New Voluntary Reporting Program Costs Hit a Nerve

BY JOYCE FRIESEN 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 from to report on instead of 36. CMS is also 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 CPT 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 CPT codes. CMS spokesman Peter Ashkenaz told this newspaper, “This will provide clinicians with the flexibility of utilizing either CPT or CPT II codes” for the program, he said.

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 fact, 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.

In light of the changes, 44% of pay physicians will be even less able to comply with any reporting, voluntary or not.

DR. FIELDS

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 with 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, John Sokolovsky, a senior analyst with the Medicare Payment Advisory Commission (MedPAC), said at a commission meeting last month. Physicians who want 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 usually delivered through satellite facilities, where “sometimes drugs cannot be mixed.” Ms. Sokolovsky said. In a recommen-dation to Medicare, 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 coordination. MedPAC research director Karen Milgate indicated at a commission meeting last month. Seeing multiple physicians puts beneficiaries at greater risk of medication confusion and health care costs, she said. In sampling inpatient, outpatient and physician office visits from 2003, with various combinations of diabetes, coronary artery disease, and congestive heart failure, “we found that on average beneficiaries who live 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 23% had half or more of their care billed by one physician, which is much lower than the percentage of patients who see 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 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; New York, N.Y.; 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 HealthFocus. 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, down from 92% in 2006. Of those accepting the subsidy 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