

MedPAC: Doctors 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. “There’s abundant evidence that some providers do a better job than others,” he said. “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.

“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 increase the ability of physicians to assess and report on patient 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. ■

Medicare Advantage Plans Targeting Special Groups

BY MARY ELLEN SCHNEIDER
Senior Writer

WASHINGTON — Medicare managed care plans, known as Medicare Advantage, can now design targeted health plans for low-income and institutionalized patients.

“Those are the beneficiaries who have the most to gain from our health care system but only if they get help in maneuvering the complexity and putting all the different kinds of services that they need to receive together in an effective way,” said Mark McClellan, M.D., administrator for the Centers for Medicare and Medicaid Services.

Under a provision in the 2003 Medicare Modernization Act, Medicare Advantage plans can limit enrollment to beneficiaries who are dually eligible for Medicare and Medicaid, or long-term institutionalized beneficiaries.

Already health plans are starting to take advantage of the new provisions, Dr. McClellan said at a meeting on Medicare and

Medicaid sponsored by America’s Health Insurance Plans.

This new option is a key way for Medicare, which was designed to care for acute problems, to begin addressing the increasing needs of low-income and frail seniors, said Patricia Smith, director of the Medicare Advantage Group at CMS.

“It’s a baby step for the program, but it’s a very important one,” she said.

CMS has issued interim guidance on special needs plans for “dual eligible” and institutionalized beneficiaries and is preparing a final regulation on the special needs plans, said Danielle Moon, director of the division of enrollment and eligibility policy at the CMS Center for Beneficiary Choices.

Under interim guidance released by CMS, health plans have to offer the specialty plan to the entire group of dual eligibles, instead of targeting a subset of that group. Plans can’t just target the Qualified Medicare Beneficiaries or the Special Low-income Medicare Beneficiaries, Ms. Moon said. ■

POLICY & PRACTICE

Autism Education Costs High

The cost of educating children with autism is almost triple that of educating children who receive no special education services, according to a report from the Government Accountability Office. The GAO reviewed data from the Special Education Expenditure Project funded by the Department of Education and found that the average cost of educating a child with autism—\$18,000 in the 1999-2000 school year—“was among the highest per-pupil expenditures for school-age children receiving special education services in public schools.” The report also noted that the number of autistic children given special education services increased by more than 500% in the last decade. Rep. Diane Watson (D-Calif.), who co-commissioned the report, said “that better diagnosis and a broader definition of autism may in part explain the substantial increase in autistic children. However, I believe that further studies should be undertaken of other risk factors, including the correlation between mercury-containing vaccines and higher rates of autism.”

More Drug Treatment Courts Urged

The federal government should spend \$30.5 million to increase the number of drug treatment courts nationwide, according to John P. Walters, director of the Office of National Drug Control Policy. “Drug treatment courts... are an effective way of reducing the drug problem in America,” Mr. Walters said in a statement accompanying the release of President Bush’s 2005 National Drug Control Strategy. He quoted research showing that, of 17,000 drug program graduates nationwide, only 16.4% had been rearrested and charged with a felony in the first year. “By giving judges the power to refer people to treatment we reduce criminal recidivism, save taxpayer money, and heal those who have become enslaved by drug addiction.” The 1,600 drug courts now operating in the United States emphasize treatment and frequent monitoring instead of prison time.

Groups Push Nondiscrimination Bill

A coalition of mental health groups is lobbying for the passage of the Medicare Mental Health Copayment Equity Act, which would mandate that copayments for mental health services be the same as those for other health services. Currently, there is a 50% copay for mental health services, compared with a 20% copay for most other health care services. “This is discrimination, plain and simple,” James H. Scully Jr., M.D., medical director of the American Psychiatric Association, said in a statement. “Passage of this legislation is long overdue.” The bill’s chief sponsors are Rep. Ted Strickland (D-Ohio) and Rep. Tim Murphy (R-Pa.). Other groups supporting the legislation include the American Association for Geriatric Psychiatry and the National Alliance for the Mentally Ill.

Paxil Distribution Halted

The Food and Drug Administration halted distribution of Paxil CR (paroxetine controlled release), an antidepressant made by GlaxoSmithKline, in early March. The agency cited “ongoing concerns about manufacturing quality” but said it did not believe the drug posed significant harm to consumers. During an inspection, the FDA found that “the Paxil CR tablets could split apart and that patients could receive a portion of the tablets that lacks any active ingredient, or alternatively a portion that contains active ingredient and does not have the intended controlled-release effect.” GlaxoSmithKline said in a statement that it agreed the drug posed no immediate threat and urged patients taking the drug to speak with their physicians if they had questions. The company said it was working to resolve the problems as quickly as possible.

Views on Assisted Suicide

More than half of physicians responding to a national survey said that they believe it’s ethical to assist a patient in committing suicide. Approximately 57% of the 1,000 physicians said it was ethical, while 39% said it was unethical. The survey was conducted by HCD Research, a marketing and communications research company, and the Louis Finkelstein Institute for Social and Religious Research. In addition, 41% of the physicians surveyed would endorse the legalization of physician-assisted suicide under a wide variety of circumstances, while 30% support its legalization in a few cases and 29% oppose any legalization. Although many physicians support physician-assisted suicide as a public policy, the results were mixed when it came to personally participating in an assisted suicide. About 46% said they would not assist a patient for any reason, 34% would assist a patient in a few cases, and 20% would assist under a wide variety of circumstances.

Conflict-of-Interest Rules Targeted

People with direct financial conflicts of interest should not be put on Food and Drug Administration advisory committees, a coalition of public interest groups has recommended. Financial conflicts undermine “the public’s faith in the fairness and credibility of the panel’s work,” the Center for Science in the Public Interest, the National Women’s Health Network, the U.S. Cochrane Center Consumer Coalition, and eight other groups said in a letter to Acting FDA Commissioner Lester Crawford, D.V.M., Ph.D. The groups cited the FDA advisory committees that recently reviewed the safety of cyclooxygenase-2 inhibitors, noting that 10 of the 32 members had direct financial conflicts. In addition to prohibiting scientists, physicians, and clinicians with relevant conflicts of interest from serving on advisory committees, the groups also recommended that people with any industry ties make up no more than half of a committee.

—Joyce Frieden