health and health care, University of California, San Francisco. Leadership at the federal level is needed to ensure that performance measures achieve national goals for health care improvement, he said.

The committee recommended that Congress should authorize $100 million to $200 million in annual funding for the national board from the Medicare Trust Fund. This amounts to less than one-tenth of 1 percent of annual Medicare expenditures.

What's lacking in the report is a recommendation for Congress and the private payers to put money into the system to help defray costs of this type of reporting, Dr. Fields said. "The two must go hand in hand, because this type of reporting costs money." Otherwise, pay for performance is going to be an extreme burden to physicians—primary care physicians in particular—if they don't have technology to do pay for performance, he said.

Questions remain on whether pay for performance can improve quality, Dr. Fields noted. "Some of the private payers don't buy into that. When they talk about quality, what they really mean is saving money." For certain diseases, this type of reporting has been effective, "but it's not yet been shown to be effective over a wide series of medical problems."

If a universal system is instituted, it needs to be pilot tested first, to find out if it can improve quality, he said. "There needs to be a gradual shift from reporting aspects [of clinical measures] to actual quality measures."

Requested by Congress, the report is the first in a series that will focus on the redesign of health insurance to accelerate the pace of quality improvement efforts in the United States. Subsequent reports will evaluate Medicare's Quality Improvement Organization program and analyze payment incentives. ■

Pilot Pay-for-Performance Projects on View

BY JOYCE FRIEDEN

Associate Editor, Practice Trends

WASHINGTON — Provider groups are behind the curve when it comes to anticipating acceptance of pay-for-performance programs, Jeff Flick said at a health care congress sponsored by the Wall Street Journal and the CNBC.

Take, for instance, the Premier Hospital Quality Incentive Demonstration program funded by the Centers for Medicare and Medicaid Services, under which hospitals report data on 34 quality measures, said Mr. Flick, the CMS regional administrator in San Francisco. The program gives a bonus each year to the 20% of hospitals with the highest score, but those who have not improved a certain amount after 3 years are penalized.

When the program was launched several years ago, "The American Hospital Association said, 'No hospital is going to do this,' " Mr. Flick said. "Hospitals are afraid to even report information about quality, but the idea that they could be penalized financially ... the [AHA] thought it would never happen. But there were 300 hospitals on board immediately."

Similarly, the American Medical Association recently said it did not support CMS's new physician voluntary reporting program, under which physicians would volunteer to report 36 pieces of data on their practices. The AMA's opposition "is not a shock; those kinds of organizations are very nervous about this," he said.

Many physicians are ready to start focusing on quality, he continued. "They want to publish information, they want to know how they compare, they want to be paid based on performance. That doesn't mean the AMA is going to support it."

The program uses "G codes" to enter the data, which can make for a bit of a hassle for physicians not familiar with them. "If every physician in this country had an [electronic health record], this would be easy; I think this would be done," he said.

Other pay-for-performance demonstration projects include:

► **Group Physician Practice Demonstration.** Large multispecialty practices will be rewarded financially for improving care for chronically ill Medicare patients.

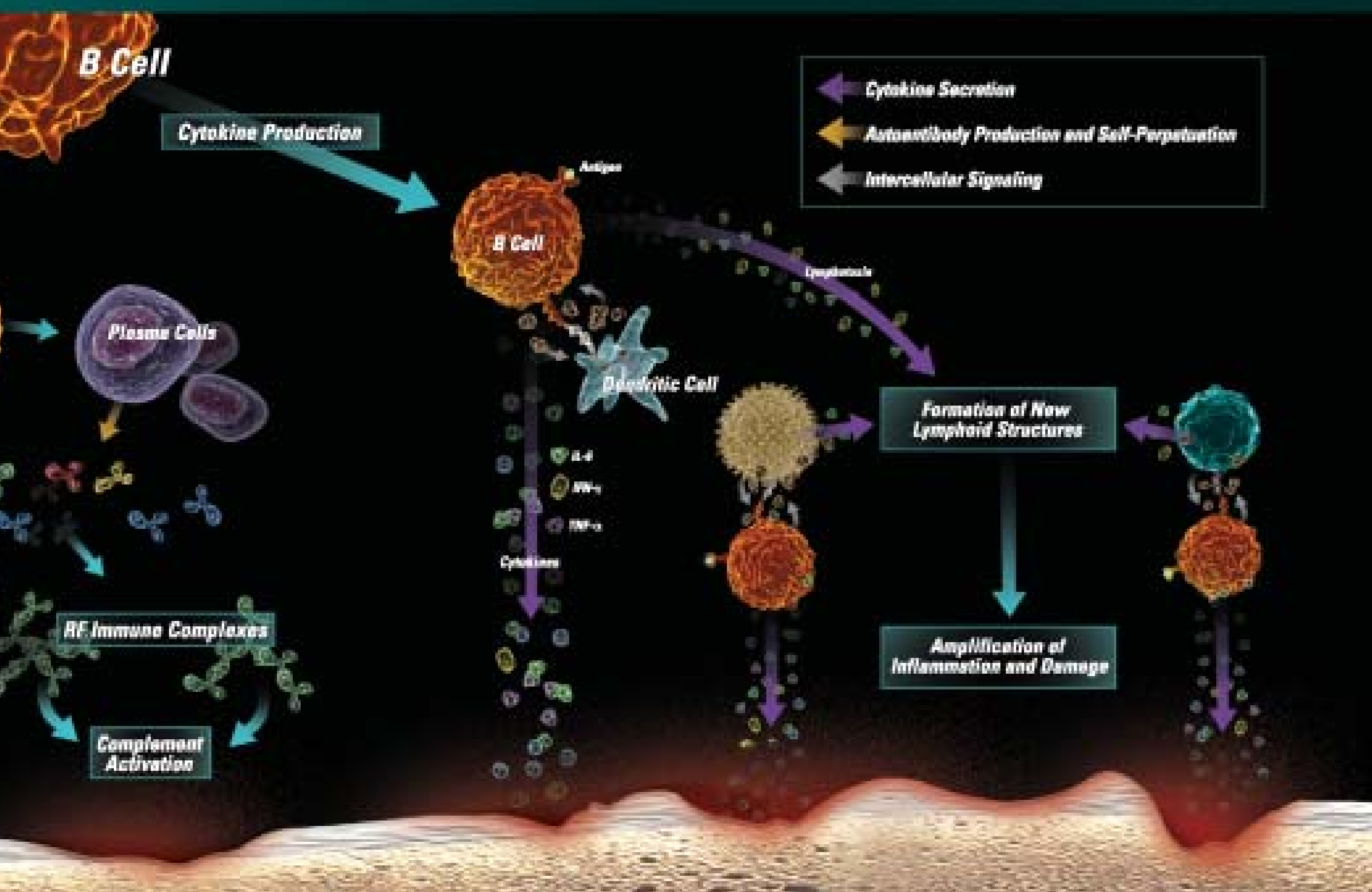
► **Coordinated Care Demonstration.** Hospitals and other health care organizations in 15 sites are trying to prove that providing coordinated care for patients with particular chronic illnesses will increase patient satisfaction and save Medicare money.

► **Benefits Improvement and Protection Act (BIPA) Disease Management Demonstration.** This program coordinates care and provides a prescription drug benefit for up to 30,000 patients with diabetes, congestive heart failure, and coronary artery disease.

"Watch the demonstrations—watch them very carefully," Mr. Flick said. "They give a very good picture of where CMS thinks it's going to go." ■

CHANGING THE WAY WE SEE RA

IN RHEUMATOID ARTHRITIS



AUTOREACTIVE B CELLS PRODUCE AUTOANTIBODIES THAT MAY HELP DRIVE THE DISEASE PROCESS IN RA[3,5,10,11]

B cells produce autoantibodies such as RF, anti-CCP, anti-GPI, and anti-RA33. RF immune complexes within the synovium may

- activate the complement system and stimulate an immune response[3,10]
- bind to, and activate, macrophages in the synovium[11]

Macrophages activated by immune complexes produce proinflammatory cytokines that perpetuate inflammation and joint destruction.[11]

ACTIVATED B CELLS MAY PRODUCE CYTOKINES KNOWN TO PROMOTE INFLAMMATION AND JOINT DAMAGE IN RA[3,4,6,12]

B cells may be activated to produce cytokines such as TNF-α, IL-6, and lymphotoxin in a variety of ways:

- antigen binding to the B-cell receptor[4,6]
- binding of the costimulatory ligand found on activated T cells, macrophages, and dendritic cells to the costimulatory receptor on B cells[4,6,12]
- exposure of B cells to cytokines produced by other cells[4]

B-cell–produced lymphotoxin may also indirectly perpetuate RA by promoting the formation of new tertiary lymphoid structures in the synovium.[4]

The increased understanding of the potential roles of B cells may provide further insight into the pathogenesis of this systemic autoimmune disease and ultimately change the way we see RA.

©2005 Genentech, Inc., and Biogen Idec Inc. All rights reserved. 8076000

Genentech | biogen idec