POLICY & PRACTICE

CMS Launches Enrollment Site

A new, Internet-based system will let physicians and nonphysician practitioners apply for Medicare enrollment, check on applications, make changes, and view information on file. The Provider Enrollment, Chain and Ownership System is now available in 15 states and the District of Columbia, and the Centers for Medicare and Medicaid Services said it would expand availability to all states in early 2009. PECOS, available at https://pecos.cms.hhs.gov, can process an enrollment application as much as 50% faster than can be done with paper, CMS said. PECOS also will speed up required reporting of practice location and other changes in enrollment information, CMS said.

FDA Approvals Increase

The FDA approved 21 new molecular entities and 4 new biologic drugs in 2008, compared with 17 NMEs and 2 biologics in 2007. Four of the 2008 approvals came in December. In 2006, the FDA approved 22 new drugs and biologics. Although the agency has increased the annual number of novel therapies approved in recent years, it is still not meeting statutory deadlines for reviewing and approving products. The FDA said it did not meet the 2008 target of reviewing 90% of approval applications within the time limits set by law. Many of the delays were attributable to resource constraints, the agency said. The FDA has hired 800 new people to review drug and biologic applications, which should help reduce delays by the second half of 2009, according to analyst Ira Loss at the firm Washington Analysis. However, delays may persist for new diabetes therapies and opioids, Mr. Loss said, noting that the potential for cardiac toxicity and abuse hangs over those products.

Hospitalizations Hit Coverage Gaps

Interruptions in Medicaid coverage are associated with a higher rate of hospitalizations for conditions that often can be treated in ambulatory care settings, according to a study in the Annals of Internal Medicine. Researchers in California found that adults' increased risk for hospitalization for conditions including asthma, diabetes, and hypertension is highest in the first 3 months after an interruption in Medicaid coverage. The authors suggested that when states require enrollees to demonstrate eligibility frequently, the Medicaid programs see increases in hospitalizations for the common health conditions. "Although states may attempt to save money in the short term by dropping Medicaid coverage for those who cannot keep up with frequent reporting requirements, this study shows that disruptions in coverage come at the risk of increased hospitalization for conditions that can typically be treated in a less expensive primary care setting," said lead author Dr. Andrew Bindman, professor of medicine at the University of California, San Francisco.

E-Rx Systems Boost Savings

Electronic prescribing systems that let doctors select lower-cost or generic medications can save $845,000 per 100,000 patients per year and possibly more, according to a study funded by the Agency for Healthcare Research and Quality. The researchers examined the change in prescriptions written in community practices before and after two Massachusetts insurers launched e-prescribing systems. The doctors prescribed electronically only 20% of the time—generally relying on traditional prescription pads—but those who did use e-prescribing with formulary support increased generic prescriptions by 3.3%. "Our results likely represent a conservative estimate of the potential savings," said lead study author Dr. Michael Fischer of Brigham and Women's Hospital in Boston. "As doctors e-prescribe more frequently, the amount saved could increase dramatically." The physicians who wrote electronic prescriptions were slightly younger and more likely to be female than those who did not, the study indicated.

PhRMA Revises Ad Guidelines

The Pharmaceutical Research and Manufacturers of America has advised drug makers to state when actors portray medical professionals in direct-to-consumer drug advertisements and to acknowledge any compensation given to real medical professionals in ads. The new, nonbinding guidelines also support the inclusion of "black box" warnings in the ads, and underscore that companies shouldn't promote off-label uses. Rep. John Dingell (D-Mich.), who has led investigations into direct-to-consumer ads, commended PhRMA for the new guidelines but noted that the organization hasn't endorsed a 2-year prohibition on such ads for newly approved drugs, as recommended by the Institute of Medicine. "Although this revision is the first step toward protecting American consumers, there is much more that can be done," Rep. Dingell said.

Medical Home Issues Identified

Key issues that face medical home initiatives include how to qualify physician practices as medical homes, how to match patients to such practices, how to get physicians and other providers to coordinate their care of patients in medical homes, and how to pay practices that serve patients in this way, according to a study by the Center for Studying Health System Change, a think tank, and Mathematica Policy Research Inc., a research firm. These issues "have potential to make or break a successful program," the report's authors said.

—Jane Anderson

Health Care Spending Was 16.2% of 2007 GDP

BY DENISE NAPOLI
Associate Editor

WASHINGTON — Growth in U.S. health care spending slowed in 2007 to 6.1%, the lowest annual growth rate since 1998.

But at $2.2 trillion, or $7,421 per person, health care spending still represented 16.2% of the nation's overall gross domestic product and was an increase from 16% in 2006, according to data published by a group of statisticians and economists from the Center for Medicare and Medicaid Services' Office of the Actuary.

"Do we feel glad that the cost growth overall in 2007 was the lowest in quite some time, since 1998?" asked Richard Foster, CMS chief actuary. "Sure, we're happy about that. But it was still 6.1%. How much did GDP grow that year? How much did your wages increase? We still have this affordability problem," he said.

The data indicate most of the spending slowdown in 2007 was a result of the markedly lower 4.9% rate of growth in retail prescription drug spending, which amounted to $227.5 billion (10% of total spending) and represented the slowest rate since 1963. In 2006, by contrast, drug spending grew by 8.6% (Health Aff. 2009;28:246-61).

The slowing in retail prescription drug spending was deemed to be a result of three factors: the growth in generic prescription drugs (67% of filled prescriptions in 2007 were generic, up from 63% in 2006); a slower price growth in all drugs (thanks both to the increased use of generics and also the introduction of drug discount programs at national retailers such as Walmart); and increased safety concerns related to numerous black-box warnings issued this year (68 compared with 58 in 2006 and 21 in 2005).

Growth in spending on physician and clinical services remained stable from 2006 to 2007 with a 6.5% increase, accounting for $478.8 billion or 21% of the total health care bill.

Taken separately, the increase was mostly sustained by a growth in spending for clinics, which grew at an average annual rate of 8.5% from 2004 to 2007. ("Clinics" were defined as outpatient care centers and ambulatory service centers.) As a result of cuts in imaging reimbursement and flat or very small payment updates, payments to physicians grew at an average of 6.4% over the same period.

Hospital spending accounted for $696.5 billion or 31% of the total in 2007, with an increase of 7.3%. Nursing home care was 6% of the total, or $131.3 billion, with an increase of 4.8%, up slightly from 4.0% in 2006.

The nation's health care tab in 2007 was split nearly evenly between public and private payers, with 46% coming from the public side—about the same as in 2006, according to Anne Martin, an economist at the CMS Office of the Actuary and a coauthor of the report.

Medicare spending increased 7.2% in 2007, following an 18.5% increase in 2006 that resulted from the implementation of the Part D program that year. Meanwhile, private health insurance premiums grew at a more modest 6.0%.

Lead author and CMS statistician Micah Hartman said that although the current recession did not overlap enough with data reported in this study to have an effect—only 1 month—a set of health spending projections for 2008-2018 will be released sometime in February.

Mr. Foster predicted that the projections will have much less of an upside. "I wouldn't expect the 6.1% to stay that low," he said. "I wouldn't expect the good news to continue." ■

Details About PQRI Measures For 2009 Now Available Online

Detailed descriptions of the quality measures and measures groups that can be used as part of the 2009 Medicare Physician Quality Reporting Initiative are now available online.

Officials at the Centers for Medicare and Medicaid Services also have posted an implementation guide for claims-based reporting in 2009 and instructions for reporting using measures groups.

Among the 153 measures eligible for reporting in 2009, there are 52 new measures including elder maltreatment screening and follow-up planning, glucocorticoid management in rheumatoid arthritis, and influenza immunization in pediatric end-stage renal disease.

The measures and related guidance documents are available at www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp.

Late last year, CMS officials began listing the names of physicians and other health care professionals who reported on at least 1 of the 74 PQRI measures in 2007 at www.medicare.gov/physician.

Along with the listing of physicians, CMS officials included general information about the PQRI program. They noted that physicians may have had good reasons not to report measures and that a failure to report through PQRI doesn't reflect a lack of commitment to high-quality care.

For example, CMS officials wrote that reporting quality data may have been too costly for some physicians or that physicians may have been engaged in other quality improvement reporting activities.

—Mary Ellen Schneider