Group Practice Demo Achieved Modest Savings

BY SUSAN BIRK

CHICAGO — The Medicare Physician Group Practice Demonstration achieved modest cost savings and quality enhancements in the project's first 2 performance years, researchers reported at the annual research meeting of AcademyHealth. Data released in August reinforce that finding.

The project involves 10 large, geographically diverse physician group practices with a total of 5,000 physicians caring for 200,000 Medicare fee-for-service beneficiaries. The practices include multispecialty groups, integrated delivery systems, faculty groups, and a physician network.

During each year of the project, each group was retroactively assigned a population of Medicare beneficiaries, with an average of 20,000 patients per group (range 10,000-37,000). Each group was held accountable for total Part A and Part B expenditures for these patients.

Patients had complete freedom of choice in providers and were not required to receive care through the participating group practice. However, only patients who received most of their outpatient evaluation and management for the year from the group practice were assigned to the group. Groups that kept increases in expenditures below 2 percentage points of their target growth rate shared up to 80% of the savings; Medicare retained 20%.

The group practices assumed all business risks associated with investments related to their participation in the demonstration, and there was no guarantee of savings.

"Savings are a function of the ability of the group to control growth in Medicare spending as well as changes in [health] status of their assigned population over time relative to their local market," explained John Pilotte, a senior research analyst at the Centers for Medicare and Medicaid Services.

The groups were free to make whatever investments and enhancements that they felt were necessary to reach their quality and efficiency goals.

In the second year of the project, four groups shared a total payment of $13.8 million. In the third year, five groups will share payments totalling $25.3 million.

In the first year of the demonstration, two participating group practices earned a total performance payment of $7.3 million and two lost a total of $1.5 million, Gregory Pope of RTI International in Waltham, Mass., a nonprofit research and development firm working with the CMS, reported at the meeting.

In the second year of the project, four groups shared a total payment of $13.8 million and one lost $2 million. Savings to Medicare totaled $677,000 and $1.6 million for the first and second years, respectively.

Results for the third year were announced in August; five physician groups will receive performance payments totaling $25.3 million as part of their share of $32.3 million of savings generated for the Medicare Trust Funds in that year, the CMS announced.

Quality was assessed by the groups' adherence to 27 measures as indicated by Medicare claims and clinical records data. The measures, developed by the CMS in collaboration with the American Medical Association and the National Committee for Quality Assurance, covered heart failure, diabetes, coronary artery disease, hypertension, and preventive care.

Two group practices complied with 10 of the quality markers in performance year one, while five groups complied with all 27 quality markers in the second year, said Musetta Leung of RTI International.

In the second year, all of the group practices met all of their quality targets for heart failure and coronary artery disease.

Achieving the diabetes-related quality measures remained a challenge. Still, second-year performance data indicated significant improvements, Ms. Leung said.

In the project's third year, all 10 groups achieved benchmark performance on at least 28 of the 32 measures reported, according to the CMS. Two groups—Geisinger Clinic in Danville, Pa., and Park Nicollet Health Services in St. Louis Park, Minn.—achieved benchmark performance on all of the 32 performance measures.

Over the first 3 years of the demonstration, the physician groups increased their quality scores an average of 10 percentage points on 10 diabetes measures, 11 points on 10 heart failure measures, 6 points on 7 coronary artery disease measures, 10 points on 2 cancer screening measures, and 1 percentage point on 3 hypertension measures.

Additional research is needed to determine the keys to success, according to Mr. Pilotte of the CMS. "Trying to figure out how to make this work in a program that processes over 1 billion claims each year is not a small feat. … It takes a while to get these projects up and running both from our side of the house and the provider side."

Although the group practices generally have sophisticated health information management systems and dedicated information technology leadership, "even that doesn't seem to be enough to control growth in expenditures. … There are probably other things going on that we haven't fully identified that are necessary to be successful."

Overall, "the results show we're moving in the right direction, but bringing in expenditure growth under target is challenging under the existing target-setting methodology even for these large organizations," he said.

One key lesson learned so far during the demonstration is that "leadership and champions within the organization are really important," Mr. Pilotte said. "All of these groups have someone who is on point for monitoring and reporting the quality metrics to us every year and developing mechanisms … to be able to capture the information."

Another lesson learned is the importance of having quality measures consistent with clinical practice and high-quality care in order to achieve physician buy-in.

"That's why we spent a fair amount of time early on with these physician groups on which measures we were going to use and to gain their support, because it really wouldn't be possible without them," he said. ■

For more information, visit www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp.

Joyce Frieden contributed to this report.

Coordinated Care Could Save Medicare $10 Billion a Year

BY JOYCE FRIEDEN

More coordinated care can reduce the rate of hospital readmissions among Medicare beneficiaries by more than 25%, a study has found.

"Policymakers should take notice of this and other studies that demonstrate what's already working in some health care plans," Len Nichols, Ph.D., director of the health policy program at the New America Foundation, a Washington think tank, said in a statement. "It's time to move away from the current fee-for-service payment system toward one that emphasizes value rather than volume, enhances the value of primary care, and holds providers accountable for quality and efficiency."

The study involved 13 plans in the Medicare Advantage program, under which private health plans contract with Medicare to care for beneficiaries. The study was sponsored by the Alliance of Community Health Plans (ACHP), an organization of nonprofit, community-based, and regional health plans. All of the plans in the study were members of ACHP.

Gerard Anderson, Ph.D., of Johns Hopkins University, and colleagues focused their research on two areas: hospital readmissions and preventable hospital admissions/emergency department (ED) visits.

"These measures were chosen for several reasons," they wrote in a report released by ACHP. "First, readmissions and preventable hospitalizations are expensive for the Medicare program. Second, there is an established literature on how to measure readmissions and preventable hospitalizations. Third, they can be used to evaluate if health plans can improve outcomes for Medicare beneficiaries and save money for the Medicare program."

The researchers compared the rates of readmissions and preventable admissions/ED visits in the fee-for-service Medicare program with those of the 13 health plans studied. The study spanned the first 6 months of 2007 and used the third quarter of that year to monitor any readmissions or follow-up care.

The investigators found that the national Medicare fee-for-service readmission rate was 18.6%, while the ACHP plans in the study had an average rate of 13.6%—a rate that was 27% lower. Based on previous readmission cost data, the Medicare fee-for-service plan could have saved nearly $5 billion if it had had the same readmission rate as the ACHP plans in the study, Dr. Anderson and his associates said.

On average, ACHP member plans had preventable inpatient hospitalization rates in 2007 that were 13% of the national average, the researchers noted. Based on an average payment per discharge of nearly $8,400 in 2007, bringing Medicare's fee-for-service preventable hospitalizations down to the same level as the ACHP plans would have saved the program $4.5 billion, according to the study.

As for preventable ED visits, the rate among the Medicare fee-for-service patients was 15.5 visits per 100 beneficiary months, compared with an average of 2.2 visits for the ACHP plans studied (range, 0.5-7.8). The average ACHP plan had 86% fewer preventable emergency dept. visits than the Medicare fee-for-service program. Based on an average ED visit payment of $510, reducing Medicare fee-for-service preventable ED visit rate to the rate experienced by the 13 plans studied would have saved Medicare $900 million.

The results suggest that "the approaches adopted by these plans—which include greater focus on primary care, care coordination, transitional planning post-discharge, prevention measures, and active case management—are improving care for their beneficiaries, keeping people out of the hospital, and lowering costs," the authors wrote in the ACHP report. "If the Medicare fee-for-service program had similar rates of readmissions and preventable hospitalizations, then the Medicare program would have saved approximately $10 billion in the year of the study." ■