Plan to Pay for Performance Looks Likely

BY MARY ELLEN SCHNEIDER
New York Bureau

SAN DIEGO — Within the next few years, Medicare is likely to move from a system of pay for reporting to pay for performance, Jeff Flick, a regional administrator for the Centers for Medicare and Medicaid Services, said at the annual meeting of the American College of Physicians.

Mr. Flick, who is based in San Francisco, predicted that Congress is likely to approve funds to continue the Medicare Physician Quality Reporting Initiative (PQRI) in 2008. However, in future years the program is likely to convert to a pay-for-performance system, he said, which could be similar to the system being developed for hospital value-based purchasing.

"I believe we're not going to move away from this," he said.

PQRI is a voluntary program that will let physicians earn a bonus of up to 1.5% of their total allowed Medicare charges during the last 6 months of 2007 for reporting on certain quality measures. Congress authorized the establishment of the 6-month pay-for-reporting program last December as part of the Tax Relief and Health Care Act of 2006. Changes to PQRI—and actual implementation of a pay-for-performance system—would require additional legislation from Congress.

Officials at the Centers for Medicare and Medicaid Services have selected 74 quality measures that can be used across specialties. If four or more measures apply, physicians must report on at least three for at least 80% of cases in which the measure was reportable. If no more than three measures apply, each must be reported for at least 80% of the cases in which a measure was reportable, according to CMS.

ACP has estimated that the typical internist will be able to earn about $1,500 for reporting over the 6-month period. But the amount earned will depend on the case mix of the practice, said Robert Doherty, senior vice president for governmental affairs and public policy at ACP.

"If you look at this program, it's one that can teach us a lot for the future. It's not the answer," Mr. Doherty said. "But if you do participate, you'll learn a lot about the program."

ACP officials would rather see a "weighted" performance payment that would take into consideration the impact and the additional work related to measures for chronic diseases, he said.

But physicians who participate will have a chance to learn about the quality of care they provide and to get ready for pay for performance, Mr. Flick said. Physicians will also send a message to Congress that they are not afraid of quality, he said.

What is fundamentally driving the program is the need to move toward value, he said. CMS is currently receiving data on hospital, home health, and nursing home quality, but not on physicians. "We need data. We need to begin to understand information on quality of care," Mr. Flick said. ■

Cardiologist Shortage Anticipated

BY BRUCE JANCIN
Denver Bureau

NEW ORLEANS — Unless the training duration is shortened, the number of general cardiologists in practice in the year 2020 will be only two-thirds of the projected need, Dr. Jeffrey L. Williams predicted at the annual meeting of the American College of Cardiology.

By 2038—expected to be the peak year of the impending shortage—the number of general cardiologists on hand will be only 47% of the anticipated need for more than 62,400 of the physicians, leaving the nation nearly 34,000 short, added Dr. Williams, a fellow in clinical electrophysiology at the University of Pittsburgh.

Shortening the duration of training required for general cardiologists—a key recommendation to address the coming cardiologist shortage proposed in the report of the 35th Bethesda Conference sponsored by the ACC—will help, but not nearly enough, Dr. Williams added.

The Bethesda Conference report recommended fast tracking general cardiologists such that they would complete a 3-year cardiology fellowship after 2 years of general internal medicine residency instead of the conventional 3 years (J. Am. Coll. Cardiol. 2004;44:216-9 [doi:10.1016/j.jacc.2004.05.016]).

This would produce a greater number of general cardiologists with the same amount of funding.

But Dr. Williams calculated fast tracking would increase the number of general cardiologists practicing in 2020 from 22,365 to only 23,761—still well below the projected need for 33,459, based on the accepted ratio of 6 per 100,000 population.

The looming critical shortage of cardiologists is due to a confluence of factors. The number of U.S. medical school graduates matching in internal medicine residencies has declined dramatically over the last 20 years. Fewer cardiologists are being trained today than a decade ago. An estimated 10% will retire in the coming decade. The baby boomers are reaching the age when cardiovascular disease rates climb sharply. The average patient load in cardiovascular medicine is declining, and maintaining those lower loads requires more physicians, Dr. Williams continued.

The Bethesda Conference didn't address the possibility of fast-tracking fellowships in electrophysiology (EP) and interventional cardiology. This would entail 2 years of general cardiology fellowship followed by 2 years of subspecialty training. Dr. Williams incorporated this concept into his modeling and concluded it would result in a further modest gain in the number of general cardiologists, because it would free up funds for close to 350 trainees who would no longer be taking a third year of general cardiology.

Doubling the number of cardiology fellows being trained and incorporating fast tracking for electrophysiology and interventional cardiology would essentially thwart the projected shortage of general cardiologists in 2020 but would produce a glut by 2050, according to Dr. Williams' projections.

Dr. JoAnne M. Foody called his study a useful first look at potential approaches to the looming shortage of cardiologists.

"The study shows we need to think more critically about the long-term implications of the workforce shortage and develop cogent approaches to address the issue," said Dr. Foody of Yale University, New Haven, Conn.

If anything, Dr. Williams' projections as to future need for cardiologists are conservative, because they don't fully incorporate the effects of rising rates of obesity, metabolic syndrome, and type 2 diabetes.

Dr. Foody said fast tracking electrophysiology training is tricky because the subspecialty is currently reinventing itself.

"[Electrophysiology] is really changing rapidly. It's hard to sort out what it will look like in 10 years. Will it be a composite that includes components of heart failure? I predict that we're likely to see multiple different tracks within EP," she said. ■