Health Care Quality Measures Have Plateaued

BY JOYCE FRIEDEN

WASHINGTON — After more than a decade of steady gains, health plans are seeing some quality improvement scores plateau, according to a report from the National Committee for Quality Assurance.

"We don't seem to put our power behind what we really want," NCQA president Margaret E. O'Kane said at a press briefing announcing the results. "The status quo is still unacceptable."

The report included 2008 data from a record 979 plans—702 health maintenance organizations and 277 preferred provider organizations—that collectively cover 116 million Americans.

Plans did record improvement on a few measures. For example, on average, 79% of patients in commercial plans were successfully monitored while taking certain medications such as diuretics, up from 74% in 2006. And among Medicare Advantage plans, the percentage of heart attack patients who received beta-blockers at discharge and stayed on them for at least 6 months climbed 10 percentage points, to an average of 78%, during the same time period.

In addition, some areas seemed to plateau because they had reached their maximum potential: For instance, the percentage of children and adults with persistent asthma who were prescribed asthma medications stayed steady at more than 92%.

One exception to the lackluster trend was in diabetes care. Some health plans achieved quality ratings in the highest quartile and per-patient expenditures in the lowest quartile.

But there is room for improvement in other areas, Ms. O'Kane said. Among commercial plans, for example, 57% of measures showed no statistically significant improvement from 2006 to 2008; that figure was 64% in Medicaid plans and 86% in Medicare plans.

Specifically, among Medicare Advantage plan members, no improvement was seen on measures assessing medication use in arthritis or screening for cervical cancer. Further, the percentage of Medicare patients with poor blood sugar control did not decline as hoped.

Measures with overall plan compliance below 50% included follow-up of children on attention-deficit/hyperactivity disorder medications (34%) and initiation of alcohol/drug dependency treatment (43%).

Although the recession has taken its toll on some plans' quality budgets, Ms. O'Kane pointed out that achieving higher quality does not necessarily involve spending more money.

Some health plans achieved quality ratings in the highest quartile for care of diabetes patients even as they were in the lowest quartile for expenditures on those patients. Emulating those plans "is where the trend should be moving," she said.

Vernon Smith, Ph.D., a former Medicaid director currently at consulting firm Health Management Associates, said part of the plateau for Medicaid plans may come from tight state budgets.

"States are in no position to undertake new quality initiatives on their own," he said. "So the impetus really must come at the federal level, and the burden really falls to Congress and the federal agencies overseeing Medicare and Medicaid."

Ms. O'Kane had several recommendations for moving quality improvement forward, including the creation of insurance exchanges and requiring plans to report quality and patient satisfaction data, tying payment to performance, expanding demonstrations of the patient-centered medical home and increasing payments for primary care, and introducing quality bonuses for Medicare Advantage plans.

The data in the report were incomplete because some health plans didn't submit data and because fee-for-service programs—such as Medicare—typically do not have quality tracking mechanisms, Ms. O'Kane noted. ■

Enforcement of Red Flags Rule Delayed Until June

BY MARY ELLEN SCHNEIDER

The Federal Trade Commission once again has delayed enforcement of the Red Flags Rule, giving physicians until June 1, 2010, to comply with new requirements aimed at preventing identity theft.

The rule, which was issued by the Federal Trade Commission (FTC) in 2007, most recently had been scheduled to go into effect Nov. 1. But this is not the first time that the FTC has delayed the enforcement date. The agency has been pushing back enforcement of the rule every few months for about a year. Most recently, the FTC issued a statement on Oct. 30 saying that it was again delaying enforcement at the request of members of Congress.

Congress has been working on a legislative solution to exempt some physician practices and other small businesses from the identity theft requirements. On Oct. 20, the House passed a bill (H.R. 3763) that would exempt physician practices with 20 or fewer employees from the Red Flags Rule. The Senate has yet to act on the bill.

Rep. John Adler (D-N.J.), one of the chief sponsors of the legislation, said the regulations would be burdensome and expensive for small businesses and that physician practices were not meant to be caught up in this regulation.

"The Federal Trade Commission went too far and went beyond the intent of Congress," Rep. Adler said on the House floor Oct. 20.

The rule also is being challenged in court. On Oct. 30, the U.S. District Court for the District of Columbia ruled that the FTC cannot apply the regulation to lawyers.

Under the Red Flags Rule, all creditors, including physician practices, must establish a written identify theft–prevention program to protect consumers. The Red Flags Rule requires physician offices and other health care institutions to conduct risk assessments to determine their vulnerabilities to identity theft and respond to those risks.

The rule has raised the hackles of organized medicine. Groups such as the American Medical Association have objected, saying that it is inappropriate to classify physician practices as creditors simply because they allow patients to defer payment while the practices bill insurance companies. The Red Flags Rule also would add financial and administrative burdens on practices, the AMA said, because it duplicates existing privacy and security requirements put in place under the Health Insurance Portability and Accountability Act.

"For over a year, the AMA has continued to make the case to FTC that physicians are not creditors, and the red flags rule should not apply to them—now attorneys and members of Congress are also rightly raising concern with the FTC's broad interpretation," Dr. Cecil Wilson, the AMA's president-elect, said in a statement. "The FTC's latest delay of 7 months should give them the time they need to take a good, hard look at the rule and finally revise the list of groups to which it applies." ■

Multispecialty Groups Are Feeling Recession's Pinch

BY ERIK GOLDMAN

DENVER — Multispecialty group practice revenue dropped last year for the first time in a decade as practices across the country felt the impact of the recession, but primary care revenue appears relatively healthy.

The Medical Group Management Association's Cost Survey for 2009 showed a 1.9% decline in mean total medical gross revenue among multispecialty groups, as well as a 9.9% drop in volume of medical procedures (indicated by relative value units provided per patient) and an 11% decrease in total patient volume. Not surprisingly, bad debt from fee-for-service charges increased by 13%.

The 2009 report, released at the MGMA's annual conference, was based on 2008 data and so represents a snapshot of the early phase of the recession. Current conditions could be a significantly worse, but won't likely show up until the next survey, said Dr. William F. Jessee, president and chief executive officer of MGMA, who presented the data.

Though fully one-third of practices surveyed reported a decrease in total revenue in 2008, the news isn't all bad. Data on single-specialty groups showed some clear winners, even in these hard times. In particular, cardiologists reported a 7.9% mean increase in total revenue after operating costs. Pediatricians topped that, with a 9% increase. Family physicians reported a 2.4% mean increase.

Hardest hit were gastroenterologists, with a 5% drop in revenue. In general, the procedure-based specialties are feeling the hardest squeeze, Dr. Jessee noted.

Dr. Jessee said that group practices are tightening their belts.

On average, practices reported reducing support staff costs by 1.5%, though there were no reported significant changes in number of staff members. That means only one thing: Many employees have taken pay cuts. In some cases, the doctors themselves are taking home less pay, he pointed out.

Thirty-five percent of practices have instituted hiring freezes, and 34% say they've cut operating budgets. Thirty-seven percent said that they have postponed capital expenditures.

Over one-third of the practices in the survey said that they have seen an increase in the number of uninsured patients in 2008.

Solo and physician-owned small group practices have been especially hard hit by the recession, and increasingly they are reaching out to hospitals and the large group practices for a lifeline. MGMA surveys over the last decade show clearly that America's doctors are huddling up and selling out to larger health care entities, Dr. Jessee said.

The number of MGMA member groups owned by hospitals grew by 20% during the 5-year period from 2003 to 2008, and they now comprise 10% of the organization's total membership.

During that time, the average number of physicians in MGMA member group practices increased from 16 in 2003 to 19 in 2008. The number of doctors in the average hospital-owned group rose from 64 to 76, a 19% increase. "There's a big, big trend toward consolidation," Dr. Jessee said. ■