Pay for Performance

KATHY HANSEN, DON LAVANTY

In today's climate of focus on the healthcare consumer, much attention is being paid to improving patient safety and quality of care. There is heightened interest in distinguishing healthcare providers who are "good performers", who provide safe and efficient care from poorer performers whose outcomes may not be as good. Some payers feel that one way to encourage performance improvement is to pay good performers better than other providers.

The Center for Medicare and Medicaid Services (CMS) began a Pay for Performance program for hospitals on a pilot basis about two years ago. Hospitals that participate in the pilot project keep statistics on a number of measures in diagnosis groups common in the Medicare population, such as acute myocardial infarction (AMI), coronary artery bypass grafts (CABG), heart failure, pneumonia, and hip and knee replacement. If hospitals achieve certain levels of compliance with the goals of the measures, they are paid 1% to 2% more than the usual DRG payment.

A few examples of the over thirty pay for performance metrics defined by CMS are:

- AMI: aspirin at arrival
- AMI: thrombolytic within 30 minutes of arrival
- AMI: percutaneous coronary intervention received within 120 minutes of arrival
- CABG: post operative hemorrhage or hematoma
- Heart failure: smoking cessation advice/counseling provided
- Pneumonia: oxygenation assessment within 24 hours
- Pneumonia: blood culture collected prior to first antibiotic assessment
- Hip and knee replacement: prophylactic antibiotic received within one hour prior to surgical incision

Washington Beat is intended to provide a timely synopsis of activity in the nation's capitol of importance to clinical laboratory practitioners. This section is coordinated jointly by Kathy Hansen, Chair of the ASCLS Government Affairs Committee, and Don Lavanty, ASCLS Legislative Counsel. Direct all inquiries to ASCLS (301) 657-2768 extension 3022; (301) 657-2909 (fax); or mail to ASCLS, 6701 Democracy Blvd., Suite 300, Bethesda MD 20814, Attention: Washington Beat.

On January 31, CMS announced that ten large physician groups across the country would participate in a three-year pilot project of pay for performance for physicians. Physicians will continue to be paid on a fee-for-service basis, but will be eligible for performance payments based on how well they improve patient outcomes and avoid costly complications. The quality measures focus on the many of the same chronic illnesses in the Medicare population as do the hospital measures, including congestive heart failure, coronary artery disease, diabetes, and hypertension, as well as preventive services such as screenings for breast and colorectal cancer, and immunization for flu and pneumonia.

Another proposal related to pay for performance for physicians surfaced in January that would have a very direct impact on the laboratory. During hearings on January 12, the Medicare Payment Advisory Commission (MedPAC) made a recommendation that CMS should require laboratories to report test results to CMS on the claim for payment. From a reading of the transcript of the proceedings of the MedPAC, it is not clear how the data would be used to evaluate physician performance, perhaps by measuring the percentage of abnormal results. In addition to using this strategy to evaluate physician performance for pay for performance, MedPAC discussion focused on the requirement as a way to encourage all providers to use information technology (electronic medical record). The electronic medical record has been a focus of the Bush administration's health policy.

Laboratorians are likely to be skeptical about the effectiveness of laboratory values alone as a measure of physician effectiveness, taken outside the context of the larger medical record. In addition, the American Clinical Laboratory Association (ACLA), the association that represents the larger national reference laboratories, has appeared before the MedPAC to raise a number of concerns about the recommendation:

- Considerable cost and effort would be required for laboratories and hospitals to reprogram computer systems to transmit test results to the billing systems to appear on claims. In most institutions, results are reported electronically and test charges are billed electronically, but there is no interface between those systems that would link results to test charges.

- The MedPAC suggests that laboratories would standardize nomenclature for tests using LOINC codes, which are more specific that CPT codes. LOINC codes are not commonly used now, and conversion would be a huge effort.
- Not all test results are numeric, and not all tests are reported with a reference range. Lengthy narratives accompany many microbiology and flow cytometry results, for example.
- Laboratory values should be interpreted in the light of other information about the patient found in the medical record.
- Last but not least, the recommendation would need to be examined in the light of HIPAA's "minimum necessary" privacy standard.

MedPAC discussed whether it might be better to recommend starting the requirement with a subset of specific test results, but in the end stayed with the recommendation that all test results be reported. It did acknowledge that the recommendation represents "…a complex undertaking" and this included a two to three year transition period for implementation.

ACLA is now briefing key congressional staff about their concerns about the MedPAC proposal. The College of American Pathologists (CAP), along with other physician groups, opposes the MedPAC's proposal to set aside 1% to 2% of physician payments to be redistributed on the basis of performance.

The MedPAC recommendations have gone to CMS, which will have to decide whether to accept them. If CMS decides to move forward, proposed regulations would be published in the Federal Register for comment. ASCLS will monitor this situation closely and register opinions and submit comments whenever appropriate. Regardless of how one views the concept of pay for performance and its potential to improve patient outcomes and patient safety, this particular proposal seems to be unreasonably burdensome for laboratories to implement, and to have limitations in the validity of the conclusions that could be drawn about physician performance from the raw laboratory data.