

PAY-FOR-PERFORMANCE

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Introduction

Pay-for-performance (P4P) is a payment system model predicated on rewarding physicians, hospitals, medical groups, and other healthcare providers for meeting certain performance measures for quality and efficiency. Also known as “value-based purchasing,” several factors in the rapidly changing health care environment have recently brought P4P to the forefront of health policy discussions. This position statement outlines The Endocrine Society’s position related to the implementation of a P4P system within Medicare. Specifically, the Society is concerned about the potential negative impact of a P4P system on patients and the physicians who care for them. Therefore, it is critical that any national P4P system address these concerns.

Background

Managed care and private sector insurance programs began implementing P4P initiatives in the early 1980s to control costs and increase efficiency through incentive programs to providers. In the past few years, there has been a focus on perceived gaps in the quality of healthcare, steadily rising costs, disparate access to health services, and concerns regarding supposed overuse, underuse, and misuse of services. Furthermore, there has been a recent consumer-driven trend where patients are demanding more data to enable them to make informed decisions about care. Finally, reports such as the Institute of Medicine’s 1999 report, which estimated that nearly 98,000 Americans die annually as a result of avoidable patient safety errors¹, highlighted these perceived deficiencies. There has been an ever-increasing focus on the need to adhere to best practices of care and to implement accountability in the practice of medicine.

Further motivating the P4P movement is the push by some members of Congress for a far-reaching pay-for-performance system. These Members have vowed not to fix the flawed Medicare payment formula without implementing some type of P4P model. The current formula for determining physician reimbursement under the federal Medicare program, based on the sustainable growth rate (SGR), fails to keep up with annual increases in costs of practice. As a result, for the last several years, the Centers for Medicare and Medicaid Services’ (CMS) annual Medicare Physician Fee Schedule update have included across-the-board cuts in physician Medicare reimbursements. In the last few years, Congress has stepped in to offer a temporary legislative fix, averting negative updates and either replacing them with

incremental positive updates or freezing current year rates. It is becoming clear that future congressional action to fix the current payment system will be contingent upon implementation of P4P components within the Medicare program. In fact, Congress and the CMS have already begun codifying a P4P system and implementing voluntary programs.

Considerations

A pay-for-performance infrastructure is contingent upon the development of evidence-based performance measures—a task that has proven challenging. To date, several groups are working to develop and test measures for implementation. However, it is difficult to develop standardized measures across medical specialties. In addition, developed measures must be tested, which can be tedious, time-consuming, and expensive. A proper infrastructure is critical to ensure appropriate and systematic data collection of data from practices, as well as protect patient privacy.

Proposals from Congress and government agencies have attempted to link P4P initiatives with existing Medicare reimbursement streams. Several medical groups believe that full P4P implementation is only possible with the repeal of the current Medicare physician payment formula that is based on the SGR, replacing it with a new formula that reflects increases in medical practice costs.

Positions

The Endocrine Society has taken the following positions on any pay-for-performance system that may be implemented in the future.

Development of valid performance measures

Any pay-for-performance or “value-based purchasing” program must take into consideration the unique needs of the wide range of specialists and the patients they treat. The Society encourages the Administration (CMS) and Congress to work with stakeholders to fairly and appropriately select or develop quality measures, as well as implement systems for collecting and analyzing performance data. Evidence-based performance measures must be developed in a transparent process by the medical specialties and be validated through a consensus-based organization involving multiple stakeholders. Furthermore, variations must be allowed to meet the unique needs of an individual patient based on the physician’s clinical judgment.

Linking P4P to changes in physician payment system

The Society also understands that the medical community is at a critical juncture with regard to the Medicare program and reimbursement mechanisms and encourages replacement of the current Medicare physician payment formula with a more equitable and appropriate system. Any P4P program will not work under the current SGR payment formula. The two are inconsistent methodologies, and the Society believes that the SGR must be repealed if P4P is to be successfully implemented.

Data collection issues

The Society maintains that data collection requirements intrinsic to P4P programs should not place financial or administrative burdens on providers. Any unintended or negative impacts on patient care associated with these requirements or additional burdens should be minimized.

Protection for small practices

Many clinician members of the Society operate within small endocrine practices, which may not have the resources (staff, technology, infrastructure, etc.) to comply with the reporting requirements of P4P programs. Furthermore, some small practices care for underserved beneficiary populations and rely on flexibility to provide optimum health services to patients. The Society is concerned that such practices may be penalized unfairly as a result of their size, patient portfolios, and ability to comply with new, more rigorous regulations. Along the same lines, many practices do not currently possess the hardware or technology necessary to collect and report performance and quality measures. The Society is concerned that endocrine practices (particularly small practices) will face even further financial hardships to finance new infrastructure tools to participate in a national P4P program. The Society views the appropriate funding of this equipment and technology as an unanswered, crucial question for P4P program development.

Coordination of care

Endocrinologists often function in an environment where several medical specialties, as part of an overall team of health care providers, are necessary for the complete delivery of patient care. Further, the care an endocrinologist provides often overlaps with that of other specialties. P4P programs must take into account patients' outcomes that rely on multi-

disciplinary approaches and reflect the work of each contributing specialist—holding each provider accountable for his/her performance.

Adjustment for complex patients

Any P4P program must take into account the impact of patient non-compliance. Successful treatment and care of patients with endocrine disorders is often dependent on patient compliance to prescribed and recommended regimens, as well as follow-up activities. Protections must be in place so that otherwise excellent physicians do not receive “low performance” results due to patients who do not comply with treatment regimens.

Similarly, patients who exhibit nonspecific combinations of symptoms are often referred to endocrinologists by other physicians for evaluation to determine if the symptoms are hormone-related. These evaluations can be complex, time-consuming, and costly. Ultimately, an endocrinologist may conclude that no endocrine problem exists, and no treatment can be recommended. Physicians should not be penalized for being asked to rule out metabolic/endocrine causes, even when the workup is negative.

In addition, many endocrinology patients suffer from advanced diseases or complex co-morbidities with no easily measurable outcome. Performance measures must be able to account for these complex cases and also for accompanying patient education, adjustment of medication, and regular monitoring that is necessary for such patients.

¹ Institute of Medicine. To Err is Human: Building A Safer Health System. 1999.