Financial incentives embedded in the US health care delivery system have the potential to influence physician behavior. Changes to the Medicare Physician Fee Schedule by the US Centers for Medicare and Medicaid Services (CMS) represent one potential incentive—although variable in extent—whereby the amount paid to a clinician for a health care service is set. In 2016, the CMS decreased the reimbursement for prostatectomy for prostate cancer, cutting its work relative value units by approximately 33.4% (from 32.06 to 21.36). Li et al1 examine the outcomes of this payment change by assessing the use of procedures that may be performed concurrently with prostatectomy (eg, urethral suspension and pelvic lymphadenectomy), potentially as a means to recoup lost compensation.

Using commercial and Medicare supplemental claims data for men diagnosed with prostate cancer between 2009 and 2019, Li et al1 performed a retrospective cohort study of patients undergoing robotic prostatectomy. They found that payments were higher for episodes associated with vs without urethral suspension for men with commercial insurance ($3678 vs $3332) or Medicare supplemental insurance ($2927 vs $2379). Interrupted time-series analysis was implemented to measure the use of urethral suspension before and after the reduction in payment for prostatectomy in 2016. Use of urethral suspension had been increasing since 2012 (approximately 20%-30%) but did not change significantly after the reduction in prostatectomy reimbursement in 2016 (0.06% [95% CI, −0.08 to 0.21] for commercially insured patients vs −0.08 [95% CI, −0.28 to 0.13] for Medicare beneficiaries). The observed plateauing of urethral suspension use after the decrease in payment for prostatectomy may reflect the CMS restriction of its billing to men with a preexisting diagnosis of urinary incontinence. Although only 25.0% of men undergoing urethral suspension met this criterion, there was wide geographic variation in its use (ranging from 0.9% to 37.0% in the Phoenix, Arizona, and Atlanta, Georgia, metropolitan areas, respectively).1 It remains unclear whether such variation is financially motivated, particularly given evidence suggesting that urethral suspension may shorten the time to urinary continence—a common functional end point after prostatectomy.2 Although the use of concurrent procedures may be motivated by financial incentives in some contexts, it is important to understand the value that these services provide, as Li et al1 acknowledge. If the procedure is beneficial to patients, then payer and clinician incentives should align to promote its use.

Under traditional fee-for-service payment models, physicians are compensated for providing a service and thus have implicit incentives to increase use. Prior work has shown that such incentives play a strong role in contexts in which there is clinical uncertainty and decision making is discretionary. For instance, physician ownership of ambulatory surgery centers and radiation vaults is associated with higher rates of outpatient surgery (eg, cataract surgery)3 and radiation therapy for prostate cancer,4 respectively. In both contexts, ownership imparts the ability to capture facility payments in addition to the professional fee for service. A more direct association of reimbursement and use was demonstrated with gonadotropin-releasing hormone agonists in the treatment of prostate cancer. Following passage of the 2003 Medicare Modernization Act that reduced reimbursement for gonadotropin-releasing hormone agonists by approximately 50.0%, there was a 13.0% decline in their use in clinically inappropriate contexts while appropriate use remained
unchanged. Thus, incentives afforded through payment policy can be used to promote clinician behavior that aligns with quality.

When constructed properly, payment models motivated by quality can promote high-value use and decrease low-value use. Recent efforts aimed at curbing rapidly rising health care costs in the US include the development of a variety of alternatives to traditional fee-for-service (eg, global payment, bundled payment, and pay-for-performance) models. Initial analyses of the Maryland All-Payer Model, a global payment plan, demonstrated a substantial decrease in hospital-acquired conditions (ranging from 0.4% for knee arthroplasty to 11.3% for coronary artery bypass grafting) and a parallel reduction in hospital costs. Nonetheless, some worry that alternative forms of payment can have unintended consequences, particularly when incentives are misaligned with quality. Common criticisms of these new models include avoidance of patients with higher risk for disease, which is potentially evident in some contexts in the Maryland All-Payer Model, and withholding appropriate care to reduce spending. The Hospital Readmissions Reduction Program (HRRP) is a CMS pay-for-performance initiative that financially incentivized a reduction in hospital readmissions for several conditions, including heart failure. Although the program was successful in reducing 30-day risk-adjusted readmissions for heart failure by 1.6%, HRRP implementation was associated with higher 30-day (1.4%) and 1-year (5.0%) risk-adjusted mortality in these patients, raising concerns that program incentives may have compromised patient care in the heart failure context.

Although mechanisms for the association of HRRP policy and risk-adjusted mortality are likely multifactorial, the HRRP example illustrates that payment policies must be rigorously evaluated and redesigned if necessary. It also highlights that a one-size-fits-all approach to payment models (eg, across multiple conditions) may be harmful in some circumstances. Invariably, incentives must be tailored to specific clinical contexts to promote high-value care. In the context of adjunct urethral suspension at the time of prostatectomy, it is unclear how Medicare’s payment policy has affected its use; however, there is substantial regional variation as reported by Li et al, demonstrating the need to clarify the procedure’s value and align incentives with appropriate use.

ARTICLE INFORMATION

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