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Docs, hospitals favor quality demos

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Physicians and hospitals say they're in favor of the growing number of CMS demonstrations to improve quality—they just want to make sure they are reimbursed fairly if and when these demonstrations are put into practice.

Early last month, the agency reported glowing results of three of its quality demonstration projects, one for large physician practices, one for small and solo physician practices, and one for hospitals, with plans to launch new demonstrations that focus specifically on gain-sharing between doctors and hospitals. These efforts are all part of the CMS' value-based purchasing initiative, the main objectives of which are to tie Medicare payments to performance on quality and efficiency, an effort that has been eyed by lawmakers and the Obama administration as a way to reduce costs and improve care.

Ultimately, Congress has the reins of quality in its hands, as “only Congress can create or change a Medicare payment methodology,” a CMS spokesman says. Both House and Senate lawmakers have shown an interest in value-based purchasing initiatives such as medical homes and accountable-care organizations in which hospitals and physicians share responsibility for the quality and cost of care delivered to patients.

That interest may be piqued further by a separate report released late last month that found a connection between health information technology and clinical performance.

Value-based purchasing is becoming more important as Americans become more aware of public reporting and “want to get the best care for best cost,” says Jean Rico, vice president of clinical process improvement at 291-bed St. Vincent Medical Center, Los Angeles, a participant in one of the quality demonstrations, the CMS/Premier Hospital

Quality Incentive Demonstration.

Too often, however, value-based purchasing “is equated with a dollar amount rather than quality itself, and I think there needs to be a balance,” Rico says.

On a conceptual basis, the American Hospital Association favors value-based purchasing because it better aligns the payment system with the delivery of higher quality, says Nancy Foster, vice president for quality and patient safety with the AHA.

But as Congress and the Obama administration move forward in adopting such initiatives, it's important that value-based purchasing “not be a backdoor methodology for generating savings,” Foster says.

As an example, President Barack Obama's original budget proposal included a provision on hospital quality incentive payments, for which there were significant cost savings—about \$12 billion over 10 years—attached to that measure. Engaging in a process to better align incentives to drive higher-quality care makes sense, “but if it's just a nice title for an effort to suck money out of the system, that doesn't make sense,” Foster says.

In the meantime, participation in these demonstrations “will give us all information about what will work, and what we might need” to promote higher quality, improve safety and deliver care in a more efficient manner, according to Foster.

Joan Brennan, vice president of quality and performance excellence at AtlantiCare in Egg Harbor Township, N.J.—one of the participants in the CMS' new hospital gain-sharing demonstration, the Physician Hospital Collaboration Demonstration—sees this as an opportunity to find out “what gets in the way of achieving the best cost in the care of a particular patient,” such as delivering test results to a physician in a timely manner. “We need to work at innovative ways to get doctors actively engaged in the ultimate goal of delivering the best care at the lowest cost.”

Gain-sharing takes place when a hospital pays incentives to a physician who assists in saving internal hospital costs while improving quality and efficiency. The demonstration, which began in July, is designed to track patients after a hospital episode to determine the impact of hospital-physician collaborations on preventing short- and long-term complications and duplication of services.

Value-based purchasing “takes real work” for the hospital and physician to accomplish, as its main goal is to “change patterns of care to get the quality outcomes you're looking for,” says Donald Fisher, president and CEO of the American Medical Group Association. If value-based purchasing language ever makes it into healthcare reform law, “we need to have reimbursement policies in place that will reward coordinated care,” Fisher says.

Physicians in particular are going to look at what they'll have to spend to accrue these savings under a value-based purchasing program, Fisher says. “We can't put hurdles in the way for physicians to make these investments,” if the Physician Group Practice demonstration protocol is ever put into legislative language, he says.

Fisher made these comments keeping in mind that participating physician groups in the Physician Group Practice demonstration had to invest “a lot of startup costs and do infrastructure improvements to get the quality improvements they needed.”

And yet, not all of them have reaped significant rewards under this demonstration, in which physician groups earn incentive payments based on the quality of care they provide and the estimated savings they generate in Medicare expenditures for the patient population they serve.

In total, only six of the 10 practices have benefited from the \$46.4 million in incentive payments awarded by the CMS over the first three years of the project. Failure to meet a complicated threshold on financial performance is the ongoing reason why some of the participating groups have not been receiving significant bonuses under this project.

Park Nicollet Health Services, St. Louis Park, Minn., a provider that's participating in both the physician group practice and hospital demonstration projects, has yet to reap any bonuses from the group practice demonstration.

David Wessner, its CEO, would like to see some modifications to the threshold on financial performance. Despite this one flaw in the project, “the idea of sharing savings on the total cost of care is the right challenge to healthcare organizations,” and that's what this demonstration provides, he says. Wessner says he will retire at the end of the year.

Separately, according to new physician pay-for-performance results for the state of California, the adoption of health IT appears to help reduce geographic variations in clinical performance.

Practices in the San Francisco Bay Area and Sacramento performed better overall in 2008 than the statewide average for clinical quality, patient experience, IT adoption and coordinated diabetes care, while Los Angeles lagged behind.

The report was conducted by the Integrated Healthcare Association, a not-for-profit based in Oakland, Calif. The association's pay-for-performance program includes eight health plans and more than 225 medical groups with 35,000 physicians caring for 10.5 million HMO members.

Clinical quality improves with the adoption of health IT and its use in care management, according to the report. Physician groups that adopt health IT performed better than those that did not, regardless of geographic location. Overall, physicians statewide improved in six out of seven clinical quality measures, including diabetes care and colorectal cancer screening, according to the report. Performance in appropriate treatment for children with upper-respiratory infections showed a small decline of 0.4%.

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