AMA Proposes Bundled Pay for Coordinated Care

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WASHINGTON — The U.S. health care delivery system should be overhauled to organize medical practice around "integrated care cycles" that are coordinated by a central physician and to reward physicians for providing value, Michael E. Porter said at a media briefing presented by the Journal of the American Medical Association.

The proposals are a shortened version of a book written by Mr. Porter, the Bishop William Lawrence University Professor at Harvard Business School, Boston, and his coauthor, Elizabeth Olmsted Teisberg of the University of Virginia's Darden Graduate School of Business, Charlottesville.

According to Mr. Porter and Ms. Teisberg, a value-based system has three principles: providing value for patients, organizing delivery of care around conditions and care cycles, and measuring results, preferably risk-adjusted outcomes that are measured over the full cycle of care, not just an individual care episode (JAMA 2007;297:1103-11).

"Physicians focused on value for patients will no longer see themselves as self-contained, isolated actors," the authors wrote. "Instead, they will build stronger professional connections with complementary specialists who contribute to patient care across the care cycles for their patients."

The authors pointed out that they do not advocate a single-payer system. They say instead that competition is healthy but the current system supports the wrong kind of competition.

It rewards physicians and health plans for taking patients away from one another or for shifting costs onto a competitor, rather than for providing value for the patient in the form of improved clinical outcomes, said the authors.

Physicians are in the best position to change the delivery of health care, they said. "Physicians have to get out of the bunker," Mr. Porter said at the briefing.

He said they could lead by becoming part of a care team and agreeing to accept a piece of a payment that would be bundled for the episode of care, not for an individual service. And they can take the lead in defining outcomes measurements, Mr. Porter said.

In the article, the authors said that pay for performance models are also going down the wrong track, because they are aimed only at getting physicians to comply with processes of care. That will not provide value to the patient and, with more and more such measures, will likely lead to micromanagement of medical practice, they said.

A study published the same week in the New England Journal of Medicine found that pay-for-performance proposals under Medicare aren't likely to work well under the current system, because patients' care is not being coordinated by a single provider. In fact, beneficiaries are seeing multiple physicians—typically seven physicians in four practices in a given year—which "impedes the ability of any one assigned provider to influence the overall quality of care for a given patient," wrote the investigators, who were with the Center for Studying Health System Change and the Memorial Sloan-Kettering Cancer Center's Health Outcomes Research Group (N. Engl. J. Med. 2007;356:1130-9).

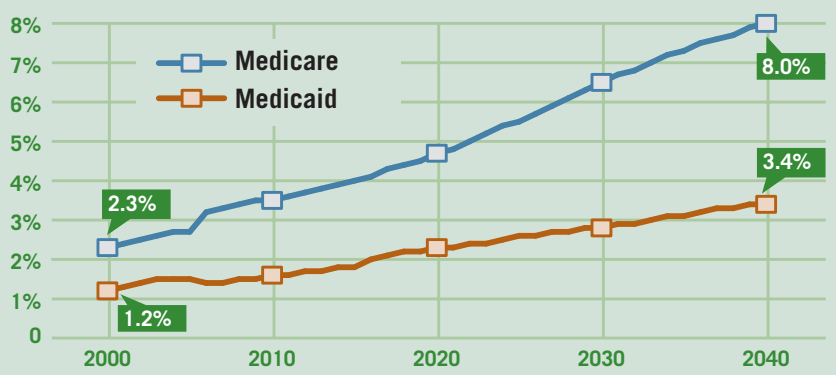
Mr. Porter and Ms. Teisberg envision a future in which most physicians are allied in partnerships or working for large group practices or staff-model managed care organizations, so that the care can be delivered more efficiently.

Their model is similar to the medical home concept that's being promoted by the American College of Physicians and the American Academy of Family Physicians. Under the concept, insurers would provide a bundled payment to a physician to coordinate care and there would be a pay-for-performance element based on patient outcomes.

Medicare will pay for a 3-year, eight-state demonstration of the medical home, and ACP and AAFP are working with IBM Corp. on testing such a program with its employees in Austin, Tex. ■

DATA WATCH

Medicare Expected to Increase at a Faster Rate Than Medicaid as Percent of GDP



Notes: Based on 2005 and 2006 data. GDP is gross domestic product.
Source: Government Accountability Office

ELSEVIER GLOBAL MEDICAL NEWS

POLICY & PRACTICE

Alzheimer's Affects 5 Million

About 5.1 million Americans are living with Alzheimer's disease, according to a recent report from the Alzheimer's Association. While most people with the disease are over age 65, 200,000-500,000 people younger than 65 have early-onset Alzheimer's or other dementias. Without improvement in treatment, the group estimated that the prevalence of the disease could reach 11-16 million by 2050. Direct and indirect costs of Alzheimer's disease add up to more than $148 billion a year. Medicare's cost of caring for patients with Alzheimer's and other dementias is expected to climb from $91 billion in 2005 to more than $189 billion by 2015. But Harry Johns, president and CEO of the Alzheimer's Association, expressed hope. "There are currently nine drugs in phase III clinical trials for Alzheimer's, several of which show great promise to slow or stop the progression of the disease," Mr. Johns said in a statement. "This, combined with advancements in diagnostic tools, has the potential to change the landscape of Alzheimer's."

Alzheimer's Treatment Delays

Race and ethnicity may play a role in delays in diagnosis and treatment of Alzheimer's disease, according to an Alzheimer's Foundation of America survey. The survey found that 70% of African American and 67% of Hispanic caregivers were likely to dismiss the symptoms of Alzheimer's as old age, compared with 53% of caregivers of other races. Further, about 67% of African American caregivers and 63% of Hispanic caregivers said they did not know enough about the disease to recognize symptoms, compared with 49% of caregivers of other races. The stigma of a diagnosis was also a concern. For example, 36% of African American caregivers cited concerns about stigma as delaying diagnosis, compared with 22% of Hispanic caregivers and 18% of caregivers of other races. The survey, conducted by Harris Interactive and sponsored by Forest Pharmaceuticals Inc., included 655 adults who provide care for someone with the disease.

25% of Stays for Mental Health

One-quarter of all patients age 18 and over admitted to the hospital in 2004 had a mental health or a substance abuse disorder, according to the federal Agency for Healthcare Research and Quality. Almost 2 million admissions were primarily for a mental health or substance abuse issue. Another 6 million patients were admitted for another condition but were subsequently diagnosed with a mental health or substance abuse problem. Dual diagnoses accounted for 1 million of the 8 million total stays, and suicide attempts accounted for 179,000 admissions, with the majority involving patients aged 18-44 years. However, most of the mental health and substance abuse disorders were in older patients, with those over age 80 accounting for 21% of hospitals stays, mostly for dementia. Medicare covered half the inpatient stays, Medicaid paid 18%, and private insurers covered 24%. Eight percent of patients were uninsured. The AHRQ report can be found at www.ahrq.gov/data/hcup/factbk10/.

NIH Launches Addiction Study

In response to the growing prescription drug abuse, the National Institute on Drug Abuse is launching the multisite Prescription Opioid Addiction Treatment Study (POATS). The researchers will examine the efficacy of buprenorphine/naloxone (Suboxone) combined with either intensive or brief drug-counseling approaches. Investigators aim to enroll about 648 participants at 11 sites. "Opioid analgesics were designed to help people in pain, and we want to be sure that those who require them for legitimate reasons can continue to effectively manage their pain," Dr. Nora D. Volkow, NIDA director, said in a statement. "However, we must also recognize the risk of addiction to pain medications and develop treatments for those who become addicted to them."

Psych Drug Spending Soars

Spending on medications for mental health conditions surged 150% from 1997 to 2004, rising from $8 billion to $20 billion in that 7-year period, according to AHRQ. The agency said the largest increase was for antipsychotic agents, where spending rose from $1 billion to $4 billion by 2004. But spending for antidepressants dwarfed that total; from 1997 to 2004, spending more than doubled, from $5 billion to $12 billion. The number of overall prescriptions for mental health–related prescriptions rose from 142 million to 244 million; at least 33 million Americans were prescribed a psychotherapeutic drug in 2004. The data are in the AHRQ report, Trends in the Use and Expenditures for the Therapeutic Class Prescribed Psychotherapeutic Agents and All Subclasses, 1997 and 2004.

CMS Extends NPI Deadline

Physicians and other providers who fail to comply with the May 23 deadline to acquire and start using a National Provider Identifier will not be penalized if they can show they deployed a "contingency plan," the Centers for Medicare and Medicaid Services announced. "Covered entities that have been making a good faith effort to comply with the NPI provisions may, for up to 12 months, implement contingency plans," said CMS Acting Administrator Leslie Norwalk in a statement. The agency decided to create this grace period after it became clear that many entities would not be able to fully comply by the original deadline, she said. The new compliance guideline can be downloaded from the agency's Web site (http://www.cms.hhs.gov/NationalProvIdentStand) and explains what is considered a "good faith effort."

—Alicia Ault