MedPAC: Physicians Ready for Pay for Performance

BY JENNIFER SILVERMAN
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WASHINGTON — Congress should establish a quality incentive payment policy for Medicare physicians, the Medicare Payment Advisory Commission recommended.

In light of the challenges facing Medicare, "nothing is more important" than distinguishing between providers based on performance, MedPAC Chairman Glenn Hackbarth said at a commission meeting. "Providers are not all created equal—there's abundant evidence that some providers do a better job than others. To continue to pay them as if they're all performing equally well is a tragic situation."

And that was just one of several of the commission's recommendations aimed at establishing a pay-for-performance system across health care channels, using information technology in Medicare initiatives to financially reward providers on the basis of quality. At press time, the recommendations were scheduled to appear in MedPAC's March report to Congress.

"Physicians are ready for a pay-for-performance program," Karen Milgate, a MedPAC research director said at the meeting.

Those participating in such a program could use various facets of information technology to manage patients, such as registries to track patients and identify when they need certain preventive services, or systems for detecting drug interactions, Ms. Milgate said. These types of information have the potential to improve important aspects of care, and increase physician ability to assess and report on their care.

"Without information technology, it would be difficult for physicians to keep up with and apply the latest clinical science and appropriately track and follow up with patients," she said. "This is true for primary care and especially for patients with chronic conditions. But [it is] also true for surgeons and other specialists, to ensure follow-up after acute events and coordination with other settings of care."

Considering that it's the only information collected on physicians, Ms. Milgate noted that claims-based measures could be used to determine whether beneficiaries received appropriate follow-up care.

The claims-based process puts no burden on physicians and research shows it's widely available for a broad group of beneficiaries and physicians, she said. "However, the depth of information on each kind of physician is unclear and we do know that claims based measures are not available for every single type of physician."

Because these actions would redistribute resources already in the system, they would not affect spending relative to current law, although they may increase or lower payments for providers, depending on the quality of their care, she said.

Nicholas Wolter, M.D., a MedPAC commissioner from Billings, Mont., cautioned that physicians may be reluctant to embrace yet another change that would limit their revenue, after the sustainable growth rate. Pay for performance might be "another irritation, rather than an incentive."

Are all physicians equally ready for such a system? "I'm not sure that's true," he added.

Smaller practices in particular may not be ready to provide the clinical information necessary for a mature pay for performance initiative, Alan Nelson, M.D., a commissioner representing the American College of Physicians, said in an interview. "However, the insistence of payers for incentives to promote quality is something that can't be ignored."

Although a differential payment system that rewards higher quality "is almost certainly in our future," Medicare should proceed with caution on this initiative, taking care to not increase the administrative burden—and always being aware of unintended consequences, Dr. Nelson said.

Most of these information technology developments "seem to apply more to primary care physicians than other specialties," observed commissioner William Scanlon, Ph.D., a health policy consultant from Oak Hill, Va. "The question is how we would differentiate the rewards for different specialties even on the structural measures."

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DR. NELSON

He suggested that Congress create a project to test these rewards on an ongoing basis, to accumulate evidence that it was working effectively among the various specialties.

Mandating use of information technology could accelerate use, but "providers could find such a requirement to be overly burdensome," MedPAC analyst Chantal Worzala said. Such requirements could become appropriate as the health care market develops.

The panel also recommended that prescription claims data from Medicare's Part D program be available for assessing the quality of pharmaceutical and physician care. "Linking prescription data with physician claims could help identify a broader set of patients with certain conditions, and help determine whether they filled or refilled a prescription and received appropriate pharmaceutical care," Ms. Milgate said.

Rewards could also be given to providers who improve outcomes in care for their patients in other settings, such as physicians whose patients do better in hospitals, or home health agencies who manage their patients' care transition to nursing homes, MedPAC analyst Sharon Bee Cheng told commissioners. ■

Medicare Advisers Call for National Standards on Imaging

BY JENNIFER SILVERMAN
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WASHINGTON — A federal advisory panel wants to raise the bar on quality and use of imaging services.

In a series of recommendations, the Medicare Payment Advisory Commission called for national standards for physicians who bill Medicare for interpreting diagnostic imaging services, and for any provider who bills Medicare for performing such services. MedPAC advises Congress on Medicare payment issues.

There is evidence of variations in the quality of physician interpretations and reports, MedPAC analyst Ariel Winter said at a recent commission meeting. "Ensuring that only qualified physicians are paid for interpreting imaging studies should improve diagnostic accuracy and treatment," he said.

Standards for physicians would be based on education, training, and experience required to properly interpret studies. Private organizations would be charged with administering the standards, Mr. Winter said.

Several MedPAC commissioners questioned whether Medicare should get involved in the business of credentialing or accrediting physicians for interpreting imaging studies. Whether in cardiology or another specialty, Medicare would be taking on responsibilities that previously fell to licensing boards, specialty society certification, or other private sector organizations, said MedPAC commissioner Sheila Burke, R.N., of the Smithsonian Institution.

"It is a new area and it's not entirely clear to me that Medicare may be the right place for that to occur," she said.

Mr. Winter acknowledged that some providers might not be able to meet these standards, or incur costs to meet them. For example, they might have to invest in newer equipment or higher credentialed technicians, or they might have to obtain additional education, he said.

'The goal is to encourage physicians who order significantly more tests than their peers to reconsider their practice patterns.'

Measuring physicians' use of imaging services should be part of MedPAC's broader effort to profile fee-for-service physicians on their use of all services, Mr. Winter said. Radiologists can influence which tests physicians order, but physicians are important to the analysis on imaging because "they determine whether a test is appropriate," he said.

Under the MedPAC recommendations, CMS could develop measures of imaging volume for a patient seen by a physician, and could compare these measures to peer benchmarks or clinical guidelines, Mr. Winter said. The agency could then provide this information to the physician in confidence.

"The goal is to encourage physicians who order significantly more tests than their peers to reconsider their practice patterns," Mr. Winter said.

On other recommendations related to imaging, the panel voted that the Department of Health and Human Services improve Medicare's coding edits that detect unbundled diagnostic imaging services, and reduce the technical component payment for multiple imaging services performed on contiguous body parts.

Better coding will help Medicare pay more accurately for imaging services and help to control rapid spending growth, Mr. Winter said. Providers who bill for unbundled or multiple imaging procedures would experience a decrease in Medicare payments, though it's not anticipated that this would affect their willingness and ability to provide quality care to beneficiaries, Mr. Winter said.

MedPAC also proposed to strengthen the rules in the Ethics in Patient Referral Act (Stark law), which restrict physicians' investment in the imaging centers to which they refer Medicare or Medicaid patients. The restrictions already apply to radiology and certain other imaging services, but it's unclear whether nuclear medicine is a radiology service, Mr. Winter said.

The panel ultimately voted to include nuclear medicine and positron emission tomography procedures as designated health services under the Stark law. Investment in facilities that provide nuclear medicine services is associated with higher use, creating financial incentives to order additional services and to refer patients to facilities in which the physician is an investor. This undermines fair competition, Mr. Winter said.

Not according to Michael J. Wolk, M.D., president of the American College of Cardiology, who criticized MedPAC for recommending "restrictive tactics" to ratchet down the use of PET scans, CT, and MRI.

Studies that support these recommendations are biased, and specifically exclude examination of these procedures, Dr. Wolk said.

In a statement, he asked that policy makers take more time to look at this issue and evaluate the long-term health benefits of this technology, in addition to the immediate costs. ■