MedPAC: Physician Reviewing Flawed

By Jennifer Silverman

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

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. CMS usually accepts 90% of the committee’s recommendations.

By law, RVUs are reviewed every 3 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 being part of the process,” she said.

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 19 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 Medicare 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.

MedPAC will hear more about the issues this month, the April 22 meeting, and is expected to begin the second phase of its work: making recommendations for long-term restructuring of the Medicare system.

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 tectonic issue for physicians, one that separates old from young, progressive from Luddite, and those who want to be part of a 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, D.C.

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

Certifying a basic, minimally featured EHR system will aid physicians, he said. Another barrier to EHR adoption is the lack of a sound business model. A “pay-as-you-go” financial model is not feasible, and financial incentives will be needed to accelerate the transition, Dr. Brailer said, without specifying any further details. Large physician groups and hospitals are far ahead of small physician offices in adopting EHRs. Jodi Goldstein Daniel, an HHS senior staff attorney who also spoke at the meeting, said more than 50% of large practices have adopted EHRs, but only 13% of small practices have done so. Dr. Brailer’s office will monitor the adoption gap annually, to see if it is closing.

“Physicians need to know what electronic health records (EHRs) is the variety of products on the market.

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

Commission vice-chair Angus King, former governor of Maine (I), said he thought the issue could be dealt with because the ability of the physician to pick any preferred drug if it was clinically necessary to do so. He noted that in Maine, such override requests are usually filled within 72 hours.

Commission member Carol Berkowitz, M.D., president of the American Academy of Pediatrics, said she was concerned about how well such an override system would work. Dr. Berkowitz practices in Los Angeles, said that “in my experience it’s 30-45 days before it gets approved.”

At its next meeting, scheduled for late this month, the commission is expected to begin the second phase of its work: making recommendations for long-term restructuring of the Medicare system.