**MedPAC: Physician Reviewing Flawed**

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**WASHINGTON** — The current process for valuing physician services may result in inaccurate pricing and need to be reviewed, researchers said during a meeting of the Medicare Payment Advisory Commission.

Relative value units (RVUs) are assigned to services in the physician fee schedule to determine how payment rates vary, one service relative to another. The Centers for Medicare and Medicaid Services reviews and modifies the RVUs for selected services based on recommendations from the RVS Update Committee (RUC), a panel made up of representatives of national and specialty medical societies.

By law, RVUs are reviewed every 5 years. The next review is scheduled for completion in 2007.

There are problems with this review process, much of which involves the subjective nature of measuring physician work. Dana Kelley, a research contractor to the Medicare Payment Advisory Commission (MedPAC), told the advisory committee: “The physicians themselves are intimately involved in setting the RVUs [but at the same time] have a financial interest in how those services are weighted, she said. RVUs also affect the possibility of biased reporting.

Specialty societies, which have much to gain by RUC decisions, can submit “compelling arguments” that the values are incorrect, Ms. Kelley said. While the RUC has safeguards to make sure that some specialties don’t dominate the review process, “there’s an important [and] remaining issue,” she said.

Physicians who perform a specific service are often surveyed to determine the “weight” of a particular service. In answering these surveys, physicians obviously have a financial incentive to indicate that their service should be highly weighted, she said.

The assumption that current RVUs are accurate ignores the fact that they may change over time, Ms. Kelley said. “Even starting from the premise that it’s set correctly, the way a service is performed can change its value.”

Also, there is a strong bias in favor of identifying and correcting undervalued codes, she said. “Previous 5-year reviews have led to substantially more increases than decreases in RVUs. This results in passive devaluation of some codes.”

Inaccurate payments for physician services can distort the market for health care services, said Kevin Hayes, Ph.D., a MedPAC research director. “It can boost volume for certain procedures that are [perceived to be] undervalued.”

Changes in the way medicine is practiced are going to come for a while, he said. “In 20 years, we may be thinking that according to the values of the day, a particular service was undervalued.”

John Rugge, M.D., CEO of the Hudson Headwaters Health Network, in Glens Falls, N.Y., added that “with psychotropic medications, there’s a huge danger in [substituting] one antipsychotic for another, one atypical antipsychotic for another; they clearly have to be tailored to the individual. And these are people in most need.”

Commission vice-chair Angus King, former governor of Maine (I), said he thought the issue could be dealt with by the ability of the physician to determine whether or not a preferred drug was indicated.

“People don’t really want to see health IT become a stra- tegic wedge between the haves and the have-nots,” said Dr. King, senior staff attorney who also spoke at the meeting.

“We also think the type of incentives that we need so we can look at most assets, including trusts and annuities. And although it will be somewhat controversial, we believe that housing—which is an increasingly valuable asset—should also be put on the table.”

The tiered copayment proposal, which would allow states to implement higher copayments for nonpreferred drugs, also raised a lot of interior concerns from the RUC.

John Monahan, president of state-sponsored business at WellPoint, the for-profit California Blue Shield plan, said that he understood the need for “Getting people to increase utilization of generics by even 5% would be an incredible savings.”

**Government Attempts to Ease EHR Transition, Level the Playing Field**

**SAN DIEGO** — Government strategies for health information technology will aid physicians by lowering the cost, improving the benefits, and lowering the risks, said David J. Brailer, M.D., Ph.D., national coordinator for health information technology, at the annual meeting of the American Health Lawyers Association.

Information technology “is a taxonomic issue for physicians, one that separates old from young, progressive from Luddite, and those who want to be part of the performance-based future from those who want to practice the way they have for years,” said Dr. Brailer of the Department of Health and Human Services, Washington.

“We are trying to be non-regulatory, to use a market-based approach, and that means we want to work with the willing. Surveys suggest that many physicians at least half today would do this if they could figure out how to do it,” he said.

One barrier to adoption of electronic health record systems (EHRs) is the variety of products on the market.

Certifying a basic, minimally featured EHR system will aid physicians, he said. Another barrier to EHR adoption is the lack of a “pay-as-you-go” financial model for the federal incentive program. And if the financial incentives are not accelerated in the transition, Dr. Brailer said, “we need to accelerate the adoption of EHRs.”

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Mr. Sheppach said the NGA favored intensifying restructuring of the Medicaid system.

**WASHINGTON** — Hurricane Katrina has put many things on hold, including the fate of $10 billion in cuts to the Medicaid program that were proposed by a federally appointed commission.

The Medicare Commission, which was called for by the fiscal year 2006 federal budget agreement and charted in May by Health and Human Services Secretary Mike Leavitt, included 13 voting members and 11 nonvoting members representing a variety of interests. It was given a deadline of Sept. 1 to come up with ways to cut the money from the Medicaid budget.

After only two meetings, the commission announced its list of ways to achieve the cuts: changing the reimbursement formula for prescription drugs, tightening rules for asset transfers prior to receiving nursing home care, and allowing states to increase copayments for nonpreferred drugs.

Also, a lot of news has circulated “on the notion that the disruption of Katrina would still be counted as assets for the Medicaid.”

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Ray E. Stowers, director. “It can boost volume for certain streams to their children or other people so they can [qualify for] Medicare.”

To prevent people from taking advantage of some of the loopholes in the law, Mr. Sheppach said the NGA favored increasing the “lookback” period—the period during which any assets transferred would still be counted as assets for the beneficiary in determining Medicaid eligibility—from 3 to 5 years.

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