Medicare Group Demo Achieved Modest Savings

BY SUSAN BIRK

CHICAGO — The Medicare Physician Group Practice Demonstration achieved modest cost savings and quality enhancements in the project's first 2 performance years, researchers reported at the annual research meeting of AcademyHealth. Data released in August reinforce that finding.

The project involves 10 large, geographically diverse physician group practices with a total of 5,000 physicians caring for 200,000 Medicare fee-for-service beneficiaries. The practices include multispecialty groups, integrated delivery systems, faculty groups, and a physician network.

During each year of the project, each group was retroactively assigned a population of Medicare beneficiaries, with an average of 20,000 patients per group (range 10,000-37,000). Each group was held accountable for total Part A and Part B expenditures for these patients.

Patients had complete freedom of choice in providers and were not required to receive care through the participating group practice. However, only patients who received most of their outpatient evaluation and management for the year from the group practice were assigned to the group. Groups that kept increases in expenditures below 2 percentage points of their target growth rate shared up to 80% of the savings; Medicare retained 20%.

The group practices assumed all business risks associated with investments related to their participation in the demonstration, and there was no guarantee of savings.

"Savings are a function of the ability of the group to control growth in Medicare spending as well as changes in [health] status of their assigned population over time relative to their local market," explained John Pilotte, a senior research analyst at the Centers for Medicare and Medicaid Services. The groups were free to make whatever investments and enhancements they felt were necessary to reach their quality and efficiency goals.

In the first year of the demonstration, two participating group practices earned a total performance payment of $7.3 million and two lost a total of $1.5 million, Gregory Pope of RTI International in Waltham, Mass., a nonprofit research and development firm working with the CMS, reported at the meeting. In the second year, four groups shared a total payment of $13.8 million and one lost $2 million. Savings to Medicare totaled $677,000 and $1.6 million for the first and second years, respectively.

Results for the third year were announced in August; five physician groups will receive performance payments totaling $25.3 million as part of their share of $32.3 million of savings generated for the Medicare Trust Funds in that year, the CMS announced.

Quality was assessed by the groups' adherence to 27 measures as indicated by Medicare claims and clinical records data. The measures covered heart failure, diabetes, coronary artery disease, hypertension, and preventive care.

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In the third year, all 10 groups achieved benchmark performance on at least 28 of the 32 measures reported, according to the CMS. Two groups—Geisinger Clinic in Danville, Pa., and Park Nicollet Health Services in St. Louis Park, Minn.—achieved benchmark performance on all 32 performance measures.

Over the first 3 years of the demonstration, the physician groups increased their quality scores an average of 10 percentage points on 10 diabetes measures, 11 points on 10 heart failure measures, 6 points on 7 coronary artery disease measures, 10 points on 2 cancer screening measures, and 1 percentage point on 3 hypertension measures.

Additional research is needed to determine the keys to success, according to Mr. Pilotte of the CMS. "Trying to figure out how to make this work in a program that processes over 1 billion claims each year is not a small feat. ... It takes a while to get these projects up and running both from our side of the house and the provider side."

Although the group practices generally have sophisticated health information management systems and dedicated information technology leadership, "even that doesn't seem to be enough to control growth in expenditures."

One key lesson learned so far during the demonstration is that "leadership and champions within the organization are really important," Mr. Pilotte said. "All of these groups have someone who is on point for monitoring and reporting the quality metrics to us every year and developing mechanisms ... to be able to capture the information."

Another lesson learned is the importance of having quality measures consistent with clinical practice and high-quality care in order to achieve physician buy-in. "That's why we spent a fair amount of time early on with these physician groups on which measures we were going to use and to gain their support, because it really wouldn't be possible without them," he said. ■

For more information, visit www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp.

Joyce Frieden contributed to this report.

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Agency Calls for Fee Efficiency

Medicare should review and possibly reduce fees when physicians provide multiple services to individual patients on the same day, the Government Accountability Office recommended. To date, the Centers for Medicare and Medicaid Services hasn't done enough to "reduce excess physician payments" reflecting efficiencies that doctors achieve when delivering multiple services. "When two services are furnished together, a physician reviews a patient's medical records once, but the time for that activity is generally reflected in fees paid for both services," according to the GAO. Adjusting payment policies to reflect multiple-service efficiencies could save more than $500 million a year, the GAO said.

Tobacco Makers Challenge Law

Five tobacco manufacturers, along with a retailer, have filed suit to challenge the constitutionality of the new federal law that limits many forms of tobacco advertising. The plaintiffs chose the U.S. District Court for the Western District of Kentucky to argue that the law interferes with their First Amendment right to free speech. Lawmakers approved the Family Smoking Prevention and Tobacco Control Act last spring, setting new limits on tobacco promotion and giving the Food and Drug Administration authority to regulate tobacco products. The law prohibits most color and images in advertising, mandates larger warnings on tobacco products, and bans ad campaigns aimed at underage smokers. The tobacco interests say the law hampers their ability to communicate with adult customers.

Heart Group Scorns Sugar

The American Heart Association has recommended that Americans drastically cut their intake of sugar to ward off obesity and related conditions. Survey results from 2004 showed that the average American consumed about 22 teaspoons, or 355 extra calories, per day of sugar added to food during processing—mainly in sugar-sweetened drinks. But the AHA said that men should consume no more than 9 teaspoons (150 calories) a day of this added sugar, while women should limit themselves to 6 teaspoons (100 calories). One 12-ounce can of soda contains about 8 teaspoons. In a "scientific statement" published in the Sept. 15 issue of Circulation, the AHA noted that limited clinical trial data link sugar consumption with obesity, but observational studies associate a higher intake of soft drinks with higher body weight and lower intake of nutrients.

Medical Groups Post Losses

Many physician groups that are part of large, integrated provider organizations are operating at a loss, according to the American Medical Group Association's 2009 Medical Group Compensation and Financial Survey. But losses for the doctors' operations do not necessarily mean that the larger organizations are losing money overall, Tom Flatt, AMGA director of communications and publications, said in an interview. "These large, integrated systems actually have revenues coming in from other parts of the organization, so they can stay afloat," he said. In 2008, only physician groups in the Eastern United States broke even, while losses elsewhere ranged from $120 per physician in the South to $3,254 per physician in the North. AMGA blamed declining reimbursement, competition for specialists, and the cost of new technology.

Supplement Maker Fined $70 M

In a case brought by the Federal Trade Commission, a marketing group that used infomercials to tout calcium and herbal supplements as effective treatments for cancer, Parkinson's disease, heart disease, and autoimmune conditions has been ordered to pay about $70 million in consumer refunds. Last year, the U.S. District Court for the District of Massachusetts ruled that the companies and individuals involved in marketing the supplements had falsely represented their safety and efficacy. Judge George O'Toole considered potential financial penalties separately, and has now ordered the restitution in order to strip from the defendants all profits derived from the supplement sales. He also issued injunctions to prevent the defendants from making similar claims about other products.

Snapshot Shows Practice Patterns

Despite concerns about physicians' willingness to accept new patients from public programs, most U.S. doctors say they're doing so, according to a Center for Studying Health System Change survey. About three-quarters of physicians reported accepting new Medicare patients and more than half took new Medicaid patients. The public programs provided nearly half of physicians' practice revenue in 2008, according to the survey. Other findings from the snapshot of how physicians practice medicine: Nearly one-third work in solo or two-physician practices, and 15% are in groups of three to five physicians. The composition of the physician workforce by sex appears to be changing—while nearly three-quarters of U.S. physicians were men in 2008, about 41% of those under 40 years old were women. The center predicted that a gender shift in the profession will continue in coming decades.

—Jane Anderson