# Ranks Need to Increase by 75%

**Shortage** *from page 1*

ed States have one or more pediatric rheumatologists involved in patient care, according to 2004 data from the American College of Rheumatology.

"The scarcity of pediatric rheumatologists is long-standing," said Dr. Christy Sandborg, chief of pediatric rheumatology at Stanford (Calif.) University and an American College of Rheumatology board member. The subspecialty has been among the smallest in pediatrics since the American Board of Pediatrics began offering a certifying exam in the field in 1992.

While there have been some increases in the number of certified pediatric rheumatologists and trained fellows since 2003, it's still a challenge to find physicians interested in training in pediatric rheumatology, said Dr. Sandborg, who contributed to the HRSA report.

One of the problems is that many physicians are never exposed to the concept in medical school, she said. Further, pediatric rheumatology is a cognitive specialty so it is not as well compensated as other areas of medicine.

The reimbursement issues make it difficult to maintain pediatric rheumatology programs at academic medical centers, where most practices are located, said Dr. Thomas J. A. Lehman, chief of the division of pediatric rheumatology at the Hospital for Special Surgery in New York.

"In academia it is always difficult to maintain a program because the reimbursement rate is so low and the care of the children is so intense," he said.

In addition to seeing the rheumatologist, many pediatric patients also will need to see a physical or occupational therapist, get counseling from a social worker or nurse practitioner, and undergo laboratory procedures—all within the context of an office visit. In general this array of services is not reimbursed at a level that even covers expenses, Dr. Lehman said.

"It will remain difficult to recruit physicians to pediatric rheumatology until they no longer believe they are taking on more responsibility and working harder and longer for less money," he said.

The report noted that a survey of pediatric rheumatologists shows that they blame the current shortage on low salaries, inadequate reimbursement, and poor working conditions. For example, a pediatric rheumatologist working as an assistant professor earns on average $115,000, compared with $144,000 in areas such as pediatric cardiology or neonatal medicine, according to the HRSA report.

The shortage also has clinical consequences for patients, physicians interviewed for this article said. Adult rheumatologists generally provide the bulk of the care for children with rheumatic diseases when pediatric rheumatologists are not available, but they often lack the proper training to handle children, said Dr. Lehman, adding that the examination, the appropriate normal values, drug dosages, and family and school issues are all vastly different in children.

**It will remain hard to recruit physicians into pediatric rheumatology as long as they believe they are working harder and longer for less money.**

Dr. Sandburg noted that pediatricians, most of whom were never exposed to pediatric rheumatology in medical school, may fail to recognize rheumatic disease in their patients.

At least 337 pediatric rheumatologists are needed to meet patient needs of the 285,000 children in the United States with pediatric rheumatic diseases, the HRSA report stated. The estimate is based on an average practice capacity per pediatric rheumatologist of about 443 patients. This is the appropriate practice size considering that these patients are so complex and their management so time consuming, Dr. Sandborg said.

The report also outlined a number of possible solutions for increasing the workforce, such as increasing the availability and financing of fellowship training, providing incentives to trainees to practice in underserved areas, and targeted loan repayment programs.

Education and training for adult rheumatologists and primary care physicians is another approach, the report said. For example, officials could change the requirements for internist rheumatology fellowship training to include training in the care of adolescents and provide exposure to pediatric rheumatology during pediatric residency.

The report also called for pilot testing a telemedicine network that would link pediatric rheumatologists with distant physicians.

The report is a real opportunity to drum up support for pending federal legislation that includes provisions aimed at increasing the ranks of pediatric rheumatologists, said Amy Melnick, chief public policy officer for the Arthritis Foundation. The group is supporting the Arthritis Prevention Control and Cure Act of 2007 (S. 626/H.R. 1283), which would authorize loan repayment programs for pediatric rheumatology and increase institutional training grants to support the field. ■

# Medicare Demo Allows MDs to Share Savings

BY MARY ELLEN SCHNEIDER
*New York Bureau*

Preliminary results of a demonstration project that allows physician groups to share in savings they earn for the Medicare program has also resulted in quality gains, according to the Centers for Medicare and Medicaid Services.

The Medicare Physician Group Practice Demonstration is a 3-year project that encourages group practices to improve coordination of care for patients with chronic diseases.

The project offers the practices financial incentives that meet clinical targets and save the Medicare program money above a certain threshold. In the first year, 10 participating practices were assessed based on their performance on evidence-based diabetes measures.

In the first year (April 2005–March 2006), all participating practices improved their clinical management of diabetes and met targets on at least 7 of 10 measures; two practices improved on all 10 measures.

Measures for the first year included hemoglobin $A_{1c}$ management and control, blood pressure management, lipid measurement, LDL cholesterol level, urine protein testing, eye exam, foot exam, influenza vaccination, and pneumonia vaccination.

In addition to improving care, the demonstration saved the Medicare program about $9.5 million, Herb Kuhn, CMS acting deputy administrator, said during a press conference to announce the first-year results.

"We are seeing substantial and verifiable improvements in the quality of care for patients and improved efficiency in the delivery of that care," Mr. Kuhn said. The results show that Medicare is "on the right track" in terms of providing incentives for coordinating care, he said.

The demonstration includes 10 large, multispecialty group practices with a total of about 224,000 Medicare beneficiaries. The 10 group practices are Dartmouth-Hitchcock Clinic, Bedford, N.H.; Deaconess Billings (Mont.) Clinic; the Everett (Wash.) Clinic; Geisinger Health System, Danville, Pa.; Middlesex Health System, Middletown, Conn.; Marshfield (Wisc.) Clinic; Forsyth Medical Group, Winston-Salem, N.C.; Park Nicollet Health Services, St. Louis Park, Minn.; St. John's Health System, Springfield, Mo.; and University of Michigan Faculty Group Practice, Ann Arbor.

The demonstration encourages physicians to coordinate Part A and Part B Medicare services, invest in new care management programs, and redesign care processes.

If these investments save money for the Medicare program, the physician groups are able to share in a portion of the savings.

These performance payments are in addition to the regular fee-for-service Medicare payments received.

Physician groups may share up to 80% of the savings, which are distributed based on financial performance and achievement of benchmarks in care quality measures, Mr. Kuhn said.

To receive a performance payment, the practices' total Medicare spending growth rate must be more than 2 percentage points lower than a comparison population of Medicare beneficiaries in their local market area.

While all the practices met clinical targets for at least seven diabetes measures, only two practices received performance payments.

The Marshfield Clinic, and the University of Michigan Faculty Group Practice earned performance payments for quality and efficiency improvements.

In total, the two groups earned $7.3 million in payments; however, the two practices that met benchmarks in every clinical area—St. John's Health System and the Forsyth Medical Group—did not receive payments.

While other participating practices did achieve lower Medicare spending growth rates than comparison populations in their local markets, their savings did not meet the 2% threshold to share in the Medicare savings, Mr. Kuhn said.

Part of the problem may be that not all practices were able to fully deploy their initiatives in the first year, Mr. Kuhn said. "I think, overall, it's trending in a very positive way."

Findings from the first-year evaluation has revealed an emphasis among the practices on care coordination, chronic disease management, efforts to avoid unnecessary hospitalizations, proactive case management, timely follow-up after hospital stays, and the use of health information technology.

For example, St. John's Health System is using a Web-based patient registry aimed at helping physicians to plan patient visits.

In the second and third years of the program, the group practices will be assessed on additional measures related to heart failure, coronary artery disease, hypertension, and cancer screening. ■

## FYI

### Medicare Fee-for-Service Tool

The Alliance for Health Reform is offering an online booklet that contains links to resources describing the basics of Medicare private fee-for-service plans, advantages and incentives of the plans, and difficulties encountered by beneficiaries. To download the booklet, visit www.allhealth.org/publications/Medicare/Medicare_Private_Fee-for-Service_Plans_65.pdf.

### Free RX Savings Card

The Together Rx Access Card is a free prescription savings card for legal residents of the United States who are not eligible for Medicare, do not have prescription drug coverage, and meet certain household income levels. Most card holders will save 25%-40% on more than 300 brand-name prescription products. Savings also are available on a range of generic products. For more information on the card, which is sponsored by a group of pharmaceutical companies, visit www.togetherrxaccess.com.

### Prescription Assistance Fact Sheet

The National Council on Patient Information and Education is distributing a fact sheet to advise consumers who lack health insurance or prescription drug coverage about prescription assistance programs and prescription savings/discount programs that can help them to obtain the medications they need. For more information, read the fact sheet at www.talkaboutrx.org/documents/paps.pdf.