

NORTH AMERICAN SPINE SOCIETY

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Position Statement:

Pay-for-Performance

Background

After reviewing recommendations made by the Medicare Payment Advisory Commission (MedPAC) in early 2005, the House Ways and Means Health Subcommittee began considering a proposal to tie Medicare physician reimbursements to performance. MedPAC's recommendations call for restructuring the provider reimbursement system away from a formula-based mechanism (SGR) to aligning payments with quality. At the same time, over the last two years, the Centers for Medicare and Medicaid Services (CMS) has been coordinating demonstration projects under which Medicare provides bonuses to physicians and/or physician groups making specific improvements in the quality of care they provide to fee-for-service beneficiaries.

Congressional discussions and pending legislation have prompted response from physician groups emphasizing physician concerns that, if not properly constructed and implemented, such a pay-for-performance plan could drive physicians from the Medicare program, jeopardizing access to high-quality care for the Nation's elderly and disabled.

The interest in exploring pay-for-performance began early in 2000. The release of the Institute of Medicine reports To Err is Human: Building a Safer Health System (1999) and Crossing the Quality Chasm (2001) increased public awareness of the need for improvements in the US health care system. The reports awakened the public to patient safety and quality concerns, placing quality issues on the national agenda. In addition, Crossing the Quality Chasm openly questioned the current reimbursement system and called for a redesign of health care delivery and payment policies to reward improvements in quality of care.

In 2005, the idea of paying physicians based on their performance is one of the hottest and most openly debated topics in the health care arena. Proponents say pay-for-performance serves both patients and US health care well by increasing quality of care and reducing costs. Critics say it could drive physicians from the system and that providers should be affording patients the best possible care without incentives. CMS and select private insurers are developing and testing different ways to incentivize providers for reporting on and implementing different measures. The eventual goal is not simply to just collect data for quality improvement purposes, although it is hoped that pay-for-performance will result in improved quality; but to financially reward—or punish—physicians based on their numbers. Although the concept of pay-for-performance does not sit well with many physicians, it is wise to be prepared for full implementation of a system that incorporates pay for performance plans.

NASS supports implementation of pay-for-performance when guided by the following principles:

- 1. Performance measures must be evidence-based, not consensus-based, and scientifically sound (eg, reliable, valid).*
- 2. Measures should be clinically important in areas where improvement will have significant impact on burden of disease/illness.*
- 3. There must be adequate risk adjustment when attempting to measure performance.*
- 4. Performance measures used for physician accountability must measure performance on variables within direct control of the physician (ie, not system- or patient compliance-related or those related to patient satisfaction which may not objectively measure actual quality of care, but patient perception).*
- 5. Physician measures should be specialty or disease-specific. In addition government and other payers should work with organized medicine, specifically medical specialty societies, to develop and select performance measures.*
- 6. Data collection should be feasible, reliable and not impose undue burden on physicians or CMS. The costs of data collection, reporting and analysis must be justified by the potential for improvement in care. In addition, data collection (via electronic means) should not be financially prohibitive for those physicians serving underfunded or underserved communities.*
- 7. Pay-for-performance should not be instituted in a budget neutral environment.*
- 8. Results of demonstration projects on pay-for-performance should be evaluated and their conclusions considered in the administration of the CMS and other programs.*
- 9. Physician performance scores should be reported confidentially to physicians for quality improvement purposes, not public reporting or penalty.*
- 10. Pay-for-performance on a large scale should be phased-in, pilot tested and validated on a voluntary basis.*
- 11. Measures should be reviewed and updated, as appropriate, to reflect current clinical practice.*

Assuming the above principles are used, pay-for-performance has the potential to encourage quality improvement through implementation of evidence-based medicine.

It is at the heart of NASS' mission to advance quality spine care, and to this end, NASS will work with a broad range of public and private agencies, including governmental agencies, medical professionals and others, to ensure implementation of evidence-based performance measures to improve the quality of care for spine patients.

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