Medicare Offers 1.5% Bonus

Pay for Reporting *from page 1*

To get started, physicians must familiarize themselves with the program and the measures and figure out for how many patients they will be able to gather and report data, Mr. Baker said.

They also should consider the technical issues involved in reporting and whether those changes are feasible. "It's certainly a challenge for everyone to ramp up to do this in a short period of time," he said.

CMS officials have selected 74 quality measures that can be used by physicians across specialties. If four or more measures apply, physicians must report on at least three measures for at least 80% of cases in which the measure was reportable.

If no more than three measures apply, each measure must be reported for at least 80% of the cases in which a measure was reportable.

Although payments will be provided to the holder of the tax identification number, the results will be analyzed at the physician level, the CMS said. As a result, Medicare officials are requiring that the National Provider Identifier number be used on all claims.

The reporting period will run from July 1 through Dec. 31, 2007, and all claims must reach the National Claims History File by Feb. 29, 2008.

Any Medicare-enrolled eligible professional can participate in the program, regardless of whether they have signed a participation agreement with Medicare to accept assignment on all claims. In addition, physicians are not required to register to participate in the Physician Quality Reporting Initiative.

Medicare will use a claims-based reporting system for the program and will require practices to enter either CPT Category II codes or temporary G-codes where CPT-II codes are not available. The codes can be reported on either paper-based CMS 1500 forms or electronic 837-P claims. The quality codes should be reported with a $0.00 charge.

The bonus payments earned will be made in a lump sum in mid-2008, CMS officials said. Physicians can earn up to a 1.5% bonus, subject to a cap. The cap is structured to ensure that physicians who do more reporting will receive higher payments.

Under the law that established the Physician Quality Reporting Initiative, the program is excluded from a formal appeals process. However, CMS officials said they plan to establish some type of informal inquiry process. In addition, they are currently developing a validation procedure for the reporting process that is likely to involve sampling.

In addition to the bonus payment, physicians who participate will receive a confidential feedback report from the CMS sometime in 2008. Those reports are expected to include reporting and performance rates. However, the quality data reported in 2007 will not be publicly reported.

For 2008, the CMS is required under statute to propose the new measures in August 2007 and finalize them by Nov. 15, 2007. Next year's measures are likely to include structural measures, such as the use of electronic health records or electronic prescribing technology. CMS officials are also working on the possibility of allowing physicians to report using either registry-based systems or electronic records systems in 2008.

Of the 74 measures released by the CMS, 21 apply to family medicine, said Dr. Rick Kellerman, president of the American Academy of Family Physicians. In an effort to make the process more user friendly, AAFP officials are strongly urging family physicians to report on the three diabetes measures available. This will make it easier for physicians to report because they can concentrate on a single diagnosis, Dr. Kellerman said.

The AAFP is developing a data collection sheet for physicians and another for the back office staff, he said. The academy also is developing tools to help physicians calculate their potential bonus payment under the program.

"It does not look like it will be overly burdensome," Dr. Kellerman said.

Because the CMS has selected measures that have been vetted by physician organizations and reflect current medical practice, most physicians should not have a problem with that aspect of the program, said Dr. Janet Wright, a cardiologist in Chico, California, and chair of the performance assessment task force of the American College of Cardiology.

The hurdle will be in changing the workflow in the office, she said. For some, the bonus payment will not be enough to offset the cost of making these administrative changes. However, the ACC is developing a special coding form that can be attached to the visit encounter form in an effort to streamline the process. In addition, participation in the program will help provide the CMS with information on the real-life experiences of cardiologists, Dr. Wright said. ■

More information on the Physician Quality Reporting Initiative is available online at www.cms.hhs.gov/PQRI.

FYI

Quality Reporting Answers

Answers to more than 50 frequently asked questions about the Physician Quality Reporting Initiative are available on the CMS Web site. Visit www.cms.hhs.gov/PQRI and scroll down to the "Related Links Inside CMS" section. Click on the "All PQRI FAQs" link to access the list.

Doctor-Patient Partner Guide

The American Medical Association and the AARP have jointly produced a free downloadable pamphlet that outlines shared responsibilities for physicians and patients. The goal is to improve patient safety by encouraging patients to be partners with physicians in managing their health. For more information, visit the AMA online at www.ama-assn.org/ama1/pub/upload/mm/370/amaaarpmessage.pdf.

POLICY & PRACTICE

House Passes Stroke Legislation

Legislation to increase awareness of the warning signs of stroke recently passed the House of Representatives. The Stroke Treatment and Ongoing Prevention Act of 2007 (H.R. 477) was introduced by Rep. Lois Capps (D-Calif.) and Rep. Chip Pickering (R-Miss.) and would establish grants for residency training materials and continuing education materials. Similar but broader stroke legislation (S. 999) was introduced in March by Sen. Thad Cochran (R-Miss.) and Sen. Edward Kennedy (D-Mass.) and includes grants to develop stroke care systems. "This bill represents a national commitment to end the suffering from stroke," Sen. Kennedy said in a statement.

Pain Treatment Centers Recognized

The American Pain Society highlighted the accomplishments of six multidisciplinary pain programs around the country as part of its first Clinical Centers of Excellence in Pain Management Awards. Recipients were chosen from 90 applicants and were judged by pain experts. Awardees focused on improving overall functionality and quality of life, according to the APS. The programs included the Comprehensive Pain Treatment Center at New York University Medical Center, New York; the Rosomoff Comprehensive Pain Center in Miami; the Pain Management Center at Brigham and Women's Hospital in Boston; the Pain Management Center and PainCARE at the University of California, San Francisco; the Cincinnati Children's Hospital Medical Center; and the Chronic Pain Rehabilitation Program at the James A. Haley Veterans Affairs Hospital in Tampa.

Traumatic Brain Injury Screening

In an effort to improve the diagnosis and treatment of traumatic brain injury in returning soldiers, Sen. Hillary Clinton (D-N.Y.) and Sen. Susan Collins (R-Maine) have introduced new federal legislation. The "Heroes at Home Act of 2007" (S. 1065) calls on the Secretary of Defense to establish a protocol for neurocognitive assessments of all members of the armed forces before and after deployment to Iraq and Afghanistan. Traumatic brain injury affects 1 in 10 soldiers and is considered a "signature wound" of soldiers deployed in those theaters, according to Sen. Clinton. The legislation would establish a program through the Department of Veterans Affairs to train family members of veterans with traumatic brain injury to be caregivers. It also would create a pilot project to test telehealth technology's use in assessing cognitive functioning. The legislation was drafted in consultation with the American Academy of Neurology and has been endorsed by the Brain Injury Association of America.

Medicare Funding Woes

The first-ever "Medicare funding warning" was issued by the program's trustees in their annual report, requiring the President to propose funding reforms within 15 days of submission of the fiscal 2008 budget and Congress to address the proposal on an "expedited basis." The warning—mandated by the Medicare Modernization Act of 2003—was triggered by the fact that for the second year in a row, over 45% of next year's projected Medicare outlays will come from general government revenues. The trustees noted that higher tax revenues and lower projected benefit payouts have extended by 1 year the date that the Part A will be exhausted, but added that the impending retirement of 78 million baby boomers will deplete the Medicare trust fund by 2019 unless lawmakers enact major changes. Medicare Part B and Part D both are projected to remain funded because current law automatically provides financing to meet next year's costs. But expected cost increases will raise financing needs from general revenue and substantial increases in beneficiaries' premiums, the trustees' report said. The report highlights the need for a long-term fiscal plan for Medicare, said American Medical Association Board Chair Cecil Wilson in a statement. "Arbitrary, drastic payment cuts to the physicians who are the foundation of Medicare are not the answer," Dr. Wilson said, adding lawmakers should act to stop next year's 10% Medicare physician payment cut to protect seniors' access to care.

AARP to Offer Health Insurance

Senior advocacy group AARP said that it will add a Medicare Advantage plan run by UnitedHealth Group to its offerings next year, along with several other products from Aetna Inc. aimed at adults aged 50-64 years. Medicare Advantage, to be launched Jan. 1 is expected to enroll 1 million Medicare beneficiaries initially, AARP officials said. In addition AARP's agreement with UnitedHealth includes Medicare Supplemental insurance, Part D plans, and indemnity insurance products. AARP said that it will dedicate $500 million of its royalty payments from the two insurers over the next 10 years to fund a program to help Americans find health information and assistance.

Jurors Often Side with Doctors

Contrary to popular belief, juries in malpractice cases usually sympathize more with physicians than patients, according to a law professor who reviewed studies involving malpractice cases from 1989 to 2006. University of Missouri, Columbia, School of Law professor Philip Peters found that plaintiffs rarely win weak cases, although they have more success in "toss-up" cases and better outcomes in cases with strong evidence of medical negligence. Peters, whose study appeared in the Michigan Law Review, said several factors favor medical defendants, including superior resources, physicians' social standing, social norms against "profiting" by injury, and willingness to give physicians the benefit of the doubt when evidence conflicts.

—Mary Ellen Schneider