MedPAC: Physicians Ready For Pay for Performance

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

In light of 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, Ms. Milgate pointed out.

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.

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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.

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. ■

POLICY & PRACTICE

More Talk, Fewer Errors

Most physicians have witnessed medical mistakes—but few are willing to talk about it, results of a study of more than 1,700 physicians, nurses, and clinical care staff indicated. Specifically, 84% of physicians and 62% of nurses and other clinical care providers have seen coworkers taking shortcuts that could be dangerous to patients, and 88% of physicians work with people who show poor clinical judgment. Yet fewer than 10% of providers address problem behavior by colleagues, which routinely includes trouble following directions, poor clinical judgment, or taking dangerous shortcuts. The study was cosponsored by the American Association of Critical-Care Nurses (AACN), and VitalSmarts, a company that specializes in organizational performance and leadership training. "The truth is we must build environments that support and demand greater candor among staff if we are to make a demonstrable impact on patient safety," AACN President Kathy McCauley, R.N., said in a statement.

Get Sick, Go Bankrupt

It doesn't pay to get sick: Medical problems contributed to about half of all bankruptcies involving 700,000 households in 2001, according to a study published as a Web-exclusive article by the journal Health Affairs. More than 2 million people are directly affected by medical bankruptcies annually. "When medical debts and lost income from illnesses leave families facing a mountain of bills, bankruptcy is their last chance to stop the collection calls and try to put their lives back on track," said study coauthor Elizabeth Warren, the Leo Gottlieb, Professor of Law at Harvard University, Boston. Most who have been bankrupted by medical problems had health insurance. Among those with private insurance, one-third had lost coverage at least temporarily by the time they filed for bankruptcy. The researchers obtained their information by surveying 1,771 bankruptcy filers and reviewing their court records.

Health Savings Accounts = Debt?

Nearly half of all insured adults who have a high deductible health plan have medical bill problems or debts, compared with less than one-third of those with lower-deductible plans, according to a study from the Commonwealth Fund. "Health savings accounts (HSAs) coupled with high deductible health plans have potential pitfalls, especially for families with low incomes or individuals with chronic health conditions, who are at greater risk of accruing burdensome medical debts and facing barriers to needed health care," said Commonwealth President Karen Davis. Individuals with high-deductible plans also struggle with access problems, such as not filling a prescription, or skipping a medical test or treatment, due to cost. To prevent medical access problems and debt, Ms. Davis suggested some legislative fixes for HSAs, such as reducing deductibles for lower-income families and requiring provider discounts for uninsured, low-income families.

New HHS Chief and Medicaid

Medicaid reform will be high on the agenda for new Health and Human Services Secretary Michael O. Leavitt. "Medicaid is not meeting its potential," Mr. Leavitt, former governor of Utah and former head of the Environmental Protection Agency, said at health care congress sponsored by the Wall Street Journal and CNBC. "It's rigid, inflexible, inefficient, and, worse yet, not financially sustainable. We need to have a serious conversation about Medicaid." Among the ideas he's considering are negotiating reductions in the prices Medicaid pays for prescription drugs and closing loopholes relating to coverage for long-term care. He also wants to stop states from manipulating Medicaid rules to garner federal matching funds. President Bush in the meantime focused on medical liability reform and health savings accounts in his State of the Union address, asking Congress to move forward on tax credits to help low-income workers buy insurance, and on establishing community health centers in impoverished counties.

Older Patients and the Internet

Online health information has the potential to become an important resource for seniors "but it's not there yet," the Kaiser Family Foundation reported in a survey of 1,450 adults aged 50 and older. Of the 583 respondents aged 65 and older, less than a third had ever gone online. But more than two-thirds of the next generation of seniors (50-64 years) has done so, indicating that online resources may soon play a much larger role among older Americans. Seniors whose annual household income is under $20,000 a year are much less likely to have gone online (15%) as opposed to those with incomes of $50,000 or more (65%). "We know that the Internet can be a great health tool for seniors, but the majority are lower-income, less well-educated, and not online," said Drew Altman, the foundation's president and chief executive officer.

Projects Take on Health Disparities

The American Medical Association has teamed up with the National Medical Association and the National Hispanic Medical Association to create a commission on disparities in medical care. The commission has established four committees to examine the health care system and work to improve patient care. Two projects are underway: a survey of physicians about health care disparities and the factors causing them, and a promotion of selected training programs that use case study work, self-assessment activities, and video vignettes to increase physicians' cultural competency. More information on the commission is available at www.ama-assn.org/go/healthdisparities.

—Jennifer Silverman