Part B Insider (Multispecialty) Coding Alert

Pay for Performance: AARP Comes Out In Favor Of Pay-For-Performance Bill

Collect quality data in 2007 if legislation passes

The powerful **American Association for Retired Persons** has come out in support of pay-for-performance (P4P) legislation. If overwhelming support in the House and Senate wasn't enough to guarantee passage of a P4P bill, then the AARP's boost could seal the deal.

Senate Finance Committee Chairman **Chuck Grassley** (R-IA) introduced the "Medicare Value Purchasing (MVP) Act of 2005" with co-sponsor Sen. **Max Baucus** (D-MT). "This bill creates the financial incentives that reward those providers who deliver that quality care today, and to those who make improvements where they are needed," Grassley said on the Senate floor.

The Grassley-Baucus bill is "an idea whose time has come," said **John Rother**, the AARP's executive officer for policy and strategy. Using payment incentives to improve performance will spell better care for older and disabled Americans, he added.

In 2007, the Grassley-Baucus bill would give the full payment amount only to physicians who report quality data, while the rest would receive a 2 percent cut. And the **Department of Health and Human Services** would make that data available to the public, but not before physicians had a chance to view and correct the data about them. The Secretary of HHS may make exceptions to the data-sharing rule based on the size or specialty of practices.

The Grassley-Baucus bill would skim 1 percent off the conversion factor for all physician payments in 2008, and that would rise by .25 percent per year until it reached 2.0 percent in 2012 and succeeding years. That money would go to reward providers who meet a standard established by the HHS Secretary; or show substantial improvement over the previous year, according to a standard established by the HHS Secretary.

The bill provides for the percentage of payments available for P4P to increase in 2009 and subsequent years. Quality measures should be evidence-based, vary according to physician specialty and practice size, include measures of overuse and under use, include measures relevant to rural areas, and address the frail elderly and those with chronic conditions.

The Secretary also would start creating reports on physician quality, but the reports for 2006 and 2007 would be confidential. And the Secretary would provide each physician and practitioner with a detailed report in early 2008 on how that provider would have fared if the quality incentives had been in place for 2007.

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