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AMA's Pay-for-Performance Pact Ruffles Feathers

BY JENNIFER LUBEIL Associate Editor, Practice Trends

pecialty organizations are concerned that the American Medical Association's initiative is unilaterally setting performance goals that doctors won't be able to meet.

A recent agreement between the AMA and leaders in Congress outlines an ambitious 2-year time line for establishing performance measures, "to improve specialty quality reporting to congressional leadership," AMA Chair Duane M. Cady said in a statement.

Dr. Cady signed the agreement at the start of the past year, although the details weren't publicly disclosed until several months later. The terms were outlined in a Feb. 7 memorandum from AMA Vice Chair Michael Mannino to the state medical associations and national specialty societies.


If the plan goes through, physician groups will work with the Centers for Medicare and Medicaid Services to agree on a starter set of evidence-based quality measures for a broad group of specialties, with a goal of developing approximately 140 physician measures covering 34 clinical topics by the end of 2006.

The AMA has been working on these measures with several groups to do so, including the Ambulatory Care Quality Alliance, said Dr. Nancy Nielsen, speaker of the AMA's House of Delegates, at a briefing. The alliance is receiving funding from the Agency for Health Research and Quality and CMS to test 26 measures at six clinical sites, beginning May 1. Those measures include some developed by the consortium, among others. The pilot is crucial, as it will bring to the surface any "unintended consequences," Dr. Nielsen said. Then in 2007, doctors who report on three to five quality measures would see increased payments from Medicare.

By the end of next year, physician groups should have developed performance measures "to cover a majority of specialty care spending for physician services," the agreement said.

Other initiatives, such as working on methods to report quality data and implementing additional reforms to address payment and quality objectives, also were outlined in the agreement.

As far as Dr. Cady is concerned, nothing in the agreement with the congressional leaders should be a surprise. "It involved only (those) commitments we had previously outlined to our specialty society colleagues."

All of these steps had been documented previously in public letters to Congress and the Bush administration and distributed to medical specialty societies, he said.

Yet some of the members of the consortium said they had no advance notice of the AMA's plans to sign this pact.

This is an agreement signed with leaders on Capitol Hill on how pay for performance should be laid out, and some groups feel they should have been a part of it," Cynthia A. Brown, director of advancing value and policy at the American College of Surgeons, said in an interview.

The real problem is not about advocacy or the working of the consortium. It's about meeting deadlines on clinical measures, Ms. Brown said. Continued on following page
Continued from previous page

"Not everyone is ready for [pay for performance]," she said. Although many primary care quality measures have been written, it’s a different story for subspecialties, "because their measures haven’t even been developed yet," she said. They’re starting from ground zero," she said.

With this latest agreement, subspecialties now feel pressured to find their own groups of doctors to propose measures to run through the consortium’s process by year’s end, she said.

The criteria on performance measurement also will be different by specialty, Ms. Brown said. "Surgeons in particular often like to be judged by outcomes, and primary care doctors don’t want to be because they have a bigger problem with patient compliance. One size doesn’t fit all."

At the press briefing, Dr. Nielsen said, "this is a dastard about nothing," adding that the specialty societies had been included on the performance measure development from the start. The initial measures won’t cover all the specialties, but it was necessary to show Congress that the profession was serious about quality improvement by getting something started quickly, she said.

The AMA has tried to work with the CMS on quality measures for some time now, and it is "very difficult" to get truly significant data and information that really makes a difference, Dr. Thomas Purdon, former president of the American College of Obstetricians and Gynecologists, said in an interview.

However, it’s unlikely the data will be accurate or have real meaning unless the specialty societies are involved, "either individually or through the Council of Medical Speciality Societies," he said. "I too share the concerns of others that the data will be weak and then be used to penalize doctors’ reimbursement."

It’s true that a number of specialty groups don’t feel comfortable that they can meet these time lines, Dr. David Nielsen, executive vice president and chief executive officer of the American Academy of Otolaryngology-Head and Neck Surgery, said in an interview.

"Could the AMA [have] been more communicative about this agreement? Probably." Yet some of these specialty societies may be misinterpreting its terms, he said.

There’s an assumption that the AMA is going to be responsible for doing all of the specialty measures, Dr. David Nielsen said. "While those concerns are valid, it isn’t going to come to that." What these groups need to remember is that the AMA’s consortium is run by the specialty societies, a process that’s consensus based, he said. (The American Academy of Otolaryngology-Head and Neck Surgery is a consortium.)

"People who are upset about this aren’t comparing it to what would happen if the AMA didn’t step in," that CMS would step in and do their own measures. I’d be much happier with consortium measures than any other group of measures, because the consortium is in the best position to produce patient-centered measures of medical outcomes that are driven by physicians, and are relevant and validated," he said. He also doesn’t believe the performance goals set by the agreement are insurmountable.

Ninety measures have already been developed, he said. "If every specialty society creates one measure, we would get pretty close to that goal of 140 measures by the end of the year." The American College of Physicians, in the meantime wants, to move even more quickly than the AMA on measure development, voluntary reporting, and pay for performance, Robert B. Doherty, the college’s senior vice president for governmental affairs and public policy, said in an interview.

Physician concerns about CMS’s initial draft of the physician voluntary reporting program (PVRP) had also been interpreted on Capitol Hill as a sign of opposition to quality reporting, Dr. Maves noted. From CMS’s perspective, there’s no reason why the AMA’s agreement shouldn’t work in tandem with the PVRP, CMS spokesman Peter Adkensan said in an interview. The physician voluntary reporting program isn’t about developing measures, it’s about testing systems "on how well we can use the existing claims-based system to capture the data from the measures," he said.

The agency is testing the system on a voluntary basis to make sure it can function in a manner that works for both providers and the Medicare program, and ultimately for the beneficiaries when CMS reports the data.

"Meanwhile, making sure we have a robust set of measures to populate this program or any follow-up program that Congress may design is the critical part of the AMA’s deal with the Congress," he said.

"The key is for all of the stakeholders in performance measurement programs to stay focused on the substance," Mr. Doherty said. "We need to show Congress that the profession is committed to quality measurement and reporting."

New Options for the Management of Fibroids in the Ob/Gyn Practice

Program Overview
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Program Description
New Options for the Management of Fibroids in the Ob/Gyn Practice is an archived webcast that focuses on the treatment of uterine fibroid tumors in the modern ob/gyn practice. A panel of experts discusses the role of traditional as well as more recent therapies, and introduces a novel device called ExAblate 2000, developed by InSightec Ltd. This system, which incorporates GE Healthcare’s magnetic resonance imaging technology, allows the clinician to treat fibroids noninvasively with magnetic resonance-guided focused ultrasound surgery (MRgFUS). The system and the MRgFUS procedure received FDA approval in October 2004, which expedited review because it offers significant advantages over existing treatments for uterine fibroids.

A discussion of this type is important because between 20% and 40% of all women over 35 years of age have uterine fibroids. Fewer than 0.1% of fibroids become cancerous, but treatment is required when symptoms interfere with patient’s health or quality of life. Hysterectomy, the most frequently used treatment for fibroids, is associated with the usual surgical risks and complications, requires a hospital stay, and results in patient downtime of up to 6 weeks or more. Many of the newer therapies offer fewer risks, only a brief hospital stay, and a shorter recuperation period. The most recently introduced alternative to hysterectomy, MRgFUS, is associated with minimal risks and complications, requires no overnight hospital stay, and allows most patients to return to their normal activities in a few days.

After viewing the webcast, it should be clear that this technology represents a significant advance in treatment and is a method that ob/gyn clinicians should consider including in their treatment armamentarium.

Intended Audience
Ob/gyn specialists and other healthcare professionals involved in the treatment of uterine fibroids.

Objectives
After viewing this webcast, clinicians should understand:
• The role magnetic resonance-guided ultrasound surgery (MRgFUS) can play in the care of patients with uterine fibroids.
• How the ExAblate MRgFUS and GE Signa HDRM system works to treat uterine fibroids noninvasively.
• How ob/gyn specialists can offer this new treatment in their own practices.

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