# Part B Insider (Multispecialty) Coding Alert

## Pay For Performance: Brace Yourself For Quality-Based Payments

**But diverse specialties may doom program**

Chances are strong that policymakers will try to push through pay-for-performance - and the result could mean you lose pay while some other physician puts on a show.

The **Medicare Payment Advisory Commission** (MedPAC) seems to be prepared to recommend a sweeping program to reward physician quality in its March 2005 report. The panel won't vote until next month, but the Commissioners agreed at their Dec. 9 meeting that it seems feasible to report quality data without burdening physicians too much.

At least at first, pay for performance (P4P) data would come from extra clinical data on claim forms. Your pay would be reduced by a small amount, 1 or 2 percent, to set aside some money to reward physicians who scored high on particular measures. The amount of payments should grow over time, the Commissioners agreed. But keeping aside a pool of money to redistribute for P4P while also updating overall payments could ensnare Congress in some tricky math problems, they noted.

In January, the panel is likely to vote on recommendations that would probably include requiring providers that perform lab tests to report test results on claim forms separately, and collecting enough prescription data from the new drug benefit to assess the quality of physicians' care.

Some Commissioners, including Vice Chair **Robert Reischauer**, said asking Congress to implement P4P for the physician sector overall was probably too broad an initiative. The different physician specialties are so diverse that the Commission couldn't recommend which specific quality measures would be best for each group of doctors without more study.

If everyone doesn't have an equal chance to succeed, the government will find it's created an intolerable situation in P4P that providers ultimately will reject, suggested commissioner **William Scanlon**.

**'Whole Hospital' Exception Under Fire**

MedPAC also seems poised to recommend that Congress get rid of a big loophole in the laws that prevent physicians from sending their patients to facilities in which they have a financial interest.

The "whole hospital" exception was based on the theory that a single physician could not possibly refer enough patients to significantly affect the profitability of his or her interest in an entire general hospital, but it has had the unforeseen consequence of facilitating the rise of physician-owned "specialty" hospitals that focus on a single area such as coronary procedures or orthopedics.

Backers describe these facilities as "focused factories" that provide more cost-effective care for patients and a better environment for physicians, but critics say specialty hospitals skim the most profitable patients from struggling general hospitals. The Medicare Modernization Act placed an 18-month moratorium on the development of new physician-owned specialty hospitals.

Eliminating the whole hospital exception would essentially make this moratorium permanent, but the draft recommendations presented by MedPAC staff would grandfather in existing physician-owned specialty hospitals. The recommendations would also allow "gain-sharing" arrangements, in which physicians and hospitals share gains stemming from more cost-effective treatment, subject to safeguards to be developed by the **Department of Health**

**and Human Services**.

The draft recommendations also include some modifications to Medicare's diagnostic-related groups that critics say would reduce specialty hospitals' ability to exploit differences in profitability within and across DRGs.