

Statement



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Physician Pay-for-Performance

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The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit this testimony concerning physician pay-for-performance to the Practicing Physicians Advisory Council (PPAC). The AAMC represents nearly 90,000 full time clinical faculty associated with the nation's medical schools and group practices. Clinical faculty provide a variety of services to Medicare patients ranging from primary care to subspecialty care. On a national basis, the median amount of service provided to Medicare patients is 24% of total services across all specialties. Some departments report that as much as 49% of their clinical services are provided to Medicare patients. Thus, on behalf of its members, AAMC is keenly interested in the impact of the Medicare program on practicing physicians.

The AAMC has long supported the efforts of the Centers for Medicare and Medicaid Services (CMS) to promote its quality agenda among various provider entities, including nursing homes, home health agencies and hospitals. As a founding member of the Hospital Quality Alliance, AAMC is committed to working with CMS on quality initiatives. All AAMC Council of Teaching Hospital members that were eligible to submit data for reporting did so.

AAMC and its constituents are also supportive of CMS' initiatives in the physician quality arena. Several academic medical centers have institutes or centers dedicated to studying and understanding evidence-based medicine, patient safety initiatives and quality improvement. The recently announced CMS Physician Group Practice (PPG) demonstration project included several academic medical centers. Many academic institutions in major metropolitan markets are participating in private payer quality initiatives. Finally, academic centers have invested in or are in the process of investing in electronic medical records (EMR). In a March 2005 survey of 29 academic group practices, 20 practices reported that they had an ambulatory EMR in place and another 7 reported that they are in the process of selecting an ambulatory EMR. Eighteen of the 29 plans reported that their academic health center has an inpatient EMR.

As several other physician organizations have stated, physician pay-for-performance programs need to be based upon clear design principles and goals for which there is broad agreement. AAMC believes that key among these are:

- Improved quality of care and safety should be the primary objective of initiatives. It is well recognized that improved quality and implementation of some preventive measures can decrease health care utilization and thus also decrease costs in the long-run. However, improved quality and safety should be the primary objective of activities.
- Performance measures must be evidence-based, broadly accepted, clinically relevant, continually updated and developed with the physician community.
- Data must be fully adjusted for case-mix, sample size, age/sex distribution, severity of illness, number of co-morbidities, and patient population characteristics that may influence results.
- Fair and accurate models for attributing care when multiple physicians treat patients must be implemented.
- Initiatives need to be flexible enough to assess performance at both the individual level or the group level, as appropriate.
- Physicians must have the ability to review and correct performance data.

Experience with the hospital quality initiative provides several important lessons for physician quality initiatives. It is important to keep in mind that the complexity of implementing a quality initiative with physicians will be much greater than it has been with hospitals. The initial hospital measurement set included ten measures, with seven more added subsequently. Approximately 4,200 nonfederal acute care general hospitals participated in the initiative. In contrast, there are nearly a half million Medicare Part B providers and dozens of specialty disciplines which could potentially be involved in or impacted by quality initiatives.

The time allowed for hospitals to report and verify data, before reporting was linked to payment and publicly displayed, was necessary and invaluable. The iterative nature of the process helped to reassure all parties that data are accurate and credible. Further, the "ramp-up" time allowed for critically important communication with the hospital community.

Similarly, initiatives with physicians also need to allow adequate time for communication, measure identification, development and data review. Without such a process the credibility of the program will be jeopardized for all parties involved. Given the complexity of implementing such a system in the physician community, the AAMC urges that the initial performance measures be limited to a relatively small number of measures that meet the above-mentioned goals. An attempt to implement a large number of measures initially will increase the opportunity for inaccuracies in data submission and reporting and potentially erode the credibility of the initiative.

Further, simultaneous implementation of multiple measures, particularly if they cut across several specialty disciplines, will place increased burden on multispecialty groups. Likewise, implementation of an excessively large number of primary care oriented or specialty specific measures will place burden on physicians in relevant specialties. It is worth noting that most private payers implementing pay-for-performance programs have begun with a modest number of measures and increased them over time.

It is also worth noting that various types of quality activities will have differential impact on health care costs. Some activities may "prevent" costs from being incurred, such as activities that promote avoidance of hospitalizations. However, other activities will lead to increased utilization. The Integrated Healthcare Association (IHA) is a California leadership group of health plans, physician groups, and health systems that is involved in policy development and special projects around integrated health care and managed care. IHA recently implemented coordinated, state-wide pay-for-performance initiatives and reported the following results based upon comparison of data from the first year (2003) and test year (2002):

- ***Nearly 150,000 more women received cervical cancer screenings***
- ***35,000 more women received breast cancer screenings***
- ***10,000 additional California children received two needed immunizations***
- ***18,000 more people received a diabetes test***

Thus, while the above statistics demonstrate an increase in performance of quality-related services by physicians, they also demonstrate at least a short-term increase in health care utilization and costs. Although patients, payers and physicians may receive long-term benefits from quality improvement programs, implementation of these activities under the current SGR methodology will have negative financial consequences for physicians. AAMC appreciates the efforts of Congress and the Administration to address issues with the Medicare physician fee schedule over the past three years. However, with the fee schedule still in place, physicians face steep payment cuts over the next several years. These payment cuts will likely be even more dramatic if Medicare Part B expenditures increase initially as a result of quality-related utilization increases. Under the SGR system, spending increases that exceed the target rate result in across-the-board payment reductions.

Finally, AAMC, like a myriad of other organizations, recognizes that implementation of initiatives requires resources to reach the desired outcomes. Physicians and physician groups will need to invest in electronic medical records, patient registries and other health information technology in order to achieve the desired results. Additionally, clinical staff work redesign efforts will be essential to chronic care and patient population management strategies. It will be increasingly difficult for physicians to invest in technical and human resources in the face of continuous and steep payment cuts.

While these implementation issues are substantial, the AAMC is strongly supportive of the efforts to develop physician pay-for-performance systems. We look forward to working collaboratively in the physician community and with CMS to develop fair and effective quality improvement programs that will enhance the health of beneficiaries.