Pay for Performance Not Yet Showing Efficacy

BY TIMOTHY F. KIRN
Sacramento Bureau

SEATTLE — When the physicians of Rochester, N.Y., first had a pay-for-performance program imposed upon them, they ignored it.

"At the beginning of our program, most people would not acknowledge it existed," said Dr. Howard B. Beckman, the medical director of the Rochester Individual Physician Association (IPA). "As we talked about the profiles, people said 'I never got them,' 'I threw them away,' or 'I don't care.' "

That denial ended when the first performance-based checks were disbursed, and after 3 years, pay-for-performance measures have paid off in reduced health plan costs of almost $5 million, Dr. Beckman said at the annual research meeting of AcademyHealth.

Dr. Beckman was one of three physicians who presented research on whether pay for performance improves quality of care and efficiency in medicine enough to make worthwhile all the effort being put into it. He was the only one of the three to have a positive conclusion.

The other two investigations of pay for performance, in California and Massachusetts, looked more specifically at individual aspects of clinical care. Those investigators found they could not document an impact from the programs.

But those investigators also pointed out that, as in Rochester, it takes time for physicians to get accustomed to the idea of greater accountability, and to develop the capabilities to record and report for the programs, so their findings might reflect that the programs have not been going long enough. Or the findings may show that financial incentives do not work for professionals, something research in other fields has suggested, they noted.

After the first performance bonus checks were sent out and denial ended, there was anger. The physicians complained that

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Fragmented Care Poses Dilemma For P4P System

Pay-for-performance schemes may be thwarted by patients seeing too many doctors, making it difficult to assign any one patient's care to a particular physician, according to a study that was presented at the annual research meeting of AcademyHealth.

The average Medicare patient sees seven physicians (two primary care, five specialists) over a 2-year period, Dr. Hoangmai Pham, a senior researcher with the Center for Studying Health System Change, Washington, said at the meeting.

Dr. Pham analyzed data from Medicare sources that included claims data and nationwide physician surveys for 2000-2003. Only 53% of Medicare beneficiaries' evaluation and management visits, and 35% of their total visits, are with the physician identified as their primary, or usual-source-of-care, physician.

During a 2-year period, 30% of beneficiaries switch their usual-source-of-care physician, and in 59% of the cases where beneficiaries switch, they never even see one of the designated physicians in a year, Dr. Pham said.

According to the physician survey data, a primary care physician's regular, usual-source-of-care patients make up an average of only 39% of his or her total patient population.

In today's medical environment, it takes more than one doctor to care for a patient, Dr. Pham said.

The Department of Health and Human Services has committed the Medicare program to advancing the concept of pay for performance, Dr. Pham noted. But what is really needed is an overhaul of the medical system to allow single physicians or groups to be responsible for individual patients. Alternatively, more financial incentive in pay for performance would make it worthwhile to invest in the infrastructure physicians need to participate, because they will be able to show good performance for only a small proportion of their patients, she added.

strict performance measures impinge on their autonomy, and they were even offended by the implication that money could influence their behavior, he said.

Then, after 2 years, the general resistance abated, and the angry phone calls stopped, Dr. Beckman said. Now when he gets phone calls about the program, it is an individual physician trying to negotiate something.

The Rochester IPA represents all 3,200 physicians in the Rochester area and has insurance contracts that cover about 50% of the community market.

The program's individual physician payments vary, but overall the program pays out about $15 million a year, and the average internist can earn from $4,000 to $12,000 from the quality reports. Dr. Beckman looked at the provider profile data for patients with diabetes. He found that when expected costs were compared with actual costs in the diabetes patients in 2003 and 2004, there was a savings of about $1 million in the first year and $2 million in the second year. Most of that savings, about $1.3 million, came from reduced inpatient hospitalization costs.

Dr. Beckman pointed out that many people have expressed concern that pay-for-performance programs could be unfair to physicians with the most difficult, least compliant patients, so he looked at different practices. It appeared that differences were greater between individual doctors than they were between practices and practice locations.

Pay for performance began in California at about the same time as the Rochester program, and it has yet to show any meaningful overall improvement in clinical care, said Cheryl L. Damberg, Ph.D., a researcher for the RAND Corp. who has been analyzing data from the California collaborative managed by the Integrated Healthcare Association, which includes seven HMOs and point-of-service plans contracting with 225 physician groups.

Surveys of patient satisfaction, a part of performance that is rewarded, showed gradual, substantive improvement in the first 2 years of the program, but when Dr. Damberg looked at clinical care measures, such as aspects of diabetes care, Pap smears, and childhood immunization, any improvement seen between years is inconsistent and varied.

She concluded, based on an analysis of the patterns of improvement, that many physicians and groups are getting up to speed with reporting, so it is too early to judge the impact on actual clinical care.

In Massachusetts, doctors with pay-for-performance contracts have improved their quality since programs were introduced into the state, but so have doctors without contracts, said Dr. Steven D. Pearson, director of the Center for Ethics in Managed Care at Harvard Medical School, Boston.

He looked at data collected from the state's pay-for-performance programs put together by the Massachusetts Health Quality Partnership, a collaboration of five nonprofit health plans covering 4 million people, and physician groups representing some 5,000 primary care physicians.

Comparing Health Plan Employer Data and Information Set measures from groups with pay-for-performance contracts and control groups without contracts, Dr. Pearson found that, for four measures, the contract groups had more improvement for those years than the control groups. For 21 measures, the groups had similar improvement, but for five measures the control groups had more improvement.

Moreover, when he restricted his analysis to just groups termed "high-incentive" groups, there was still no more improvement than controls. High-incentive groups were defined as ones that could receive performance bonuses of $100,000 or more, or for whom individual primary care physicians could receive bonuses of more than $1,000.

There are two plausible explanations for the findings, Dr. Pearson said. "Either P4P has worked in Massachusetts because it is part of this atmosphere of driving quality improvement … or P4P has failed because it is either too weak—not enough money on the table—or it was poorly designed." ■

Specialty Readies for P4P

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purchasers of health insurance, with General Electric leading the pack. They want P4P plans and it is driving the payers to push down on us. Medicare and Medicaid reimbursement will likely be pegged to P4P measures, as CMS tries to run on a budget-neutral platform," said Dr. Elston. The bottom line? "You will have to participate."

Under P4P schemes, the health plans and government payers financially reward physicians who demonstrate that their practices conform to the quality guidelines, while penalizing those who do not. The penalty comes in the form of higher copayment levels for patients. Dr. Elston said the messages sent to patients are deliberately worded to cast negative light on physicians who will not participate in P4P, suggesting that the patient is required to pay more because he or she chose a doctor for whom quality care is not a priority.

P4P programs will measure physician compliance with the established quality standards via billing information, which means physicians (and their billing managers) will have to learn a whole new set of codes, linked to the ICD-9 and CPT codes.

The new codes must be based on good scientific evidence, and ideally they will be tied to best practices that show the strongest patient outcomes. It is in actively participating in the guideline and code-building process that the specialty societies have the greatest potential for minimizing the negative impact of P4P on practicing physicians.

"We cannot afford to have our future dictated by limited guidelines. We have to look closely at what is evidence based, what is reasonable, and what we can live with, and then develop guidelines from there, so that we are ready when the payers and CMS start demanding more," he said.

In dermatology, the initial focus of P4P will be in the diagnosis and management of malignant melanoma. Dr. Elston said the AAD has worked closely with the AMA, CMS, the National Committee for Quality Assurance, the National Quality Forum, and other groups to ensure that the initial melanoma guidelines, as well as all future guidelines, are strongly grounded in science, are practical, and are minimally burdensome to practicing dermatologists.

A dermatologist seeing a blind patient should not be expected to teach melanoma self-exam.

DR. ELSTON

The melanoma quality guidelines are based on three criteria, which dermatologists will be expected to fill: taking a thorough personal and family history of melanoma, taking a thorough history as well as full-body visual examination of new or changing moles, and counseling patients on doing melanoma self-examinations.

Each of these steps carries a new category II code, which a dermatologist will document in billing records and the medical record. The code for taking a history is 100XF; the one for history of new or changing moles and full-body exam is 200XF; and the one for teaching self-examination is 401XF. These codes will mesh with the ICD-9 codes for melanoma.

Dermatologists who consistently demonstrate compliance in following these guidelines will be granted the "preferred" status by the plans. Ultimately, the payers are looking to see whether adherence to evidence-based guidelines will reduce the cost of health care. In the case of melanoma, they want to see identification of a greater number of early-stage lesions, with a simultaneous reduction in late-stage, hard-to-treat malignancies.

The melanoma guidelines, like all guidelines to be used in P4P plans, do include special exclusion codes, to be used in specific cases for which the standard guidelines may not be appropriate. For example, a dermatologist seeing a blind patient should not be expected to teach melanoma self-exam. Similarly, a dermatologist in the Northeast seeing a "snowbird" patient who has a second dermatologist in Florida may not be required to do the full melanoma work-up if his Floridian colleague is doing so. There are exclusion codes for cases in which a language barrier prevents full adherence to the guidelines, as well as for cases in which a patient refuses to have the full-body melanoma exam.

Dr. Elston said the melanoma guidelines need to be approved by the National Committee for Quality Assurance, the National Quality Forum, and CMS before they are implemented. The review process is underway, and the guidelines will very likely pass muster.

He recommended that once the guidelines are implemented, dermatologists run through the melanoma protocol and code it appropriately, at least once during the calendar year for each patient in the practice.

Like it or not, all physicians will be obliged to deal with P4P systems in the near future. Active involvement in the process of developing P4P is essential to ensuring that these plans do not work against good care. "P4P is going to be a really big thing for all of us. If we do it right, it should be no big deal," Dr. Elston said. ■

Reimbursements At Risk Under New Coding Changes

In its ongoing effort to keep members abreast of important issues related to coding and reimbursement, the AAD has identified several coding changes or problems to which dermatologists ought to pay heed. Dr. Elston reported the following:

► **UHG needs the –59 modifier.** For the vast majority of health plans, procedural add-on codes should not get a "–59" modifier. However, UnitedHealth Group has a glitch in its review system that disallows the use of codes such as 17003 with other add-on codes such as those for shave excisions, unless you also include the –59 modifier.

► **Aetna, Humana cut payment for the second and third procedures.** These two large insurers have recently changed their policies regarding payment for repeat outpatient procedures associated with the same medical condition. Under the new policy, they will reimburse 100% for a first procedure, 50% for a repeat of the same procedure, and only 25% for a third round.

Dr. Elston stressed that this is out of step with the rest of the insurers who typically pay 50% for third procedures. "The 50% reduction is based on the logic that part of the original 100% reimbursement pays for office overhead, time involved in pre- and postprocedure counseling, and other costs that you're not necessarily repeating with subsequent procedures in the same patient. So, they do not want to pay you for that a second and third time." Aetna and Humana have taken this logic a step further, cutting another 25% off payment for third procedures.

► **Destruction codes and Mohs codes are up for review.** Reimbursement codes are reviewed every 5 years, and the 17000 series of codes used for destruction procedures are up for review right now. Dr. Elston recommended monitoring this process, as any changes in the 17000 series could affect dermatologists' billing by the end of the year.

Similarly, the Mohs surgery codes are up for review, and Dr. Elston said to expect changes. At issue is the fact that Mohs is simultaneously a destructive procedure and a pathologic procedure. AAD has argued that Mohs should be reimbursed differently from other surgical procedures. Payers view this as "bundling" and may seek to cut reimbursement for Mohs. Dermatologic surgeons should watch this battle closely, he said.