PHYSICIAN GROUPS IMPROVE QUALITY AND GENERATE SAVINGS UNDER MEDICARE PHYSICIAN PAY FOR PERFORMANCE DEMONSTRATION

The Centers for Medicare & Medicaid Services announced today that all participating physician groups improved the clinical management of diabetes patients in the first year of the three-year Medicare Physician Group Practice (PGP) Demonstration. This demonstration rewards providers for coordinating and managing the overall health care needs of Medicare patients with chronic conditions.

"With health care costs continuing to grow and the Medicare population expanding, it is critical that we find ways to control costs while also improving the quality of care," HHS Secretary Mike Leavitt said. "This demonstration project provides new evidence that paying for quality of care instead of volume of services helps the program, physicians and patients."

Under the demonstration, which began April 1, 2005, physician groups continue to be paid on a fee-for-service basis and have the opportunity to share in savings generated from enhancements in care management.

All ten of the participating physician groups - Billings Clinic, Everett Clinic, Dartmouth-Hitchcock Clinic, Forsyth Medical Group, Geisinger Clinic, Middlesex Health System, Marshfield Clinic, Park Nicollet Health Services, St. John's Health System, and the University of Michigan Faculty Group Practice - achieved benchmark or target performance on at least seven of the ten diabetes clinical quality measures. Two physician groups -- Forsyth Medical Group and St. John's Health System - met all ten benchmarks.

One of the unique features of this demonstration is that physician groups have the flexibility to redesign care processes for patients with chronic illness and complex health care needs, as well as invest in care management initiatives. This helps Medicare beneficiaries maintain their health and avoid further illness and admissions to the hospital at no additional cost and with no reductions in benefits. If these efforts save money for the Medicare program, the physician groups are able to share in a portion of those savings.

"Twenty-three percent of beneficiaries have five or more of the chronic conditions that account for 68 percent of Medicare spending. They see an average of 11 physicians and fill 50 prescriptions a year. Creating
payment incentives that can lead to better patient outcomes and lower total costs is the right thing to do," CMS Acting Administrator Leslie V. Norwalk said.

These physician groups have redesigned care to improve clinical quality and to create more efficient and effective delivery systems. As a result, in addition to the quality improvements across all groups, two groups - Marshfield Clinic and University of Michigan Faculty Group Practice - earned performance payments for quality and efficiency of $7.3 million as their share of the $9.5 million in savings to the Medicare program. Additional groups had lower Medicare spending growth rates than their local markets but not sufficiently lower to share in savings.

Performance in year one is based on measures developed from evidence-based guidelines for care of patients with diabetes mellitus. The measures include: HbA1c testing and control; blood pressure control; lipid testing and LDL cholesterol control; urine protein testing; eye and foot exams; and influenza and pneumonia vaccination. Additional evidence-based measures addressing congestive heart failure, coronary artery disease, hypertension and cancer screening have been added in performance years two and three.

Physician groups are measured on performance using all health care spending for patients assigned to the group in relation to a comparison population of Medicare patients from their local market area. A total of 223,893 Medicare patients were assigned to the ten physician groups in performance year 1 which ended March 2006.

Physician groups have transformed care by making lab results for diabetic patients available to physicians prior to patient encounters, preparing patients in advance for foot exams, educating patients about the importance of self-care techniques and their disease, and following-up with them in between visits. Dartmouth-Hitchcock Clinic found that educating patients with information about their medical condition results in more productive clinical encounters with patients who better understand their illness, their treatment plan, and their role in self-care.

Physician groups have focused on patients with chronic illness and complex health care needs through new care management initiatives including high-risk case management, home-based monitoring, post-discharge care transitions, and palliative care services. For example, The Everett Clinic requires a post-discharge physician follow-up visit within ten days to address any unsolved or new health care problems
and partnered with local providers to place palliative care nurses in their clinics to work directly with their physicians in order to improve end of life care.

St. John's Health System improved its performance on every diabetes measure, in part, by using a web-based patient registry that assists physicians in planning patient encounters. Forsyth Medical Group focused on enhancing the awareness of clinical staff around the needs of the patients with chronic diseases. In that way, the groups were able to assist physicians in planning and maximizing the efficiency of their patient encounters. Four other physician groups met nine of the ten benchmarks.

Billings Clinic, Geisinger Clinic, Marshfield Clinic, Middlesex Health System, and Park Nicollet Health Services, have implemented new care management programs for patients with congestive heart failure that are designed to identify changes in symptoms of heart failure early on and arrange for timely and appropriate follow-up. Through proactive monitoring, nurses at the practices can follow up directly with patients, adjust medications, or arrange for a physician to see the patient that same day in order to prevent patients from deteriorating. These systems promote a reliable timely response to the needs of non-hospitalized patients.

The PGP Demonstration has fostered a nation-wide learning collaborative for the groups who voluntarily participated in this demonstration as a result of their leadership in their communities and profession. CMS is working with the groups to identify successful health care redesign and care management models developed under the demonstration that can be spread across the health care system.