States to Revamp Relicensing Requirements

BY MARY ELLEN SCHNEIDER

State medical boards are eyeing ways to overhaul the relicensure process so that it better measures a physician's efforts to stay abreast of clinical developments.

Currently, while the public assumes that state licensure means that a physician remains competent, that's just not the case, according to Richard A. Whitehouse, the executive director of the State Medical Board of Ohio.

"There is really no measure once someone is initially licensed and has met the threshold requirements for licensure," he said. "Absent CME requirements, there's really nothing you can point to, to say that this person is maintaining their competency."

Officials involved in the redesign process, however, emphasize that the new requirements won't be a burden on practicing physicians and that most doctors are already doing enough to meet the standards under development.

The Federation of State Medical Boards (FSMB), which represents the nation's state medical boards, has been promoting the need to make relicensure a more robust process for several years.

Last spring, the organization's House of Delegates approved a framework that lays out what the maintenance of licensure process would look like in general. And over the past few months, an implementation group made up of physicians and medical board officials has been filling in the details.

The expectation is that new maintenance of licensure requirements will involve three major components: a reflective self-assessment that calls for physicians to complete a certain number of accredited continuing medical education courses; an assessment of knowledge and skills, which could be a formal exam; and some measurement of performance in practice, in which physicians would compare their practice data to those for peers and to national benchmarks.

Dr. Humayun Chaudhry, president and CEO of the FSMB, said that one of the goals in redesigning the relicensure process is to minimize the burden on practicing physicians. To that end, the FSMB implementation group's draft report calls on state medical boards to accept participation in maintenance of certification through the American Board of Medical Specialties, or osteopathic continuous certification through the American Osteopathic Association, as substantially meeting the requirements for maintenance of licensure. "That's a big advance because a significant plurality of physicians are involved in those programs," Dr. Chaudhry said.

COURTESY RICK DALTON

FSMB CEO Dr. Humayun Chaudhry (right) discusses the Maintenance of Licensure initiative with Frances Cain, Director of the FSMB's Post-Licensure Assessment System.

More than 300,000 physicians are engaged in maintenance of certification through the various boards of the American Board of Medical Specialties, and that number increases by about 50,000 physicians each year, according to Dr. Kevin B. Weiss, ABMS president and CEO.

Officials at the ABMS have been working closely with states for years on the issue of maintenance of licensure and plan to continue to be involved as states begin to pilot the concept over the next several months to ensure that board-certified physicians aren't asked to do any "double work," Dr. Weiss said. "We're going to be very active in trying to help our physician community on a state-by-state basis."

Officials at the FSMB are being careful to point out that maintenance of licensure and maintenance of certification are not meant to be equivalent. While maintenance of certification and osteopathic continuous certification could comply with the more robust relicensure requirements, board certification goes "above and beyond" basic licensure, Dr. Chaudhry said.

For the hundreds of thousands of physicians who aren't engaged in some type of maintenance of certification process, the FSMB is working with states to develop alternative pathways to demonstrate ongoing clinical competence.

The timeline for the new requirements is fairly long, Dr. Chaudhry said. The FSMB is recommending that state medical boards implement the new approach in phases that in total could take up to 10 years. The first step for any state medical board that plans to go forward with maintenance of licensure is to spend the first year educating physicians, the public, and lawmakers about what is planned and why. And each of the three components of the process should take another 2-3 years to implement, he said.

"The vast majority of physicians are already doing things to stay up to date," Dr. Chaudhry said. "In that sense, [maintenance of licensure] is simply a means by which those physicians can demonstrate what it is that they are doing."

Mr. Whitehouse, who also serves on the FSMB's implementation group on maintenance of licensure, agrees that the process will not be onerous for physicians who are making an effort to keep their clinical skills current. ■

Start E-Prescribing Now to Avoid Medicare Penalty in 2012

BY SUSAN LONDON

FROM THE ANNUAL MEETING OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

VANCOUVER, B.C. – The Centers for Medicare and Medicaid Services is currently offering providers a bonus for e-prescribing (electronically transmitting prescriptions to pharmacies). But providers will be hit with a penalty if they don't get on board soon with this practice.

"They are really promoting this," Michael K. McCormick, a practice administrator at the DuPage Medical Group in Winfield, Ill., said at the meeting. But by transitioning from a bonus to a penalty over several years, "they are giving you time to get going on it."

The Medicare Electronic Prescribing (eRx) Incentive Program, which began in 2009 and runs through 2013, provides bonus payments for e-prescribing when eligibility criteria are met, with bonus percentages being reduced over the span of the program, said Mr. McCormick, a registered respiratory therapist.

But the CMS will start financially penalizing providers who do not begin e-prescribing in 2011. The penalty for failing to e-prescribe will be 1%, 1.5%, and 2% of all Medicare Part B charges in 2012, 2013, and 2014, respectively.

The bottom line is to "e-prescribe at least 10 times in the first 6 months of 2011 so you won't be penalized in 2012," Mr. McCormick recommended. "You really need to start doing this in 2011."

The 2010 criteria require that health care providers report e-prescribing for at least 25 eligible patient encounters (which can include multiple encounters for a single patient) and that Medicare account for at least 10% of the provider's payer mix.

The bonus returned to providers for 2010 was 2% of the total Medicare Part B Physician Fee Schedule allowed charges for services for the entire year; it is 1% in 2011 and 2012, but only 0.5% in 2013.

The e-prescribing system used must meet certain criteria – for example, it must generate complete lists of all medications a patient is taking; provide information related to any lower-cost, therapeutically appropriate drugs; and, most notably, transmit prescriptions to pharmacies electronically.

Faxing of the prescription does not count, even if a computer system autogenerates the fax, Mr. McCormick cautioned. The prescription "must basically go from your computer to the pharmacy's computer, not through a fax."

To obtain the bonus, providers can report their use of e-prescribing in any of three ways. "Probably the easiest way to get started is the claims-based reporting," he said, which entails simply adding the G8553 code to the other codes. Alternately, providers can use registry-based reporting or electronic health record–based reporting.

The list of patient encounters considered eligible for e-prescribing is "pretty comprehensive," including all outpatient office visits (those having 992xx codes), home health visits, nursing home visits, and psychiatric care visits, he said. However, inpatient visits are not eligible.

A noteworthy caveat is that providers will not be able to earn both the e-prescribing bonus and another bonus for implementing the electronic health records that the CMS is offering, because e-prescribing is among the 15 core measures of electronic health record implementation.

'E-prescribe at least 10 times in the first 6 months of 2011 so you won't be penalized in 2012.'

MR. McCORMICK

Put another way, "there is no double-dipping" in 2011, Mr. McCormick said. "So if you are going to go for that [electronic health record] bonus, which is a lot more money – $44,000 per provider paid over 5 years – you can't put in for the eRx bonus as well."

Providers who are exempt from the penalty are those who generate fewer than 100 claims with eligible e-prescribing patient codes, those for whom less than 10% of patient encounters are eligible (e.g., hospital-based physicians), and those in rural areas with limited Internet service or a limited number of pharmacies that can receive prescriptions electronically.

The rules of the eRx Incentive Program, which change annually, are online at www.cms.gov/erxIncentive. ■