P4P Demo May Not Apply to Small Practices

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A Medicare demonstration project testing pay for performance among large multispecialty physician groups is yielding good data on care coordination programs, but expanding the program to small, single-specialty practices could present challenges, according to an analysis by the Government Accountability Office.

Small practices would have difficulty absorbing the high start-up costs associated with care coordination programs and the hefty price tag for electronic health record adoption and implementation, the GAO found.

The GAO report to Congress analyzed the Physician Group Practice Demonstration project.

The demonstration project aims to test an alternative payment approach that combines Medicare fee-for-service payments with incentive payments for achieving cost savings and hitting certain quality targets.

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The demonstration, which began in April 2005, includes 10 multispecialty practices, each with 200 or more physicians. Officials at the Centers for Medicare and Medicaid Services recently added a fourth year to the project, which now is scheduled to end on March 31, 2009.

CMS reported the first-year results in July 2007.

In the first year, two group practices earned bonus payments of about $7.4 million in total.

But it may be difficult to broaden this approach to other physician practices because of the large size and high revenues of the participating practices, the GAO said.

All of the demonstration practices had 200 or more physicians, but this practice size is rare. Less than 1% of physician practices in the United States have more than 150 physicians.

In fact, about 83% of all physician practices are solo or two-person groups, according to the GAO.

The practices that were included in the project weren't just bigger in terms of the number of physicians but also had more support staff and larger annual medical revenues.

On average, the demonstration practices had annual medical revenues of $413 million in 2005. By comparison, only about 1% of single-specialty practices in the country have revenues exceeding $50 million a year.

The GAO identified three advantages that the participating practices had because of their large size: institutional affiliations with an integrated delivery system that gave them greater access to financial capital, past experience with pay-for-performance (P4P) programs, and experience with using an electronic health record.

Because most of the participating practices had affiliations with large, integrated delivery systems, they had access to the funds to start or expand quality improvement programs.

The GAO estimated that on average, each participating practice invested about $489,000 to start or expand its demonstration-related programs and spent about $1.2 million on operating expenses for these programs in the first year.

The practices that participated in the demonstration also had a leg up in terms of electronic health record systems, as 8 of the 10 participating practices had an electronic health record system in place before the project began.

By comparison, in 2005, only 24% of physician practices in the United States had a full or partial electronic health record, the GAO said.

Most the participants in the demonstration also had past experience with pay-for-performance programs either through a private or public sector organization.

CMS officials told GAO investigators that they chose to focus on large practices because they affect a significant amount of Medicare expenditures and have sufficient Medicare beneficiary volume to calculate savings. ■