New Voluntary Reporting Program Costs Hit a Nerve

BY JOYCE FRIEDEN AND JENNIFER LUBELL
Associate Editors, Practice Trends

Medicare is attempting to simplify the requirements of a new voluntary reporting system that physicians claim is too burdensome.

Under the latest revision from the Centers for Medicare and Medicaid Services, physicians participating in the Physician Voluntary Reporting Program (PVRP) will have only 16 measures to choose to report on instead of 36. CMS also is working to revise the program's reporting system to provide more options for physicians.

Primary care groups opposed CMS' decision to collect clinical data through a set of Healthcare Common Procedure Coding System (HCPCS) codes or G codes—a system most physicians do not use. The agency is working with the American Medical Association to add the option to use CPT II codes as well as G codes, CMS spokesman Peter Ashkenaz told this newspaper. "This will provide clinicians with the flexibility of utilizing either G codes or CPT II codes" for the program, he said.

In light of the 4.4% cut in pay, physicians 'will be even less able to comply with any reporting, voluntary or not.'

DR. FIELDS

The 16 starter measures address a wide spectrum of clinical care, including administration of aspirin at arrival for acute myocardial infarction; control of lipids, blood pressure, and glycosylated hemoglobin for patients with diabetes; and assessment of fall risk in elderly patients.

The 20 measures removed from the original set won't necessarily be thrown out. In a fact sheet, CMS said it intended to pursue further development of those and other measures suggested by physician groups.

Reactions to the changes varied. Dr. C. Anderson Hedberg, president of the American College of Physicians, called the revisions "critically important." As reporting and pay-for-performance programs become more widespread, "uniformity and a realistic set of measures that don't create huge administrative reporting burdens are essential for physician acceptance and the success of any quality improvement and measurement program."

Any simplification of reporting is welcome, Dr. Larry Fields, president of the American Academy of Family Physicians, noted in an interview. Yet "this is still a voluntary program with no immediate benefit to patients or physicians."

In light of the 4.4% cut in physician pay that went into effect Jan. 1, physicians "will be even less able to comply with any reporting, voluntary or not," Dr. Fields said. Without a positive incentive to participate, "I expect that CMS' announcement will be met with indifference."

At a meeting of Medicare's Practicing Physicians Advisory Council (PPAC) held before the changes were announced, several physicians said the program would be a hassle for them to implement. For instance, PPAC chair Dr. Ronald Castellanos said it would cost him $15,000 to make the necessary changes in his practice to accommodate the program.

"I'm going to have to redesign my workflow between the clinical and office buildings, change the clearinghouse software, and change the software I use to send things to other providers" and to CMS, he said. "I had [a company] give me an estimate, and it's about $15,000. That's a lot of money to do a voluntary program."

In return for submitting data to the program, physicians get a report telling them how well they did on each measure within their own patient population, as well as a comparison of their performance with that of other physicians regionally and nationally. Although physicians do not need to register with CMS to submit data, they must register to receive the reports.

Dr. Michael Rapp, director of the quality measurement and health assessment group at CMS, said that although there was no money attached to the reporting process, "We want to make it beneficial to physicians." The reports are one way of doing that, but CMS would welcome any other ideas, he added.

Council member Dr. Peter Grimm, a radiation oncologist in Seattle, asked why hospitals receive a 0.4% payment incentive to report data under another reporting program, but physicians do not. "What is the rationale for that? Doctors don't need [the money], or hospitals deserve it more?"

Dr. Trent Haywood, a deputy chief medical officer at CMS, said that when the hospital reporting program started in 2002, hospitals didn't get paid either—that started later on.

Council member Dr. Laura Powers, a Knoxville neurologist, said outcomes measures wouldn't work well in a practice such as hers, where many patients have terminal illnesses. "I take care of patients who are going to die no matter what you do, but I have to make sure their quality of life is better for however long they have to live. That's why we need to have process measures."

The council passed a resolution noting that because the voluntary reporting program will require additional staff, training on use of G codes, and reconfiguration of computer program, "PPAC advises that any effort at implementing quality measures and reporting must come after physician payment reform and a reduction in current regulatory and administrative demands. Otherwise, efforts to improve care will be impeded."

The council also passed a resolution asking that CMS seek comments from the appropriate specialty societies regarding the issues raised by the voluntary reporting program, "and, like the hospital program, pay for data collection." ■

POLICY & PRACTICE

Food Allergen Labeling

All food labels now must clearly state if a product contains any ingredients with protein derived from the eight major allergenic foods. Under the Food Allergen Labeling and Consumer Protection Act of 2004 (FALCPA), manufacturers are required to identify in plain English the presence of ingredients that contain protein derived from milk, eggs, fish, crustacean shellfish, tree nuts, peanuts, wheat, or soybeans in the list of ingredients or to say "contains" followed by name of the source of the food allergen after or adjacent to the list of ingredients. It is estimated that 2% of adults and about 5% of infants and young children in the United States have food allergies. Approximately 30,000 consumers require emergency department treatment, and 150 Americans die each year because of allergic reactions to food. "The eight major food allergens account for 90% of all documented food allergic reactions, and some reactions may be severe or life threatening," said Robert E. Brackett, Ph.D., director of the Food and Drug Administration's Center for Food Safety and Applied Nutrition. The statute, however, does not require manufacturers or retailers to relabel or remove products that don't have the labeling because they were labeled before the effective date. For that reason, there will be a period of time where consumers will see packaged food on store shelves and in their homes without the revised allergen labeling, the FDA cautioned.

Rural Access to Part B Drugs

Access problems may prevent rural providers from participating in the new Competitive Acquisition Program (CAP) for Part B drugs and biologicals, Joan Sokolovsky, a senior analyst with the Medicare Payment Advisory Commission (MedPAC), said at a commission meeting last month. Physicians who elect to participate in the program will obtain drugs from a preselected list of vendors, who in turn will take on the responsibility of billing Medicare for the drugs and collecting coinsurance or deductibles from patients. Under CAP rules, drugs must be delivered to the facility where they will be administered. Chemotherapy in rural areas, however, is delivered through satellite facilities, where "sometimes drugs cannot be mixed," Ms. Sokolovsky said. In a recommendation, MedPAC said that the Health and Human Services department should allow an exception to these delivery rules for rural satellite offices of providers.

Better Coordination for Medicare

Most Medicare beneficiaries see multiple physicians, pointing to a need for better care coordination, MedPAC research director Karen Milgate indicated at a commission meeting last month. Seeing multiple physicians puts beneficiaries at greater risk for duplication of services, increases the potential for adverse events, and may also increase health care costs, she said. In sampling inpatient, outpatient and physician supplier file claims from 2003, with various combinations of diabetes, coronary artery disease, and congestive heart failure, "we found that on average beneficiaries see five physicians. Those in our chronic condition groups on average saw seven physicians. And then, when we looked at those with all three conditions on average they saw 13 physicians" in 1 year, she said. Analysts also looked at the percentage of a patient's care that was billed to one physician. For patients with three conditions, only 25% had half or more of their care billed by one physician, "which of course means that they're seeing multiple physicians," she said.

P4P: Not Local Yet

Despite the national buzz over pay for performance and the interest in Congress, such initiatives have yet to catch on in many local communities, the Center for Studying Health System Change reported in a study. "While there's been plenty of buzz about pay for performance as a way to improve health care quality, the reality is that these initiatives are off to a slow start in many communities," said HSC President Paul B. Ginsburg, Ph.D. The study was based on site visits to 12 nationally representative communities: Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. Of these communities, only two, Orange County and Boston, had significant physician pay-for-performance programs. In the other communities, where to date almost no physicians had received quality-related payments, physician attitudes ranged from skeptical to hostile, according to study results.

Retiree Drug Coverage Continues

In a survey of 300 of the nation's largest private-sector employers, almost four in five (79%) said they would accept government subsidies to continue to provide retiree drug coverage, comparable with Medicare, when the new drug benefit started this month, according to a study by the Kaiser Family Foundation and Hewitt Associates. Another 10% will provide some drug coverage to supplement the new benefit. Only 9% said they planned to stop offering drug coverage to Medicare-eligible retirees. Firms accepting the retiree drug subsidy were less certain about whether they would continue to take this approach in future years, according to survey results. Among those firms that will accept the subsidy in 2006, about four in five (82%) said they were "very" or "somewhat" likely to accept the subsidy again in 2007. Looking ahead to 2010, only half (50%) said they were likely to maintain coverage and accept the subsidy, while 22% said they were unlikely to do so, and 28% said they didn't know.

—Jennifer Lubell