Does Pay for Performance Have the Right Stuff?

If a physician thinks the measure is good, putting money behind it will speed quality improvement.

BY JENNIFER SILVERMAN
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WASHINGTON — Mix a little money with solid incentives physicians can relate to, and you've got a successful recipe for a pay-for-performance program, Ronald P. Bangasser, M.D., said at the annual National Managed Health Care Congress.

Physicians try to deliver the highest level of medical care they can, but most can't keep track of the needs of every patient, said Dr. Bangasser, a family physician and immediate past president of the California Medical Association.

Studies show that 50% of patients don't get what they need in quality of care, he said. "Most patients rate their doctor a four out of five, but they hate the health care system."

That's one reason physician groups need a data-based approach to help reduce errors and improve care, he continued. A new program in California has yielded positive results, and is "certainly one way to pay for quality," Dr. Bangasser said.

Backed by a state foundation grant, the statewide Integrated Healthcare Association (IHA) got together with medical groups, health plans, purchasers, and consumer groups several years ago to collaborate on a plan to reduce expenses for physician reporting.

The program was able to achieve this savings "by accumulating all of the health plans together, so physician groups only had one reporting mechanism instead of seven or eight," said Dr. Bangasser, medical director of the wound care department of the Beaver Medical Group L.P., at Redlands (Calif.) Community Hospital. The group participates in the IHA program.

All of the health plans and medical groups had to agree on a common set of measures and a common way to report those measures. The IHA in turn acted as a "neutral convener," in coming up with standards for reporting the data, he said.

Technical and steering committees were formed to work with technical experts on proposing measures.

The measures had to be valid and accurate, meaningful to consumers and physicians, and important to public health in California. "They also had to get harder over time," Dr. Bangasser said. In the IHA program, physicians get paid not just for performance, but also for performance improvement. "We actually have a calculator [that determines whether] people are improving."

The first payout took place in 2004, based on first-year data from 2003.

Physicians are assessed on three types of measures: clinical, patient experience, and information-technology investment.

First-year results saw little variation among the participating groups on patient experience, although variations were seen among clinical and IT measures.

There was room for improvement in both of these areas, Dr. Bangasser said. Fewer groups participated in IT measures than in the other measures, and of those who tried, "only two-thirds of them got full credit for it. It showed us that we had a huge IT deficit."

Variations occurred in the clinical measures because not all of the groups used a registry-type system—a list that details the specific diagnoses of each patient. Physicians using a registry can find out if a patient got a certain test or if they need one, Dr. Bangasser said. To date, groups that use registries "are doing much better on these measures than groups that don't."

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One of the biggest improvement areas was in cervical cancer screening, he said. Based on data comparisons between 2002 and 2003—the year the program got started—nearly 150,000 more women were screened for cervical cancer, and 35,000 more women were screened for breast cancer.

An additional 10,000 children got two needed immunizations, and 180,000 more patients were tested for diabetes.

Although some groups scored fairly high, specialists didn't fare as well. Patients cited access problems to specialists as a specific complaint in the satisfaction surveys, Dr. Bangasser said.

The estimated aggregate payment to physician groups in the IHA program in 2003 was between $40 million and $50 million, although some groups thought they didn't get paid properly, Dr. Bangasser said. There were some concerns about increased utilization and cost of services for groups participating in the program, and what the long-term returns on investment would be.

It was also determined that groups serving large Hispanic or Native American populations should get "extra credit" for having to deal with more diverse, culturally different populations.

Applying the right types of incentives is key, he said. "If a physician thinks the measure is a good idea, putting a little money behind it will speed quality improvement. However, if the physician thinks the measure is not going to improve quality, $1 million will not change behavior."

Sometimes, the simplest incentives can produce good results.

Dr. Bangasser mentioned a particularly bad influenza season in 1998, when patients had to wait in long lines to see physicians in his group practice.

"I asked all of the doctors if they'd take on two more patients a day. That's a long day, but I gave them two tickets to a movie theater for Christmas," Dr. Bangasser said.

All but two physicians took on the extra patients. "This meant that over 60 physicians saw an extra 120 patients per day," he said. ■

Physicians Advise CMS on Measuring Pay for Performance

BY JOYCE FRIEDEN
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WASHINGTON — The Centers for Medicare and Medicaid Services is jumping on the pay-for-performance bandwagon, but members of a physician advisory group warned CMS officials to be careful how they go about it.

"I'm only hoping that you'll structure this so that the quality indicators will be that you've [performed] certain processes, not necessarily the outcome [of them]," said Laura B. Powers, M.D., a Knoxville, Tenn., neurologist and member of the Practicing Physicians Advisory Council.

For example, outcomes are not good in terminal patients, Dr. Powers told this newspaper. "What outcome are they going to measure with an amyotrophic lateral sclerosis patient who is definitely going to die?" she said. Instead, Medicare should assess whether the physician has followed appropriate standards of care for terminal patients.

Trent Haywood, M.D., acting deputy chief clinical officer at the agency, said CMS has debated that very issue. "There has been a lot of discussion about what is the right thing [to measure]. We've always said that we think it's both," he said. "We definitely want process measures … and the current financial structure is also easier for measuring processes, because that's the way we traditionally pay people."

However, he added, "our goal is toward getting some evidence of outcomes. The process measures we normally collect are always related to outcomes."

Council member Peter Grimm, D.O., a radiation oncologist in Seattle, said he believes that outcomes are the most important thing to measure. "You have to have outcomes as the bottom line," said Dr. Grimm, who runs a quality assurance business involving 300 physicians. "I don't care how people get there. I just care that they get there."

'What outcome are they going to measure with an amyotrophic lateral sclerosis patient who is definitely going to die?'

In his testimony to the council, Dr. Haywood outlined the various steps Medicare is taking to introduce pay for performance into physician reimbursement, including demonstration projects with hospitals and group practices. But Dr. Grimm still was not satisfied.

"One thing I didn't hear is how you verify these [performance] data," he said. "You have to have a third party evaluate it."

Geraldine O'Shea, D.O., an internist in Jackson, Calif., said that she is concerned about the impact of pay for performance on the doctor-patient relationship.

"Could it discourage physicians from caring for noncompliant patients?" she asked. "And how do these programs ensure the most up-to-date guidelines are being used? How can we get this out to know that this is the benchmark we're going to be measured at?"

There are different ways to address patient compliance, Dr. Haywood said. "If you lean more heavily on process measures, that takes care of part of that problem, because those process measures look at whether you prescribed something or did something. But because we still want to look at outcomes measurement, we also talk about ways in which you allow that patient to be excluded. You can have documentation saying, 'Provided counseling and patient refused.' "

Council member Barbara McAneney, M.D., an oncologist in Albuquerque, N.M., said she was concerned about the expense of the computer system that would be required for physicians to keep track of their outcomes data.

"The electronic medical record (EMR) that our practice purchased some years ago is now completely inadequate because it's not searchable for tumor stage, size, or treatment," she said. "So I have been shopping for an EMR.

"The most recent quote I got for the EMR that can provide the functions I want … for a practice of nine physicians, they want $400,000," she continued. "Well, my Medicare drug money just went away, the physician fee schedule is going down, and the [Medicare payment formula] is going to nail us 30% over the next 6 years. Where am I going to find $400,000 to put in an EMR that I can search and find all stage II breast cancer patients, and see whether they got their chemotherapy, and how they are doing, and by the way, how many of them are on Vioxx, and I have got to call them up and get them off it? All these kinds of issues are really going to have to be addressed."

Dr. Haywood agreed. "You're articulating some of the barriers we face as we continue to try to work through this process," he said. "We've started to map out strategies to address some of those issues." Right now the agency is discussing the idea of certifying EMR systems to help physicians decide which ones to purchase. ■