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Part B Insider (Multispecialty) Coding Alert

REIMBURSEMENT: Should Your Physicians Receive Rewards For Decreasing Hospital Spending?

'Pay For Performance' incompatible with physician pay limits

When physicians do a good job taking care of patients, Medicare spends less on hospital care - but doctors never see any of those savings.

That could change if the **Practicing Physicians Advisory Council** has its way. PPAC passed a resolution at its May 23 meeting calling on Medicare to transfer savings on the hospital side due to physician efficiency over to the physician side.

This would be tricky to determine, but Medicare could do it by choosing an indicator and measuring it against a large enough control group, says Albuquerque, NM oncologist **Barbara McAneny**, a PPAC member who proposed the resolution. Example: For diabetic patients, Medicare could look at their Hemoglobin A1C levels or the frequency of hospitalizations for ketoacidosis, blindness, cataracts or amputations.

Hospitals automatically receive an update to their spending without the tight controls that constrain physicians, McAneny notes, and hospital spending is "not correlated with the physician side." But physicians often have to provide more care to keep patients out of the hospital.

P4P (Pay for performance) plans tend to assume that physicians aren't providing enough services already, says Santa Monica, CA thoracic and cardiovascular surgeon **William Plested**, also a PPAC member. "What you have done is increased costs on the short term because you have people going to the doctor more often," which in turn triggers steep cuts, notes Plested. P4P is incompatible with the sustainable growth rate (SGR) formula that governs physician spending, he concludes.

P4P will penalize physicians who practice in areas where all their patients have worse diets or other indicators, complains McAneny. It also assumes that one physician can take all the credit for a particular patient doing well or badly.

Another P4P problem: the performance measures don't apply to all doctors, so Medicare could end up reducing payments for all physicians and then paying out rewards to physicians who happen to see a lot of diabetic patients and meet a particular standard, notes Plested. And if P4P is based on adopting information technology, it'll reward the largest institutional practices over smaller physicians.

PPAC also approved McAneny's recommendation that CMS consider all the costs of the recovery audit contractors (RAC) project, including physicians' costs defending themselves against the audits. "If they spend $50 investigating and I spend $50 defending it, and they decide that CMS should get $10 back, we've spent $100 to move $10," complains McAneny.

Another McAneny resolution also passed PPAC: one asking CMS to publish an interim final rule on the Part B drug Competitive Acquisition Program instead of just a final rule. Doctors need more opportunity to comment on the proposal, which would require them to earmark a particular dose of a drug for a particular patient on a particular date.

McAneny says that's not realistic because often patients will have to reschedule, or will need more tests. And sometimes a particular dose comes in with a broken seal and needs to be sent back, but a patient still needs to receive treatment on schedule. "About 30 percent of the time on any chemotherapy schedule, you'll switch therapies on people," she notes.

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Also, McAneny sometimes waives copayments for chemotherapy patients, something she doubts the private companies providing drugs under the new program would be willing to do.

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