Talking points on current Medicare payment reform proposals

The House Committee on Energy and Commerce has released draft legislation replacing the SGR with a new fee-for-service system with updates based, in part, on quality reporting and participation in clinical quality improvement activities. The system would also allow physicians to opt out by participating in medical homes, ACOs, or other approved alternative payment methodologies.

This draft proposal is based loosely on a joint outline produced by the committee and the Committee on Ways and Means.

Based on these proposals, we offer the following observations:

FIVE YEARS OF STATUTORY UPDATES

The initial period of stability should be for five years and provide positive updates that track the increases in the cost of caring for Medicare beneficiaries. This time period is critical so that physicians may make the investments and infrastructure improvements in their practices that will allow them to succeed under the new system.

CONSIDER IMPROVING THE CURRENT QUALITY REPORTING SYSTEM RATHER THAN STARTING FROM SCRATCH

Rather than create an entirely new quality reporting system, Congress should consider making improvements to the current Physician Quality Reporting System (PQRS). While this system requires developing additional measures so that all physicians have meaningful measures on which they can report, it is familiar to most physicians and the basic architecture is already in place.

ALLOW ALTERNATIVE WAYS TO REPORT

In addition to traditional methods of reporting, physicians should also be able to report through EHRs or clinical data registries.

MEASURE PERFORMANCE AGAINST THRESHOLDS RATHER THAN PEER-TO-PEER

Performance measurement under a new or improved reporting system should be against a previously established threshold and not peer-to-peer. Peer-to-peer measurements might tend to discourage the sharing of best practices and stifle cooperation among competing physicians. Additionally, peer-to-peer comparisons for the purpose of payment are fraught with technical challenges such as risk adjustment, attribution, sample size, and data validity. Benchmarks should be established in a transparent public process using existing Medicare data. Physicians who fail to attain the benchmark should also be measured for improvement from previous performance periods.
TIMELY AND MEANINGFUL DATA IS THE KEY TO SUCCESS

Congress and CMS must also make significant improvements in providing feedback to physicians on their progress toward reaching benchmarks. Currently PQRS results are provided well after the performance period is concluded leaving physicians little opportunity to improve performance. Timely and meaningful feedback should be provided quarterly so that physicians can track their performance and make the adjustments necessary to meet the benchmark. Physician payments should not be put at risk if CMS cannot provide timely and meaningful data to physicians.

ALTERNATIVES TO MEASURE REPORTING SHOULD BE INCLUDED

Since many specialties do not have adequate performance measures or the measures that are in place address areas where there is little room for improvement, other options should be available for physicians to satisfy reporting requirements beyond measures. These should include participation in qualified clinical data registries, Regional Health Care Collaboratives, board certification, QIO participation, or other clinical quality improvement activities such as utilization of appropriateness criteria or clinical decision support tools.

INCENTIVES SHOULD BE POSITIVE AND IN ADDITION TO BASE PAYMENT

All physicians should be eligible for regular updates of the base payment for Medicare services. The legislation must include a method for regularly updating base payment amounts that is related to the growth in the cost of caring for Medicare beneficiaries. Incentives for achievement of quality improvement goals or activities should be in addition to the base amount.

ENCOURAGE ALTERNATIVE PAYMENT MODELS

The committees should focus heavily on encouraging the development of alternative payment methodologies. Methodologies that allow physicians to provide higher quality care and to share in the resulting system wide savings will encourage them to move into these models.