Centers for Medicare and Medicaid Services
Physician Group Practice Demonstration Project

Marshfield Clinic Experience
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Marshfield Clinic

- Over 40 centers throughout northern, central and western Wisconsin
- 750+ physicians in 80 medical specialties and subspecialties
- 361,436 patients served
- Patients seen from every county in WI, every state in the nation, as well as 25 foreign countries
CMS PGP Demonstration Overview

- Section 412 of BIPA 2000 (P.L. 106-554)
- Medicare FFS Payments + Performance Payments
- Performance Payments Derived from Practice Efficiency & Enhanced Patient Management
  - Participants must first improve efficiency (decrease costs) before shared savings can occur.
  - Quality Assessed Using 32 Ambulatory Care Measures
- 10 Physician Groups Representing 5,000 Physicians & Over 200,000 Medicare FFS Beneficiaries
- Started April 1, 2005
  - Performance year 4 started 4/1/08
Marshfield Clinic Experience

• Why did Marshfield Clinic enter the CMS PGP demonstration project?
• How did we attempt to intervene?
• What were the results of PY1?
• When do we expect to hear about PY2?
• Where are we going in the future?
Marshfield Clinic

• Mission – “to serve patients through accessible high quality health care, research, and education.”

• Long term strategy – built around the six aims of the Institute of Medicine: Care should be safe, timely, effective, efficient, equitable, and patient centric.
Why enter the CMS PGP Project?

• Consistent with the Clinic’s mission.
• Marshfield Clinic’s long term strategy built around the six aims of the Institute of Medicine.
• Marshfield Clinic was headed in a similar direction as the PGP demo and participation allowed us to accelerate our learning.
Goals & Objectives

• Encourage Coordination of Medicare Part A & Part B Services
• Reward Physicians for Improving Health Outcomes
• Promote Efficiency Through Investment in Administrative Structure & Process
Physician Group Practices

10 Physician Groups Represent 5,000 Physicians & Over 200,000 Assigned Medicare Fee-For-Service Patients

- 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
Performance payment methodology

- Groups must save > 2% and only then share in the > 2% savings
- Medicare Retains 20%
- Groups Share up to 80%
  - Performance Payments Earned for Efficiency & Quality
  - Increasing Percentage of Performance Payments Linked to Quality
- Maximum Annual Performance Payment Capped at 5% of Medicare Part A & Part B Target
## Process & Outcome Measures

<table>
<thead>
<tr>
<th>Diabetes Mellitus</th>
<th>Congestive Heart Failure</th>
<th>Coronary Artery Disease</th>
<th>Hypertension &amp; Cancer Screening</th>
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<tbody>
<tr>
<td>HbA1c Management</td>
<td>LVEF Assessment</td>
<td>Antiplatelet Therapy</td>
<td>Blood Pressure Screening</td>
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<tr>
<td>HbA1c Control</td>
<td>LVEF Testing</td>
<td>Drug Therapy for Lowering LDL Cholesterol</td>
<td>Blood Pressure Control</td>
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<td>Blood Pressure Management</td>
<td>Weight Measurement</td>
<td>Blood Pressure</td>
<td>Blood Pressure Plan of Care</td>
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<td>Lipid Measurement</td>
<td>Blood Pressure Screening</td>
<td>Lipid Profile</td>
<td>Breast Cancer Screening</td>
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<td>LDL Cholesterol Level</td>
<td>Patient Education</td>
<td>LDL Cholesterol Level</td>
<td>Colorectal Cancer Screening</td>
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<td>Urine Protein Testing</td>
<td>Beta-Blocker Therapy</td>
<td>Ace Inhibitor Therapy</td>
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<td>Eye Exam</td>
<td>Ace Inhibitor Therapy</td>
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<td>Foot Exam</td>
<td>Warfarin Therapy</td>
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<td>Pneumonia Vaccination</td>
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* Measures are cumulative over the lifetime of the project.
How did we intervene for the PGP project?

Multiple simultaneous interventions – applied to all Marshfield Clinic patients not just CMS beneficiaries.

- Best practice models developed for core conditions
- Computer based CME opportunities
- Care management programs
- Population based feedback to providers
- Health Information Technology
- Physician/Clinical Nurse Specialist regional teams
Chartless Environment – completed 2007
Leveraging information technology to transform health care

Electronic Health Record

Intervention

Clinical Data Collection

Clinical Data Repository

Actionable Data

Evidence-Based Medicine

Provider Feedback

Population Assessment
What were the results of PY1 of the CMS PGP demonstration?

- All groups improved quality measures over the baseline year.
- 8 of 10 groups had positive trends in savings.
- 2 of 10 groups exceeded the 2% savings threshold and were given a performance bonus.
- Savings to the CMS trust fund that were in excess of the 2 % threshold were ~$10.8 million (total savings of ~$21 million)
CMS PGP Demonstration Project
Results

• PY1 –
  – $4.5 million performance bonus with savings to Medicare of $12 million
  – Achieved 9 of 10 quality metrics.
• PY2 – completed 3/31/2007. No data released to date.
• PY3 – completed 3/31/2008. No data released to date.
• PY4 – started 4/1/2008.
Challenges

- Current reimbursement models do not support
  - Practice redesign
  - Care management efforts – individual or population based
- Cultural changes required – team based approach
- Enhancing speed of data delivery for feedback (rapid cycle improvement).
- Competing definitions of quality from multiple payors
- Convincing payors to engage in sharing of cost savings for currently non-reimbursed services (nurseline, anticoagulation, etc).

Lessons Learned

• Data
  – Timeliness, accuracy of internal vs external data
• Culture issues
• EHR – necessary, but not sufficient
• Population health vs individual patient needs
Future Directions

• EHR enhancements
  – Patient activation tools

• Refinement of reporting to physicians

• Practice redesign
  – Current screening requirements for primary care providers are not possible in current models given time constraints

• Include specialists in reporting