newspaper.

Alan R. Nelson, M.D., a MedPAC member and an internist, cautioned that the commission members should be careful about pay for performance.

"We have to be aware as we proceed with this of unintended consequences that could end up in worse patient care, rather than better patient care," Dr. Nelson said.

Although that's not a factor in the majority of situations, unintended consequences could occur, he said. For example, linking quality payments in the area of avoidable hospitalizations could create a disincentive. It can be difficult for physicians to decide how far to go in managing a patient's care successfully at home or if the patient needs to go into the hospital, Dr. Nelson said, but if there is a financial incentive to keep patients at home, it could create a greater risk for patients.

Pay for performance also leaves the door open to "cherry picking" of patients, Dr. Nelson said. For example, a physician may choose not to provide care to a patient who smokes, because that patient would hurt the physician's quality numbers.

The commission should also exercise caution in how it chooses to collect data, Dr. Nelson said. If Medicare is going to collect quality data using methods that impose an additional administrative burden on physicians, that time should be reimbursed. Physicians want to do a good job, he said, but they won't embrace unfunded mandates. ■