Wanted: Docs to Help Craft Pay for Performance

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CHICAGO — Physicians need to help design the pay-for-performance programs now being initiated by Medicare and other payers, or they may not like the results, Dr. Trent Haywood said at the annual meeting of the American Association of Clinical Endocrinologists.

"What it comes down to … is there's a certain level of fear, a certain uneasiness" about the program among doctors, said Dr. Haywood, who is deputy chief clinical officer at the Centers for Medicare and Medicaid Services. "The thing is for clinicians to work with us and get on board. We don't want to design a program and not have clinician input."

Medicare currently has several pilot programs under which physician and hospital pay is based in part on patient outcomes and quality of care. Demonstrations include a project with 10 large multispecialty practices nationwide, and an oncology project in which physicians are paid to report their use of guidelines as well as outcome measures for their patients.

Dr. John Rowe, executive chairman of Aetna, made a similar comment at the Society of Hospital Medicine meeting in Washington. "My fear is that the pay-for-performance train is leaving the station, and the doctors aren't on it," he said. "When I talk to people who buy Aetna's services [such as large employers], they get it. Corporate America is adopting the concept of pay for performance before the details are worked out, and the details have to be worked out by physicians."

But physicians have reservations about the pay-for-performance concept. Dr. John Nelson, an American Medical Association trustee and panelist at the AACE meeting, said Medicare's pay-for-performance program would be a great opportunity for physicians to serve patients, but only "if it improves quality, if it's voluntary, and if the data are accurate, clinically meaningful, and relevant."

However, another panelist had other ideas. Twila J. Brase, president of the Citizens' Council on Health Care, a St. Paul, Minn., group that advocates competition in health care, said that pay for performance was based on what she called the "faulty premise" of evidence-based medicine. While the original idea behind evidence-based medicine was good, "it is being perverted to allow rationing of care," she said. Because of its insistence on having all physicians practice in the same way, "evidence-based medicine will make every doctor a managed care doctor. It will lead to budget-based care, not customized care."

Rather than participating in pay-for-performance programs, Ms. Brase urged physicians to stop participating in Medicare and private insurance programs and instead have patients pay cash for each visit. She called Medicare and private insurance "the real culprits" in the health care cost spiral.

"Evidence-based medicine isn't about evidence. It's not even about science. It's about control. It's meant to centralize power and control outside the exam room, and if you let pay for performance and evidence-based medicine become the standard way that you do business, the only way you'll make a decent dollar working at your profession is to follow the directives of people who don't know what they're talking about," she said to loud applause.

Dr. Haywood seemed taken aback by Ms. Brase's comments. "This is the first time I've ever been on a panel where someone advocated the abolishment of Medicare and Medicaid," he said. "It's a shock to me."

But he agreed with Ms. Brase that consumers need more information to make better health care choices. "I think we're moving more toward consumers having more decision-making capacity. … I do believe we're going to be providing information to consumers so that they can make some of those decisions, and hopefully that leads to better quality."

One audience member wanted to know how CMS would deal with patients who, for one reason or another, don't meet the outcome goals. "How will CMS deal with … that 10% of the population who, come hell or high water, will never have a [hemoglobin] A_{1c} of 6.5%, for a variety of reasons?" she said.

Dr. Haywood said that physician input would be helpful in trying to answer that question. In the meantime, he said, CMS is considering the idea that "some patients automatically are going to get excluded—excluded for noncompliance or excluded because from the standpoint of that clinician, they've reached the therapeutic goal for a variety of reasons and won't fall into the denominator for that particular measure." ■

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