MedPAC Attempting to Measure Quality of Care

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WASHINGTON — Researchers with the Medicare Payment Advisory Commission are measuring the quality of care delivered by physicians as part of an overall analysis of physician resource use.

"We hope to look at variation in quality performance, to do this across conditions, regions, and to some extent across specialties," Karen Milgate, a research director for the commission (MedPAC), said at a recent commission meeting. "We also hope to identify any gaps in quality measurement development that we can."

The ongoing research supports the commission's long-term goal of identifying more "efficient" providers, as a tool to encourage greater efficiency in care.

Variation in resource use may include cost of a service, types of services provided, or types of specialists that patients see, Ms. Milgate said in an interview. It could also mean variation in resource use across regions. Using preliminary computer models, MedPAC researchers found variation in the cost of certain conditions.

For example, treatment of end-stage renal disease is fairly well defined, as the patient either requires long-term dialysis or a kidney transplant. For that reason, average versus median costs for end-stage renal disease episodes don't vary that much, said MedPAC researcher Niall Brennan.

Significantly more variation in cost was seen in the care of hypertension, diabetes, and heart failure. In areas where there is tremendous variation in resource use, "we might want to [see] if there are any guidelines in those areas that would better help us understand appropriate resource use levels," Ms. Milgate said.

MedPAC could identify conditions with variation in resource use where there might also be high variation in quality, Ms. Milgate said. Those might become priority areas for coordination of care.

Researchers are hoping to address questions such as "how do you attribute the care of a particular beneficiary to a specific physician?" she said. The minimum number of cases needed to get a reliable measurement, and who you actually compare a physician's performance with, are other considerations, Ms. Milgate said. "What other physicians see similar patients to that physician?"

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Ms. Milgate clarified that these claims-based measures would not necessarily be used in a pay-for-performance system.

"That's a pretty easy decision because we don't have that information" yet, she said. Researchers are planning to base this analysis on currently available information: claims data.

More than 35 indicators on conditions important to Medicare will be used to measure quality, Ms. Milgate said. "Most of them are primarily what we've talked about before as process measures. For example, for beneficiaries with coronary artery disease, did they have an annual lipid profile?" Outcomes measures would also be used. For example, for beneficiaries with diabetes, what proportion of them ended up in the hospital with short- or long-term complications that were related to their diabetic conditions, she said.

MedPAC earlier this year advised the Department of Health and Human Services to test different types of provider payment differentials, which would essentially offer monetary rewards—bonuses, for example—for meeting certain goals on health care quality.

MedPAC Chair Glenn M. Hackbarth, J.D., said he hoped that Congress was prepared to move ahead with pay-for-performance legislation. Several bills are pending to link relief from the sustainable growth rate formula to the implementation of a pay-for-performance system for physicians, he said.

"Obviously we support both ends of that bargain. We have argued that in order to assure access to quality of care, there does need to be some relief from the SGR. But at the same time, we think that it should be not just more money into the existing system, but one that consistently, in a more focused way, rewards good practice and quality of care." ■