Pay-for-Performance Pact Ruffles Some Feathers

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Specialty organizations are concerned that the American Medical Association is unilaterally setting performance goals that doctors won't be able to meet.

A recent agreement between the AMA and leaders in Congress outlines an ambitious 2-year time line for establishing performance measures, "to improve voluntary quality reporting to congressional leadership," Dr. Duane M. Cady, AMA chair, said in a statement.

Dr. Cady signed the pact at the end of last year, although the details weren't publicly disclosed until several months later. The terms were outlined in a Feb. 7 memorandum from Dr. Michael Maves, AMA vice president, to the state medical associations and national specialty societies.

The agreement was cosigned by Sen. Charles E. Grassley (R-Iowa), chair of the Senate Finance Committee; Rep. Bill Thomas (R-Calif.), chair of the House Ways and Means Committee; and Rep. Nathan Deal (R-Ga.), chair of the House Energy and Commerce subcommittee on health. If the plan goes through, physician groups will work with the Centers for Medicare and Medicaid Services to agree on a starter set of evidence-based quality measures for a broad group of specialties, with a goal of developing approximately 140 physician measures covering 34 clinical measures by the end of 2006.

The Consortium has not yet tested the physician measures; it has been working with several groups to do so, including the Ambulatory Care Quality Alliance, said Dr. Nancy Nielsen, speaker of the AMA's House of Delegates, at a press briefing. The Alliance is receiving a yet-to-be-announced amount of funding from the Agency for Health Research and Quality and CMS to test 26 measures at six clinical sites, beginning May 1. Those measures include some developed by the Consortium, among others. The pilot is crucial, as it will bring to the surface any "unintended consequences," said Dr. Nielsen.

Then in 2007, doctors who report on three to five quality measures would see increased payments from Medicare. By the end of next year, physician groups should have developed performance measures "to cover a majority of Medicare spending for physician services," the agreement said. Other initiatives, such as working on methods to report quality data and implementing additional reforms to address payment and quality objectives, also were outlined in the agreement.

The AMA has been working on these quality initiatives for some time, Dr. Cady said. "For the past 5 years the AMA has convened the Physician Consortium for Performance Improvement, which includes more than 70 national medical specialty and state medical societies." To date, the consortium has developed more than 90 evidence-based performance measures, he said. As far as he's concerned, nothing in the agreement with the congressional leaders should be a surprise.

All of these steps had been documented previously in public letters to Congress and the Bush administration and distributed to medical specialty societies, he said.

Yet, some of the members of the consortium said they had no advance notice of the AMA's plans to sign this pact.

"This is an agreement signed with leaders on Capitol Hill on how pay for performance should be laid out, and some groups feel they should have been a part of it," Cynthia A. Brown, director of advocacy and health policy at the American College of Surgeons, said in an interview.

The real problem isn't about advocacy or the workings of the consortium. It's about meeting deadlines on clinical measures, Ms. Brown said. "Not everyone is ready for [pay for performance]."

While many primary care quality measures have been written, it's a different story for subspecialties, "because their measures haven't even been developed yet. They're starting from ground zero," she said. With this latest agreement, subspecialties now feel pressured to find their own groups of doctors to propose measures to run through the consortium's process by year's end, she added.

The criteria on performance measurement also will be different by specialty, Ms. Brown said. "Surgeons in particular often like to be judged by outcomes, and primary care doctors don't want to be because they have a bigger problem with pa-

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tient compliance. One size doesn't fit all."

At the press briefing, Dr. Nielsen said "this is a dustup about nothing," adding that the specialty societies had been included on the performance measure development from the start. The initial measures won't cover all the specialties, but it was necessary to show Congress that the profession was serious about quality improvement by getting something started quickly, she said.

The AMA has tried to work with the CMS on quality measures for some time now, and it is "very difficult" to get truly significant data and information that really makes a difference, Dr. Thomas Purdon, former president of the American College of Obstetricians and Gynecologists, said in an interview. However, it's unlikely the data will be accurate or have real meaning unless the specialty societies are involved, "either individually or through the Council of Medical Specialty Societies," he said.

It's true that a number of specialty groups don't feel comfortable that they can meet these time lines, Dr. David Nielsen, executive vice president and chief executive officer of the American Academy of Otolaryngology–Head and Neck Surgery, said in an interview.

There's an assumption that the AMA is going to be responsible for doing all of the specialty measures, Dr. David Nielsen said. "While those concerns are valid, it isn't going to come to that." What these groups need to remember is [that the] AMA's consortium is run by the specialty societies, a process that's consensus based, he said. (The American Academy of Otolaryngology–Head and Neck Surgery is a consortium member.)

"People who are upset about this aren't comparing it to what would happen if the AMA didn't step in; that CMS would step in and do their own measures. I'd be much happier with consortium measures than any other group of measures, because the consortium is in the best position to produce patient-centered measures of medical outcomes that are driven by physicians, and are relevant and validated," he said.

Physician concerns about CMS's initial draft of the physician voluntary reporting program (PVRP) had also been interpreted on Capitol Hill as a sign of opposition to quality reporting, Dr. Maves noted.

From CMS's perspective, there's no reason why the AMA's agreement shouldn't work in tandem with the PVRP, CMS spokesman Peter Ashkenaz said in an interview.

The voluntary reporting program isn't about developing measures, it's about testing systems "on how well we can use the existing claims-based system to capture the data from the measures," he said. ■

IT Leaders Set Goals for Health Records

Over the next year or so, leaders in the health information technology community will work on ways to make medication history and some general demographic information available to consumers in a portable health record.

Experts at a Webcast meeting of the American Health Information Community agreed that this is the "low-hanging fruit" that could eventually pave the way for widespread access to portable, consumer-controlled personal health records. The American Health Information Community is an advisory committee to the Department of Health and Human Services.

The development of portable electronic demographic information, or registration information, would be a way to do away with the medical clipboard, HHS Secretary Mike Leavitt said.

"The timeliness of access to medical information is critical to patients," said Nancy Davenport-Ennis, CEO of the National Patient Advocate Foundation and a member of the American Health Information Community. Today, most patients feel they own their medical record but when they go to get lab results from their physician, it can often take days or weeks, she said.

But one of the major hurdles in creating secure and portable patient health records is authentications, said Dr. Reed Tuckson of UnitedHealth Group, who presented information to the group.

Other obstacles include the inability to locate patient information across multiple settings, segmentation of the consumer market, privacy concerns, low levels of consumer trust, few electronic health records to connect to, and the lack of an established business model.

But there have been some successes, said David Lansky, Ph.D., of the Markle Foundation, who presented information to the group. For example, the Department of Veterans Affairs set up a patient portal, and the Department of Defense has a similar program. And some health plans offer pre-populated personal health records. "We're not starting with a blank slate," Dr. Lansky said.

Providing medication history electronically to patients is something that could be done quickly, Dr. Lanksy said. The Markle Foundation was one of the groups that helped spearhead efforts to do just that with www.katrinahealth.org, which allowed certain physicians to access drug histories for hurricane evacuees.

—Mary Ellen Schneider