Quality Data Would Satisfy CMS

MOC *from page 1*

gout care given to those patients, propose a plan of practice improvement, and then reassess the care given to those same patients in 6 months to see whether the quality of care improved.

The advantage of the MOC process is that physicians are familiar with it, as more than 80% of all physicians participate, Dr. Cassel said in an interview.

Physicians have been eligible to receive bonuses for participation in the Medicare PQRI, but they have complained about it as a redundant, burdensome, and confusing process, and have bemoaned botched or missing payments. Even the Centers for Medicare and Medicaid Services has acknowledged problems with the program.

In a statement, Dr. Kevin B. Weiss, president and CEO of the American Board of Medical Specialties, said that "MOC reporting will give patients, health plans, and others the information they need to choose physicians based on performance and other key qualifications, including diagnostic acumen, clinical reasoning, and medical knowledge. This [law] is a significant step forward in recognizing the value of MOC in advancing health care quality for the benefit of patients."

Under the Patient Protection and Affordable Care Act of 2010 the Health and Human Services secretary will decide how MOC will fit into the PQRI process.

ABIM and other medical specialty boards seek to meet with CMS officials to help write the regulations for implementing the process, Dr. Cassel said. "Our concept is that it would be kind of an alternative pathway; … that it would include all the same conditions and measures as PQRI, but be even more comprehensive," she noted.

Family physicians already have some experience with using MOC as an alternative to PQRI. The American Board of Family Medicine received approval from Medicare to use its MOC registry for the PQRI process, according to Dr. Michael Hagen, ABFM's senior vice president. Instead of using Medicare "G" codes, physicians report actual patient data.

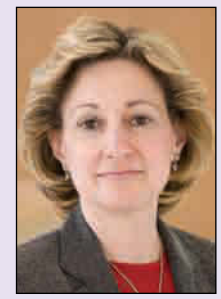
In 2008 (the first year of the registry), 260 family physicians participated. Participants could report on 15 patients over a 6-month period to receive half of the bonus, or 30 patients over a year to receive the full bonus, Dr. Hagen said in an interview. Last year, all participants were required to report on the full year; about 720 family physicians participated. Dr. Hagen said he doesn't expect the ABFM process to change anytime soon. "Our PQRI process will continue as it is until we see the final rules and regulations" regarding implementation of the new law.

Dr. Hagen said that he envisions a future in which physicians can submit data for PQRI, for MOC, and for meaningful electronic health records in one fell swoop. That will be a big relief, he said. As the three programs are currently structured, "nobody wants the same information in the same way, and it's just driving people nuts." ■

MY TAKE

Our MOC Program Is Up to the Task

Dr. Kolba's concern seems to be well placed. It is likely that rheumatologists who were certified prior to 1990 will have to complete the PQRI process.



We have worked hard to provide support for rheumatologists—members and nonmembers—to go through the important, though often daunting, process of maintenance of certification. We have created self-assessment and practice improvement products uniquely tailored for rheumatologists, and have a maintenance of certification review course to help in preparation for the secure examination.

We have received strong endorsement from the ABIM as our programs and products have been deemed to be of high quality, and these programs are similarly rated very highly by our members. We hope that CMS, other insurers, and state medical boards will work together with us (the ACR, ABIM, and ABMS and other member boards) to facilitate the process for all sorts of credentialing and demonstration of quality and lifelong learning. The connection between MOC and PQRI makes intuitive sense: Physicians should not need to go through both processes separately or in parallel.

AUDREY UKNIS, M.D., *is a professor of rheumatology at Temple University, Philadelphia. She guided development of the ACR's MOC program during her tenure as chair of the college's continuous professional development committee. She is now ACR treasurer.*

Medicare Cost Burden Must Be Borne Equally by All Citizens

BY ALICIA AULT

That physicians have received another brief reprieve from the looming 21% cut to Medicare reimbursement is not the point, according to Dr. Karen S. Kolba.

The real issue is why physicians are being asked to bear the entire burden of higher-than-expected Medicare costs, she said in an interview. "I understand there are budget implications [to rising Medicare costs], but the responsibility to provide this benefit to seniors and the disabled is the duty of all citizens, not just physicians," said Dr. Kolba, who is chair of the American College of Rheumatology's Committee on Rheumatologic Care.

President Obama signed legislation late on April 15 giving physicians another temporary reprieve from the 21% Medicare pay cut until June 1.

Dr. Kolba expects the cuts will not go through in this election year. The question is whether Congress will have the "guts" to fix the Sustainable Growth Rate (SGR) formula, said Dr. Kolba, who practices in Santa Maria, Calif.

The fate of Medicare's physician fees was in doubt as late as the afternoon of the 15th. The Senate spent most of the week debating a bill (H.R. 4851) that would delay the cuts mandated by the SGR formula as well as extend unemployment benefits and federal subsidies for COBRA benefits.

The Senate finally approved the bill, with the House doing so in quick succession. The president signed it shortly thereafter. The Congressional Budget Office estimated the cost of this brief delay in the pay cuts at $2.1 billion, the second most costly aspect of the bill after unemployment benefits extension, at almost $12 billion.

The pay cut technically went into effect on April 1, but the Centers for Medicare and Medicaid Services held all claims submitted from that date until April 15, in anticipation that Congress would reverse the cuts retroactively. But on the afternoon of the 15th, CMS officials noted in a statement that claims with dates of service on or after April 1 would be processed at the lower rate "as soon as systems are fully tested to ensure proper claims payment."

Physician groups were not pleased and began chiding members of Congress for their inaction. J. James Rohack, president of the American Medical Association, said in a statement, "Congress must now turn toward solving this problem once and for all through repeal of the broken payment formula that will hurt seniors, military families, and the physicians who care for them." Dr. Rohack warned—again—that physicians are starting to limit new Medicare patients. "It is impossible for physicians to continue to care for all seniors when Medicare payments fall so far below the cost of providing care," he said. ■

Medicaid Expansion Can Start Now, Mandated by 2014

BY MARY ELLEN SCHNEIDER

One of the cornerstones of the health care reform law is a massive expansion of the Medicaid program.

Starting in 2014, all states will be required to expand eligibility of their Medicaid programs to all adults at or below 133% of poverty, regardless of whether they have children or are disabled. And beginning last month, states could choose to open up programs to these new enrollees early. This is the first time in the history of Medicaid that states can receive federal funds for providing coverage for adults based solely on income levels.

States that begin enrolling these newly eligible adults before 2014 will receive federal matching payments at the regular rate. Starting in 2014, they will receive an increased matching rate for certain people in the new eligibility group, according to the Centers for Medicare and Medicaid Services. The agency plans to issue separate guidance on this issue later.

The immediate impact on states will probably vary, based on whether they are already covering some of the newly eligible adults with their own funds. In those states, the new federal money will mean an immediate savings. States that don't already offer expanded coverage will be spending new money to pick up their share of covering new beneficiaries.

Another question is how the expansion of the Medicaid program will impact access to care. In many states, Medicaid pays physicians at rates well below Medicare levels, and some estimates suggest that, around the country, only about half of primary care physicians even accept new Medicaid patients. Under the Health Care and Education Reconciliation Act passed as part of health reform, Congress raised Medicaid payments up to Medicare levels for primary care providers starting in 2013 and 2014.

A survey of 944 primary care physicians conducted by UnitedHealth Group found that 67% think that new Medicaid patients will struggle to find a suitable primary care physician if the Medicaid expansion is not accompanied by other reforms, such as payment increases. If payment is increased to at least Medicare levels, about half of physicians (49%) said they would be willing to take on new Medicaid patients.

"Having a Medicaid insurance card is not the same as having a primary care doctor that will treat you," Simon Stevens, chairman of the UnitedHealth Center for Health Reform and Modernization, said during a news conference to discuss Medicaid expansion. "Unfortunately, that disconnect between Medicaid benefits and health care access has in some places been growing in recent years."

UnitedHealth estimates that the cost to permanently boost Medicaid payments to physicians would be about $63 billion from 2013 to 2019, with about $50 billion of that cost currently not funded by the health care reform law. ■