Medicare Pay-for-Reporting Program Tied to a Bonus

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Starting July 1, physicians who report on selected quality measures will have a chance to earn a small bonus payment from Medicare.

The program, called the Physician Quality Reporting Initiative, was mandated by Congress and offers incentive payments to physicians who report on one to three quality measures. By doing so, physicians can earn a bonus of up to 1.5% of their total allowed Medicare charges during the 6-month reporting period.

Although even the maximum compensation isn't enough to make anyone rich, some physician organizations are advising their members to take a good look at the program because it may be the first step toward a performance-based payment system.

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Centers for Medicare and Medicaid Services officials have selected 74 quality measures that can be used by physicians across specialties. If 4 or more measures apply, physicians must report on at least 3 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.

Of the 74 measures released by 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.

"By involving ourselves in the process, we can have feedback," said Dr. James Stevens, a neurologist in Fort Wayne, Ind., and a member of the medical economics and management committee of the American Academy of Neurology. Those who give it a try will get a confidential report from the CMS about how they are doing and have a chance to provide information on what works and what doesn't.

"This experience will likely be helpful in the future," said Brett Baker, director of regulatory affairs at the American College of Physicians, adding that although the bonus payment is not significant, having some type of financial incentive attached may be enough to get people's attention.

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 how feasible it will be to make those changes.

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. 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. 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. CMS officials are also working on the possibility of allowing physicians to report using either registry-based systems or electronic records systems in 2008. ■

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

POLICY & PRACTICE

Abortion Procedure Ban Upheld

The U.S. Supreme Court last month narrowly upheld the controversial ban on so-called partial-birth abortions, marking the first time the court has forbidden a specific abortion procedure. The 5-4 decision said that the Partial Birth Abortion Ban Act, approved by Congress in 2003, does not violate a woman's constitutional right to an abortion, even though it does not contain an exception to protect the health of the mother. "The law need not give abortion doctors unfettered choice in the course of their medical practice," Justice Anthony Kennedy wrote for the majority. In separate statements, National Right to Life applauded the ruling, while Planned Parenthood Federation of America noted that with the decision the high court took away an important option for physicians. The American College of Obstetricians and Gynecologists had filed an amicus brief in support of those challenging the law.

Retail Clinics Replacing PCPs

More than 1 in 10 retail medical clinic users said the clinics have mostly or completely replaced their primary care physicians for the types of treatments offered at such facilities, according to a study from Market Strategies Inc., a research firm. "Consumers are telling us in no uncertain terms that convenience is so critical to them that they will forego traditional primary care providers in exchange for access to the kind of quick and convenient basic care services offered by retail clinics," said John Thomas, MSI vice president, in a statement. The study also indicated that consumers who have used retail clinics are open to treatment for a wider range of conditions, including migraine hypertension. Of the all the consumers polled, 30% said the clinics should compete with primary care physicians by offering a broader variety of services. The American Academy of Family Physicians said in a February policy statement that retail clinics should have a "well-defined and limited cope of clinical services," and that they should encourage all patients to have a medical home. "The retail clinic is not a substitute for the personal medical home," said Dr. Rick Kellerman, AAFP president, in an interview. He said although the study appears biased toward retail clinics, "there is a shift toward consumerism, and we do need to reengineer practices to make them more convenient."

Penalized by High Deductible Plans

High-deductible health insurance plans discriminate against women by leaving them with far higher out-of-pocket health bills than men, according to a study from Harvard Medical School, Boston. The study also found that adults 45-64 years, those with any chronic condition such as asthma or high blood pressure, and children taking even one medication were likely to suffer financially in high-deductible plans. Under the plans, patients must pay at least $1,050 before their health coverage kicks in. In 2006, the median cost of care (both insurance and out-of-pocket) for women ages 18-64 was $1,844, compared with $847 for men. For middle-aged adults, the mean expenditure was $1,849 for men and $2,871 for women. High blood pressure patients had a mean annual expenditure of $3,161, while diabetics taking at least one medication had a mean expenditure of $5,774. "Even common, mild problems like arthritis and high blood pressure make you a loser in a high deductible plan," said Dr. David Himmelstein, study coauthor.

Negotiation Could Save $30 Billion

Legislation that would allow Medicare to use its bulk purchasing power to negotiate for lower prescription drug prices under Part D could save U.S. taxpayers and seniors more than $30 billion annually, an advocacy group reported. The Institute for American Research said that about $10 billion of those savings would accrue to U.S. seniors in the form of cheaper prices, and the U.S. government could save roughly $20 billion a year by having Medicare negotiate for the same prices the Department of Veterans Affairs already gets. However, the Pharmaceutical Research and Manufacturers of America (PhRMA), which represents drug makers and opposes the legislation, said pharmacy benefit managers already are negotiating with manufacturers for lower prices under Part D.

Cuts Would Harm Seniors

Three-fourths of physicians said they believe that seniors will be harmed if Congress cuts the Medicare Advantage program, and most doctors said lawmakers should cut other programs or raise taxes rather than cut Medicare Advantage, according to the industry group America's Health Insurance Plans (AHIP). In addition, 35% of seniors enrolled in Medicare Advantage said they would skip some of the health care treatments they currently receive if the option of choosing a Medicare health plan is taken away. The findings are from two surveys released by AHIP in March.

Changing MD Demographics

A major demographic shift is underway in medicine as female physicians become more numerous, and this trend will influence how medical groups recruit and retain physicians throughout their career cycles, according to the 2006 Retention Survey from the American Medical Group Association and Cejka Search, an executive search organization. In 2006, female physicians accounted for 35% of physicians in the medical groups responding to the survey, compared with 28% in the previous survey. Factors such as "poor cultural fit" and family issues are the driving forces in physician turnover. Part-time and flexible work options also are growing in importance, the survey found.

—Jane Anderson