CMS Taking Pay for Performance Seriously

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WASHINGTON — The Centers for Medicare and Medicaid Services is experimenting with "pay-for-performance" programs, and observers say it looks as if the agency is really serious about it this time.

"This is not the first time that CMS has come around saying they wanted to pay for performance," Denis Cortese, M.D., said at a health care congress sponsored by the Wall Street Journal and CNBC. "It's the third time that we've been involved in that in 10 years. The other two faded away. This one looks real . . . and I think Congress is interested in seeing something happen. [But] whether they'll put additional money on the table to make it work has yet to be seen."

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Earlier at the same meeting, CMS administrator Mark McClellan, M.D., announced that the agency was implementing its pilot pay-for-performance project. Under the project, 10 large physician group practices will be rewarded by the agency for improving outcomes among Medicare beneficiaries.

The physicians will continue to be paid on a fee-for-service basis as usual, but CMS also will make additional payments based on quality and outcome measures for patients with chronic illnesses such as congestive heart failure, coronary artery disease, diabetes, and hypertension. The agency also will look at the practices' use of preventive services such as influenza and pneumococcal vaccinations, as well as the prevention of complications in patients with chronic illnesses.

Dr. McClellan emphasized that he was not suggesting that physician spending was a major cost problem for Medicare.

"Physicians account for a small fraction of total costs, but doctors have a lot of good ideas and they have the knowledge it takes to get more results for what we actually spend," he said. "I think [pay-for-performance] can potentially save significant amounts of money. At the same time, we're also going to be paying attention to clinical quality, so for diabetic patients, we'll be looking at hemoglobin A_{1c} levels and other well-validated measures of quality. Those will be included along with financial performance measures."

Dr. Cortese, president and CEO, Mayo Clinic, Rochester, Minn, expressed some skepticism about the way pay-for-performance will be implemented. "I noticed that performance was defined as reducing costs," he said. "I was tempted to ask, 'What happens if the quality goes up and the cost goes up with it?' If the value rises higher than cost, are they really going to pay for it? I don't believe they will."

Other groups also offered mixed reactions. Robert Doherty, senior vice president for governmental affairs and public policy for the American College of Physicians, said CMS should be commended on its efforts to test physician performance and provide a model to improve care of chronic disease.

The problem is that some of these demonstration projects are limited in scope, he said during a press briefing to release the ACP's 2005 policy framework. For example, the new physician group practice demonstration project "puts all of its eggs" in one basket by focusing solely on large group practices, he said. ACP is advocating that Congress authorize a pilot test of a new model for improving the care of patients with chronic diseases in small and medium-sized practices, where patients with chronic diseases would be encouraged to select a physician as their medical "home."

The Medicare Modernization Act of 2003 authorized a performance-based demonstration project for small physician practices, although the project is limited to just a few hundred practices in four states. "Expanding the program will give CMS a much larger universe of experience and evidence on how to tailor physician incentive programs to be most effective," Mr. Doherty said.

Physicians are not the only recipients of Medicare funds to be affected by the move toward pay-for-performance programs. CMS also is changing to performance-based incentives for its claims processors, beginning in fiscal 2005. The agency also plans to reduce the number of processors from 51 to 23 and have all contractors processing both Part A and Part B claims. ■

Jennifer Silverman, Associate Editor, Practice Trends, contributed to this report.

Comments Due on Pain Med Regs

Interested parties have until March 21 to comment on an interim policy statement on dispensing controlled substances for pain. A Federal Register statement outlines several inaccuracies that were included in an August 2004 "frequently asked questions" document that appeared on the Drug Enforcement Administration Web site. The statement also notes that the DEA plans to publish a document "aimed at providing guidance and reassurance to physicians who engage in legitimate pain treatment while deterring the unlawful conduct of a small number of physicians" Information on submitting comments can be found in a Federal Register notice published on Jan. 18; that notice is online at www.access.gpo.gov/su_docs/fedreg/a050118c.html .

— Joyce Frieden

POLICY & PRACTICE

Hey Medicare: Drugs Aren't Cheap

The 10-year estimate for the coming Medicare Part D prescription drug benefit continues to grow. President Bush's 2006 budget request for the Department of Health and Human Services indicated the cost would total nearly $1.2 trillion by 2015. Yet, if the reduced spending on drug coverage under Medicaid is factored in, the total for the new benefit is $724 billion, Mark McClellan, M.D., administrator of the Centers for Medicare and Medicaid Services, told reporters. The Congressional Budget Office estimates that the cost will be slightly higher—$798 billion. Another CBO update of this projection is expected this month.

Fiscal 2006 Budget Request

The president's 2006 budget request got mixed reviews from health care groups. Although some groups objected to a lack of appropriate funding for health professions programs, others decried the $60 billion in proposed cuts to Medicaid over the next 10 years. The Association of American Medical Colleges is opposed to cuts "that will further stretch the already taut health care safety net provided by teaching hospitals and medical school physicians," Jordan Cohen, AAMC president, said in a statement. Although pleased with a $300 million boost for community health centers, Daniel Hawkins of the National Association of Community Health Centers noted that proposed cuts to Medicaid and the National Health Service Corps presented a funding conflict. Not everyone was unhappy with the budget: The American Medical Association praised the budget's efforts to fund tax credit initiatives and expand health savings accounts.

States Meet Their Match

States have been known to recycle payments returned by health care providers, using them to draw down additional federal dollars for Medicaid—and the feds are tired of it. The administration's budget request seeks to curb such tactics, by only matching those funds kept by health care providers as payment for services. Current law also allows states to make Medicaid payments to health care providers that are far in excess of the actual cost of services. According the president's budget request, states use this additional money to leverage federal reimbursements in excess of their Medicaid matching rate or for other purposes. To halt this misuse of funds, the government proposes to limit reimbursement levels to no more than the cost of providing services. Both proposals are expected to save $5.9 billion over 5 years. "None of these efforts should affect the way physicians get paid under Medicaid," Department of Health and Human Services spokesman Bill Pierce said in an interview.

Controversial Retiree Benefits

AARP is rejoicing now that a federal judge has temporarily blocked a new rule from the Equal Employment Opportunity Commission (EEOC) regarding retiree health benefits, but some members of Congress are not. The rule, which the commission approved last April, exempts employers from age discrimination laws when it comes to designing retiree health benefits. The EEOC says the rule is designed to enable employers to better coordinate retiree benefits with Medicare, but AARP says the rule simply makes it easier for employers to reduce health benefits for older retirees, or abandon them altogether. EEOC chair Cari Dominguez said that "any delay in implementing the rule endangers vital protections for retirees." Rep. John Boehner (R-Ohio), chairman of the House Committee on Education and the Workforce, issued a statement saying that "if the AARP is successful with its lawsuit, it will surely cause more workers to lose their retiree health coverage." The judge's action, issued in early February, prevents the rule from being implemented for at least 60 days.

Proposed Wheelchair Rules Issued

In an effort to clarify the requirements, the Centers for Medicare and Medicaid Services has issued proposed new rules for coverage of wheelchairs for Medicare beneficiaries. Previously, coverage was given to patients who were "nonambulatory" or "bed or chair confined." Under the proposed rules, providers must state whether the patient "has a mobility limitation that prevents him or her from performing one or more mobility-related activities of daily living." The agency also plans to require a face-to-face meeting between the provider and the patient before a scooter or wheelchair can be ordered. Fraud has been an issue for CMS lately regarding power wheelchair coverage: The agency launched Operation Wheeler Dealer in late 2003 after finding that expenditures for power wheelchairs had increased 450% over a 4-year period.

A Level Playing Field for Hospitals

The Bush administration plans to refine the inpatient hospital payment system "to ensure a more level playing field between specialty and nonspecialty hospitals," the president announced in his fiscal year 2006 budget request for HHS. The Medicare Payment Advisory Commission has reported that specialty hospitals tend to treat relatively lower-severity patients within them, and lower shares of Medicaid patients. Yet "it's unclear what the effect of these specialty hospitals will be," Aaron Krupp, senior counsel with the Medical Group Management Association, said. "One thing MedPAC didn't look at was the quality of services for specialty versus regular hospitals. That angle would be informative," said Mr. Krupp, whose organization supports a free market system. "We are going to have a lot more to say on specialty hospitals in the coming months," when HHS releases its own report, Mark McClellan, M.D., CMS administrator, recently told reporters.

—Jennifer Silverman