VERMONT MEDICAL SOCIETY RESOLUTION

Burden of Quality Reporting

Adopted October 19, 2013

Whereas, The time spent by US physicians interacting with payers equals $82,975 per physician per year¹ and these interactions include dealing with multiple formularies; claims and billing procedures; credentialing requirements; prior authorization; and quality reporting requirements; and

Whereas, There is a lack of harmony among various quality reporting requirements and a need for additional research to determine if current quality reporting requirements actually improve health outcomes and help achieve greater efficiency; and

Whereas, Payer-specific variation in quality reporting makes it difficult for practices and policy makers to use information technology to measure health care system improvement and there is a clear need to coordinate these efforts to better deploy scarce resources and minimize burden on providers; ²

Whereas, The state of Vermont is in the process of adopting quality reporting requirements by physicians and other health professionals for commercial and Medicaid Accountable Care Organizations (ACO) that are in addition to the 33 measures required under the Medicare Shared Saving Plan ACOs and those required under the Blueprint for Health; and

Whereas, The lack of harmonization associated with quality reporting have been recently highlighted with the passage by the House Energy and Commerce Committee leaders of legislation to repeal the Medicare’s Sustainable Growth Rate (SGR) system and replace it with physician fee schedule payment updates being based on performance on new measures of care quality; now, therefore be it

Resolved, The Vermont Medical Society will work with other organizations to identify ways to standardize the definitions and calculations for quality metrics used by the federal and state government entities, insurance payers, and others; and be it further

Resolved, The Vermont Medical Society will encourage the documentation of the various quality reporting requirements imposed on physicians and their practices by payers and demonstrate any lack of harmony in the use of different measures and the use of different definitions for the same measures, as well as quantify the cost to physicians and their practices of the administrative burden of quality reporting; and be it further

Resolved, The Vermont Medical Society will seek to determine if there is research indicating that quality reporting requirements improves health outcomes and helps to achieve greater efficiency; and be it further

Resolved, The Vermont Medical Society will work with federal and state government entities, insurance payers, and others to recommend the elimination of reporting requirements where there is a lack of evidence supporting their benefits in order to reduce the administrative burden on physicians and their practices.

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² Damberg, C. Efforts to Reform Physician Payment Rand Office of External Affairs, Feb 2013. p.7