Pay-for-Performance Pact Ruffles Some Feathers

The AMA defends its agreement with Congress, but some specialty societies complain they were left out.

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Specialty organizations are concerned that the American Medical Association is unilaterally setting performance goals that doctors won't be able to meet.

A recent agreement between the AMA and leaders in Congress outlines an ambitious 2-year time line for establishing performance measures, "to improve voluntary quality reporting to congressional leadership," AMA Chair Duane M. Cady said in a statement.

Dr. Cady signed the pact at the end of last year, although the details weren't publicly disclosed until several months later. The terms were outlined in a Feb. 7 memorandum from AMA Vice President Michael Maves to the state medical associations and national specialty societies.

Sen. Charles E. Grassley (R-Iowa), chair of the Senate Finance Committee; Rep. Bill Thomas (R-Calif.), chair of the House Ways and Means Committee; and Rep. Nathan Deal (R-Ga.), chair of the House Energy and Commerce subcommittee on health, cosigned the agreement.

If the plan goes through, physician groups will work with the Centers for Medicare and Medicaid Services to agree on a starter set of evidence-based quality measures for a broad group of specialties, with a goal of developing about 140 physician measures covering 34 clinical topics by the end of 2006.

The AMA has been working on these quality initiatives for some time, Dr. Cady said. "For the past 5 years the AMA has convened the Physician Consortium for Performance Improvement, which includes more than 70 national medical specialty and state medical societies." To date, the consortium has developed more than 90 evidence-based performance measures, he said.

The consortium has not yet tested the physician measures; it has been working with several groups to do so, including the Ambulatory Care Quality Alliance, said Dr. Nancy Nielsen, speaker of the AMA's House of Delegates, at a press briefing. The alliance is receiving funding from the Agency for Health Research and Quality and CMS to test 26 measures at six clinical sites, beginning May 1. Those measures include some developed by the consortium, among others. The pilot is crucial, as it will bring to the surface any "unintended consequences," Dr. Nielsen said. Then in 2007, doctors who report on three to five quality measures would see increased payments from Medicare. By the end of next year, physician groups should have developed performance measures "to cover a majority of Medicare spending for physician services," the agreement said.

Other initiatives, such as working on methods to report quality data and implementing additional reforms to address payment and quality objectives, also were outlined in the agreement.

As far as Dr. Cady is concerned, nothing in the agreement with the congressional leaders should be a surprise. "It involved only [those] commitments we had previously outlined to our specialty society colleagues."

All of these steps had been documented previously in public letters to Congress and the Bush administration and distributed to medical specialty societies, he said.

Yet some of the members of the consortium said they had no advance notice of the AMA's plans to sign this pact.

"This is an agreement signed with leaders on Capitol Hill on how pay for performance should be laid out, and some groups feel they should have been a part of it," Cynthia A. Brown, director of advocacy and health policy at the American College of Surgeons, said in an interview.

The real problem isn't about advocacy or the workings of the consortium. It's about meeting deadlines on clinical measures, Ms. Brown said. "Not everyone is ready for [pay for performance]."

While many primary care quality measures have been written, it's a different story for subspecialties, "because their measures haven't even been developed yet. They're starting from ground zero," she said. With this latest agreement, subspecialties now feel pressured to find their own groups of doctors to propose measures to run through the consortium's process by year's end, she said.

The criteria on performance measurement also will be different by specialty, Ms. Brown said. "Surgeons in particular often like to be judged by outcomes, and primary care doctors don't want to be because they have a bigger problem with patient compliance. One size doesn't fit all."

At the press briefing, Dr. Nielsen said "this is a dustup about nothing," adding that the specialty societies had been included on the performance measure development from the start. The initial measures won't cover all the specialties, but it was necessary to show Congress that the profession was serious about quality improvement by getting something started quickly, she said.

The AMA has tried to work with the CMS on quality measures for some time now, and it is "very difficult" to get truly significant data and information that really makes a difference, Dr. Thomas Purdon, former president of the American College of Obstetricians and Gynecologists, said in an interview. However, it's unlikely the data will be accurate or have real meaning unless the specialty societies are involved, "either individually or through the Council of Medical Specialty Societies," he said. "I too share the concerns of others that the data will be weak and then be used to penalize doctors' reimbursement."

It's true that a number of specialty groups don't feel comfortable that they can meet these time lines, Dr. David Nielsen, executive vice president and chief executive officer of the American Academy of Otolaryngology–Head and Neck Surgery, said in an interview.

"Could the AMA [have] been more communicative about this agreement? Probably." Yet some of these specialty societies may be misinterpreting its terms, he said.

There's an assumption that the AMA is going to be responsible for doing all of the specialty measures, Dr. David Nielsen said. "While those concerns are valid, it isn't going to come to that." What these groups need to remember is that the AMA's consortium is run by the specialty societies, a process that's consensus based, he said. (The American Academy of Otolaryngology–Head and Neck Surgery is a consortium member.)

"People who are upset about this aren't comparing it to what would happen if the AMA didn't step in; that CMS would step in and do their own measures. I'd be much happier with consortium measures than any other group of measures, because the consortium is in the best position to produce patient-centered measures of medical outcomes that are driven by physicians, and are relevant and validated," he said.

He also doesn't believe the performance goals set by the agreement are insurmountable. Ninety measures have already been developed, he said. "If every specialty society creates one measure, we would get pretty close to that goal of 140 measures by the end of the year."

The American College of Physicians, in the meantime, wants to move even more quickly than the AMA on measure development, voluntary reporting, and pay for performance, Robert B. Doherty, the college's senior vice president for governmental affairs and public policy, said in an interview.

Physician concerns about CMS's initial draft of the physician voluntary reporting program (PVRP) had also been interpreted on Capitol Hill as a sign of opposition to quality reporting, Dr. Maves noted.

From CMS' perspective, there's no reason why the AMA's agreement shouldn't work in tandem with the PVRP, CMS spokesman Peter Ashkenaz said in an interview.

The physician voluntary reporting program isn't about developing measures, it's about testing systems "on how well we can use the existing claims-based system to capture the data from the measures," he said. The agency is testing the system on a voluntary basis to make sure it can function in a manner that works for both providers and the Medicare program, and ultimately for the beneficiaries when CMS reports the data. ■

Psychiatry Fill Rate Slips

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Northwestern University in Chicago. "The problem is you never stay at the same place. If you look at this for the last 25 years, what you see is that there are peaks and valleys."

For instance, psychiatry reached a peak a year ago; the specialty increased the numbers of U.S. medical graduates going into psychiatry by about 200 from a 5-year low, said Dr. Weissman, who is also a trustee of the American Psychiatric Association. "This is the first [percentage] decline in approximately 5 years. That to me is always of concern."

Another issue that concerns some psychiatrists is "a continued and sustained reliance" on international medical graduates to fill residency slots, Dr. Weissman said. But their participation is absolutely essential, he added.

"The reality is, we're subsidized in the United States by probably $1-$2 billion a year by people not going back to their own countries," he said, referring to physicians who go to medical school in their home countries, come to the United States for residency training, and don't return home. "If we had to have 4,000-5,000 additional medical school places, you'd have to look at the cost of the medical schools."

International medical graduates "are critical to maintain graduate medical education and critical to maintain health care," Dr. Weissman said. "It doesn't do us any good to throw stones at any group of practitioners; [if you do,] what you're really assaulting is your licensing and credentialing system."

Overall, more than 26,000 seniors graduating from medical schools—including more than 15,000 U.S. seniors—participated in the match, according to the National Resident Matching Program (NRMP), which runs the match. Nearly 22% of available slots were in internal medicine, making it the largest specialty, the NRMP said in a statement. This year, 4,735 internal medicine residency positions were offered. Of those, 97.9% were filled, with slightly more than half—56.3%—filled by U.S. medical graduates. Family practice had 2,711 slots; 85.1% of those were filled, a slight increase over last year. U.S. seniors filled 41.4% of those positions.

Pediatrics was popular, with 96.5% of its 2,288 slots filled; 72.9% were filled by U.S. seniors. And ob.gyn. continued its upward trend, with 97.9% of its slots filled, 72.4% of them by U.S. seniors. General surgery also was popular, with all but 1 of its 1,047 slots filled, 83.3% by U.S. seniors. Otolaryngology was new to the match this year and got off to a good start: 98% of the 264 slots offered were filled; 92% by U.S. medical school seniors.

The NRMP noted that graduates continued their increasing interest in "lifestyle" specialties that are considered to have more reasonable work hours. For example, 100% of first-year dermatology residency slots were filled, with U.S. seniors filling 93.3% of the slots. In anesthesiology, 97% of the positions were filled, including more than 80% by U.S. seniors. ■