CMS to Launch Pay-for-Performance Project

Under a pilot project, 10 large physician groups will be rewarded for improving outcomes.

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — The Centers for Medicare and Medicaid Services is experimenting with pay-for-performance programs, and observers say it looks as if the agency is really serious about it this time.

"This is not the first time that CMS has come around saying they wanted to pay for performance," Denis Cortese, M.D., said at a health care congress sponsored by the Wall Street Journal and CNBC. "It's the third time that we've been involved in that in 10 years. The other two faded away. This one looks real … and I think Congress is interested in seeing something happen. [But] whether they'll put additional money on the table to make it work has yet to be seen."

Earlier at the same meeting, CMS administrator Mark McClellan, M.D., announced that the agency was implementing its pilot pay-for-performance project. Under the project, 10 large physician group practices will be rewarded by the agency for improving outcomes among Medicare beneficiaries.

The physicians will continue to be paid on a fee-for-service basis as usual, but CMS also will make additional payments based on quality and outcome measures for patients with chronic illnesses such as congestive heart failure, coronary artery disease, diabetes, and hypertension. The agency also will look at the practices' use of preventive services such as influenza and pneumococcal vaccinations, as well as the prevention of complications in patients with chronic illnesses.

Dr. McClellan emphasized that he was not suggesting that physician spending was a major cost problem for Medicare.

"Physicians account for a small fraction of total costs, but doctors have a lot of good ideas and they have the knowledge it takes to get more results for what we actually spend," he said. "I think [pay for performance] can potentially save significant amounts of money. At the same time, we're also going to be paying attention to clinical quality, so for diabetic patients, we'll be looking at hemoglobin A_{1c} levels and other well-validated measures of quality. Those will be included along with financial performance measures."

Dr. Cortese, president and CEO of the Mayo Clinic, Rochester, Minn., expressed some skepticism about the way pay for performance will be implemented. "I noticed that performance was defined as reducing costs," he said. "I was tempted to ask, 'What happens if the quality goes up and the cost goes up with it?' If the value rises higher than cost, are they really going to pay for it? I don't believe they will."

Other groups also offered mixed reactions. Robert Doherty, senior vice president for governmental affairs and public policy for the American College of Physicians, said CMS should be commended on its efforts to test physician performance and provide a model to improve care of chronic disease.

Expanding the program will give CMS evidence on how to tailor incentive programs to be most effective.

MR. DOHERTY

The problem is that some of these demonstration projects are limited in scope, he said during a press briefing to release the ACP's 2005 policy framework. For example, the new physician group practice demonstration project "puts all of its eggs" in one basket by focusing solely on large group practices, he said.

ACP is advocating that Congress authorize a pilot test of a new model for improving the care of patients with chronic diseases in small and medium-sized practices, where patients with chronic diseases would be encouraged to select a physician as their medical "home."

The Medicare Modernization Act of 2003 authorized a performance-based demonstration project for small physician practices, although the project is limited to just a few hundred practices in four states. "Expanding the program will give CMS a much larger universe of experience and evidence on how to tailor physician incentive programs to be most effective," Mr. Doherty said.

Physicians are not the only recipients of Medicare funds to be affected by the move toward pay-for-performance programs. CMS also is changing to performance-based incentives for its claims processors, beginning in fiscal 2005. The agency also plans to reduce the number of processors from 51 to 23 and have all contractors processing both Part A and Part B claims.

"CMS will develop performance requirements and standards for Medicare administrative contractors through consultations with providers and beneficiaries, which will help ensure that the requirements produce desired results," the agency said in a report on Medicare contracting reform submitted to Congress last month. ■

Jennifer Silverman, Associate Editor, Practice Trends, contributed to this report.

Does Pay for Performance Have the Right Ingredients?

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — Mix a little money with solid incentives physicians can relate to, and you've got a successful recipe for a pay-for-performance program, Ronald P. Bangasser, M.D., said at the annual National Managed Health Care Congress.

Physicians try to deliver the highest level of medical care they can, but most can't keep track of the needs of every patient, said Dr. Bangasser, a family physician and immediate past president of the California Medical Association.

Studies show that 50% of patients don't get what they need in quality of care, he said. "Most patients rate their doctor a four out of five, but they hate the health care system."

That's one reason physician groups need a data-based approach to help reduce errors and improve care, he continued. A new program in California has yielded positive results, and is "certainly one way to pay for quality," Dr. Bangasser said.

Backed by a state foundation grant, the statewide Integrated Healthcare Association (IHA) got together with medical groups, health plans, purchasers, and consumer groups several years ago to collaborate on a plan to reduce expenses for physician reporting.

The program was able to achieve this savings "by accumulating all of the health plans together, so physician groups only had one reporting mechanism instead of seven or eight," said Dr. Bangasser, medical director of the wound care department of the Beaver Medical Group LP, at Redlands (Calif.) Community Hospital. The group participates in the IHA program.

All of the health plans and medical groups had to agree on a common set of measures and a common way to report those measures. The IHA in turn acted as a "neutral convener," in coming up with standards for reporting the data, he said.

Technical and steering committees were formed to work with technical experts on proposing measures.

Approximately 150,000 more women were screened for cervical cancer, and 35,000 more women were screened for breast cancer.

The measures had to be valid and accurate, meaningful to consumers and physicians, and important to public health in California. "They also had to get harder over time," Dr. Bangasser said. In the IHA program, physicians get paid not just for performance, but also for performance improvement. "We actually have a calculator [that determines whether] people are improving."

The first payout took place in 2004, based on first-year data from 2003.

Physicians are assessed on three types of measures: clinical, patient experience, and information-technology investment.

First-year results saw little variation among the participating groups on patient experience, although variations were seen among clinical and IT measures.

There was room for improvement in both of these areas, Dr. Bangasser said. Fewer groups participated in IT measures than in the other measures, and of those who tried, "only two thirds of them got full credit for it. It showed us that we had a huge IT deficit."

Variations occurred in the clinical measures because not all of the groups used a registry-type system—a list that details the specific diagnoses of each patient. Physicians using a registry can find out if a patient got a certain test or if they need one, Dr. Bangasser said. To date, groups that use registries "are doing much better on these measures than groups that don't."

One of the biggest improvement areas was in cervical cancer screening, he said. Based on data comparisons between 2002 and 2003—the year the program got started—nearly 150,000 more women were screened for cervical cancer, and 35,000 more women were screened for breast cancer.

An additional 10,000 children got two needed immunizations, and 180,000 more patients were tested for diabetes.

Although some groups scored fairly high, specialists didn't fare as well. Patients cited problems with access to specialists as a specific complaint in the satisfaction surveys, Dr. Bangasser said.

The estimated aggregate payment to physician groups in the IHA program in 2003 was between $40 million and $50 million, although some groups thought they didn't get paid properly, Dr. Bangasser said. There were some concerns about increased utilization and cost of services for groups participating in the program, and what the long-term returns on investment would be.

It was also determined that groups serving large Hispanic or Native American populations should get "extra credit" for having to deal with more diverse, culturally different populations.

Applying the right types of incentives is key, he said. "If a physician thinks the measure is a good idea, putting a little money behind it will speed quality improvement. However, if the physician thinks the measure is not going to improve quality, $1 million will not change behavior."

Sometimes, the simplest incentives can produce good results. Dr. Bangasser mentioned a particularly bad influenza season in 1998, when patients had to wait in long lines to see physicians in his group practice. "I asked all of the doctors if they'd take on two more patients a day. That's a long day, but I gave them two tickets to a movie theater for Christmas."

All but two physicians took on the extra patients. "This meant that over 60 physicians saw an extra 120 patients per day," he said. ■

Pages 56a—56d