Charter Sets Rules for Physician Report Cards

BY MARY ELLEN SCHNEIDER
New York Bureau

Under an arrangement among physicians, consumers, employers, and large insurers, some health plans have agreed to have their physician rating systems audited by independent experts, according to numerous sources interviewed by this newspaper.

The announcement comes after physicians around the country have questioned the methods used by health plans to produce the physician performance ratings for consumers.

Under the voluntary agreement, health plans would disclose their rating methods. In addition, physicians would have a chance to review their performance data and challenge them prior to publication.

"Having that transparency is a huge change," said Dr. Douglas Henley, executive vice president of the American Academy of Family Physicians, which is supporting the agreement, known as the Patient Charter for Physician Performance Measurement, Reporting, and Tiering Programs.

Giving physicians a chance to ensure that the data are accurate makes the process fair, he said. It's also beneficial for consumers who will be able to better rely on the information provided by their health plan, Dr. Henley said.

The project was led by the Consumer-Purchaser Disclosure Project, a coalition of consumer, labor, and employer organizations that support publicly reported health performance information.

Other principles of the Patient Charter state that the measures should aim to assess whether care is safe, timely, effective, equitable, and patient centered. The measures used should also be based on national standards, preferably those endorsed by the National Quality Forum. The principles of the Patient Charter do not apply to pure cost-comparison or shopping tools.

This agreement provides a foundation for physicians to build on, said Dr. David C. Dale, president of the American College of Physicians, another supporter. Now when any health plan establishes a physician rating system, physicians can ask whether it is standardized and how it stacks up against the requirements of the Patient Charter, he said.

The Patient Charter also has the support of the American Medical Association, the American College of Cardiology, and the American College of Surgeons.

And some heavy hitters in the insurance industry have agreed to abide by the principles of the charter, including trade group America's Health Insurance Plans (AHIP), as well as Aetna, Cigna, UnitedHealthcare, and WellPoint. Other health plans are likely to follow suit, said Susan Pisano, AHIP spokeswoman. Third-party review of rating systems and allowing physicians to review and challenge data before they become public will likely become the industry standard.

"We believe strongly that consumers both want and need good information on health care quality," Ms. Pisano said.

Now that the Patient Charter has laid down the ground rules for how clinical performance measures should be used, the next step is to ensure that physician ratings accurately reflect all the care given, because patients are generally scattered across multiple health plans.

Ms. Pisano said the AHIP Foundation is studying how to aggregate data from across different plans to provide a full picture of physician quality. ■

Massachusetts Health Coverage Plan for The Uninsured Is Meeting Expectations

BY JOYCE FRIEDEN
Senior Editor

WASHINGTON — The Massachusetts health coverage plan enacted in 2006 "expanded affordable coverage to 325,000-350,000 of the [state's] estimated 550,000 uninsured."

That was the message from John McDonough, D.P.H., executive director of Health Care for All, a consumer health advocacy organization in Boston that has supported the plan.

The state government recently announced that the program will cost "significantly" more than the proposed $869 million budgeted for it in 2009. One reason for the increase is that state regulators approved a 10% increase in payments to private insurers for each person enrolled in the program, in which the state subsidizes the insurance premiums. Insurers had sought a 15% increase but settled for 10% after lengthy negotiations.

Richard Powers, program spokesman, said in an interview that the real driving force behind the increased cost is growing enrollment. "Certainly, the rate increases will factor into the final figure—which has yet to be determined—but it is minor in comparison to the enrollment," he said.

The payment increase will take effect July 1. In addition, the state said it would be willing to take on additional financial risk if enrollees end up using more medical care than expected. Also, premiums will be increased for about one-fourth of enrollees—the other three-fourths will continue to pay no premiums—while copays will go up for half of those enrolled. (See box.)

Speaking at a diabetes meeting sponsored by Avalere Health, Dr. McDonough said cost increases were not unexpected. "Yes, it's true. … When you enroll a ton of people, costs do go up," he said during his talk, which was given before the announcement but after state officials had projected an increase in the program's budget.

The Massachusetts plan has engendered dislike on both extremes of the health care reform debate, Dr. McDonough said.

"You have health care fundamentalists on the left who worship at the shrine of the perpetual single payer, and you have fundamentalists on the right who bow down before the consumer-driven goddess of the unregulated market," he said.

"They agree on absolutely nothing, except for one thing: they hate Massachusetts' ecumenical experiment. … We're just doing our best; we know we're in radically experimental terrain, and we hope we're providing some ideas and some paths for [the] system [to] advance."

Health Care for All receives financial support from the Massachusetts state government to support its enrollment and outreach efforts. ■

Details of the Massachusetts Plan

Under the plan, the state has expanded Medicaid eligibility for children from those families making 200% of the federal poverty level to those families making 300%, Dr. McDonough explained. The state also set up Commonwealth Care for adults making less than 300% of the poverty level who can't get insurance anywhere else. In that program, there are no premiums for those under 150% of the poverty level, and then there is a sliding-scale premium structure for those between 150% and 300% of poverty, up to $107 per month. This program "gets at a significantly uncovered group: childless adults," he said.

For people above 300% of poverty who are having difficulty finding affordable coverage, the state offers coverage plans through a variety of private insurers, Dr. McDonough continued. Some plans have higher premiums in exchange for lower cost sharing, while others offer the opposite approach. In addition, employers are required to set up "cafeteria plans" that allow workers to deduct their health insurance premiums from their paychecks pretax.

As of July 1, 2007, the state also requires all residents to be insured, provided that there is affordable coverage available to them. Residents who do not comply with the law must pay penalties. Because some people "made a calculated decision to pay the penalty" rather than pay for coverage, the Massachusetts plan is not considered a universal coverage plan, he said. The state also exempts some residents who would normally pay the penalty from having to do so, if they are unable to find affordable coverage.

In 2007, the penalty for not having coverage was a standard $219. This year, the maximum penalty jumps to $76 per month, or $912 per year; penalties are now on a sliding scale based on the patient's income.

MedPAC Gives Final OK to Bundled Pay

BY ALICIA AULT
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WASHINGTON — The Medicare Payment Advisory Commission has given its backing to bundling payment for hospitalization, which would essentially give hospitals and physicians an incentive to control costs and avoid readmissions.

At its April meeting, the commission (MedPAC) unanimously voted to include a bundling recommendation in its June report to Congress. As a first step, physicians and hospitals should be required to report to the Centers for Medicare and Medicaid Services (CMS) on resource use and readmissions during an "episode of care," which is proposed to include the first 30 days post hospitalization. The data would be confidential initially, but by the 3rd year, should be made public, MedPAC commissioners recommended.

Once the resource and readmission data are in hand, CMS should start adjusting payment to hospitals, according to the recommendation. There would be the possibility for gainsharing among hospitals and physicians. The commissioners also voted to direct CMS to study the feasibility of "virtual" bundling under which payment would be adjusted based on aggregate use of services over an entire episode of care.

Finally, MedPAC voted to recommend that CMS create a voluntary pilot to test actual bundled payment in selected disease conditions. The pilot could throw some light on how the hospital or accountable care organization receiving the payment decided to share funds, and how Medicare might share in any savings, according to MedPAC staff.

The pilot represents Medicare's ultimate goal—making bundled payments, according to MedPAC chairman Glenn Hackbarth, a health care consultant in Bend, Ore.

The data collection and adjusting payment based on readmission are interim steps aimed at getting providers to collaborate to improve care and cut costs, said Mr. Hackbarth.

Commissioner Ronald Castellanos, a urologist in private practice in Fort Myers, Fla., reported that he thought it would take 5 or 10 years to make collaboration work, but that he agreed that it was the ultimate end point. ■