Health Law Bulletin

provided by:

MITCHELL • BLACKSTOCK

Mitchell • Blackstock • Ivers • Sneddon • PLLC

P4P Demonstration Shows Even Large, Integrated Providers Need Significant Time and Money to Achieve Results

By David Ivers, J.D. and Robert Wright, J.D., MPA

The Physician Group Practice Demonstration, the first pay-for-performance initiative for physicians in Medicare and the forerunner of ACOs, has come to the end of its 5 year-run, with important lessons for all providers.

All 10 physician groups in the PGP demonstration showed significant quality improvements, but with mixed result on cost savings. The PGP project is the model for the Medicare Shared Savings Program for accountable care organizations (ACOs) under the Affordable Care Act (the federal health care reform act). Data was recently released on the PGP demonstration, which ran from 2005 to 2010.

Under the PGP project, physician groups continued to be paid through the regular Medicare fee-for-service method, but they were eligible to share in "performance payments" for up to 80% of savings they generated. Their performance was measured based on cost efficiency and 32 quality measures phased in during the demonstration. The portion of the performance payments based on quality vs. cost efficiency began at 70% cost/30% quality/ the first year, then went to 60% cost/40% quality the second, and 50%/50% the remaining three years.

During the course of the PGP project, the 10 groups showed remarkable success in meeting quality measures. In Year 1, all 10 groups met targets on at least 7 of 10 measures; Year 2, all 10 met at least 25 of 27 measures; Year 3, all 10 met at least 28 of 32 measures; Year 4, all 10 met at least 29 of 32; and Year 4, all 10 met at least 30 of 32.

The quality measures were phased in, addressing diabetes mellitus in Year 1, adding congestive heart failure and coronary artery disease for Year 2, and hypertension and cancer screening for Years 3, 4, and 5.

The cost savings were more difficult to achieve, according to information from the Centers for Medicare and Medicaid Services. The number of groups that shared in savings broke down as follows: Year 1, two groups; Year 2, four; Year 3, five; Year 4, five; and Year 5, four. The savings shared among the groups generally tracked upward over time: $7.3 million; $13.8

million; $25.3 million; $31.7 million; and $29.4 million, in Years 1 through 5, respectively. Savings did not necessarily correlate with quality scores.

The participants invested an average of $1.7 million in the first year alone to prepare for the demonstration. Only six of the groups had recouped that much or more in shared savings by the end of the five year performance period. Fewer than half had done so after three years. The current ACO Medicare Shared Savings model envisions a three-year performance period.

Participation in the demonstration was restricted to 10 large, well-known, integrated organizations:

Billings Clinic, Billings, Montana
Dartmouth-Hitchcock Clinic, Bedford, New Hampshire
The Everett Clinic, Everett, Washington
Forsyth Medical Group, Winston-Salem, North Carolina
Geisinger Health System, Danville, Pennsylvania
Marshfield Clinic, Marshfield, Wisconsin
Middlesex Health System, Middletown, Connecticut
Park Nicollet Health Services, St. Louis Park, Minnesota
St. John's Health System, Springfield, Missouri
University of Michigan Faculty Group Practice, Ann Arbor, Michigan

CMS Administrator Donald Berwick trumpeted the project as a success, stressing the need to avoid high expectations in the short term: "We have learned to invest in sustained improvement over time, and that short-term comparisons between start-up costs and measurable results may fail to realize the long-term value of these efforts."

CMS summarized the different measures each practice group implemented to improve quality and control costs. They included patient registries, electronic medical records, dashboard reports, disease experts, evidence-based care, provider training, preventive services, care coordination and case management by nurses and social workers, coaching hospitalized patients, discharge follow-up, use of the chronic care model, patient-centered medical homes, revamped payment incentives, nurse advice line, and palliative care.

The project holds important lessons for Arkansas as it attempts to come up with new provider payment models:

•The ACO-type model requires a significant amount of time to achieve cost savings. Most physician organizations do not resemble those in the demonstration. The fact that those large, experienced, integrated organizations could not achieve dramatic cost savings in the short-run indicates that it will be a challenge for smaller, less-experienced, independent physician groups in Arkansas to do so.

•A number of the measures in the PGP demonstration are already in place in physician groups, but complete implementation of the quality measures will require money to implement, and, in many cases, changes in practice workflow.

•It is unclear how smaller providers will pay for the up-front investment required for this type of model without the support of payers who are willing to provide substantial practice supports.

•The PGP demonstration involved only physicians. The new CMS pilot program on bundled payments (See *MB Bulletin* August 26, 2011) is open only to hospitals or physician-hospital organizations. Payment reform involving other types of providers is not as common and needs more study.

• The PGP results show that higher quality and cost savings can be achieved without bundled payments, though it takes time to achieve enough cost savings to recoup the initial investment.

•The bundled payments for episodes of care that Arkansas payers are considering would move away from fee-for-service and so might achieve different results from the PGP fee-for-service demonstration. However, the underlying principles for delivering value-based care are the same for both models, e.g., care coordination, evidence-based care, electronic medical records, patient-centered medical homes, etc. Whatever the method of payment, a new care model will still require up-front investments for some practices in order to achieve the desired results.

SOURCES:

1. Centers for Medicare and Medicaid Services, Fact Sheet, *Physicians Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration* (July 2011), available at https://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf.

2. Trent T. Haywood & Keith C. Kosel, *The ACO Model—A Three Year Financial Loss?*, NEW ENGLAND JOURNAL OF MEDICINE (April 7, 2011), http://www.nejm.org/doi/full/10.1056/NEJMp1100950.