House Hears SGR Alternatives, Vows Action

BY FRANCES CORREA

FROM A HEARING OF THE HOUSE ENERGY AND COMMERCE COMMITTEE'S SUBCOMMITTEE ON HEALTH

WASHINGTON – A plan to finally replace Medicare's much maligned Sustainable Growth Rate payment formula could be unveiled by this summer, federal lawmakers predicted at a committee hearing.

"Here's the bottom line: If we get to December and we're doing an extension, that's a failure on our part," Rep. Michael Burgess (R-Tex.) said at the hearing . "We need a permanent solution that's predictable, updatable, and reasonable for this year – and nothing else will do."

"Whatever virtues the SGR had when it was created 14 years ago, … it's clear that they have vanished," noted Rep. Henry A. Waxman (D-Calif.). He added that in the past 2 years, Congress has had to pass legislation six times, blocking fee cuts of up to 21% or more.

About 30 medical associations responded to the House subcommittee's request for suggestions and proposals in developing a new system. Speaking with a five-person panel of experts from medical associations and health policy organizations, House subcommittee members considered alternatives to the current SGR formula.

One Size Won't Fit All

While the details of the plans vary, they do show a consensus on several fronts: repealing the SGR, moving away from the traditional fee-for-services payment model, and providing a 4- to 5-year transition period in which providers can experiment with a variety of payment systems.

The expert panel also stressed the importance of avoiding a "one size fits all" solution.

"I think we should also have a realization that what will work in one part of the country will not work in another part of the country, and that's why we have continued to talk about a variety of options," said Dr. Cecil Wilson, president of the American Medical Association.

Dr. Wilson pointed to the provisions in the Affordable Care Act that allow for a variety of models of accountable care organizations, embodying the concept of options in the medical system. In that spirit, he said that the AMA has formed a physician leadership group to evaluate the effectiveness of alternative payment methods.

COURTESY AMERICAN MEDICAL ASSOCIATION

'What will work in one part of the country will not work in another,' said Dr. Cecil Wilson (center).

To strengthen primary care's role in Medicare, the American Academy of Family Physicians backs payment reforms that would boost primary care reimbursement and support the concept of the patient-centered medical home (PCMH). AAFP President Roland A. Goertz noted in written testimony to the committee that the proposal would create a blended reimbursement system for primary care delivered within a PCMH: fee-for-service payments and pay for performance, plus care management fees for PCMH-related activities that don't involve direct patient care.

Dr. David Hoyt, executive director of the American College of Surgeons, said the college is analyzing the use of bundled payments for surgery. Dr. M. Todd Williamson, of the Coalition of State Medical and National Specialty Societies, introduced the option of private contracting, in which patients would be free to apply their benefits to a doctor of their choice, who would be free to opt out on a per-patient basis.

Harold Miller, executive director of the Center for Healthcare Quality and Payment Reform, suggested an episode-of-care payment plan through which hospitals and physicians jointly charge one price for all services included in a hospitalization. The model would also include a warranty stating that any infections or complications would be treated at no additional cost. Also, a physician practice would receive one payment for all patient needs associated with chronic diseases or other conditions.

Rep. Burgess, who is also a doctor, said organizations should focus on ways to address patients with chronic conditions, adding that 80% of Medicare funding is spent by 20% of beneficiaries with chronic illnesses.

Is IPAB the New SGR?

Rep. Fred Upton (R-Mich.) raised concerns about the Independent Payment Advisory Board (IPAB), created by the Affordable Care Act. The board sets expenditure targets, on which it bases spending cuts. In 2018, targets will be based on the gross domestic product. "Sounds a lot like SGR, which we're trying to get rid of," Mr. Upton said. "Since hospitals are exempt from IPAB cuts through the rest of the decade, it seems that the IPAB has the potential to undermine any serious efforts at physician payment reform." Some panelists agreed.

"It's not impossible that [the IPAB] could serve a function," Dr. Wilson said, "but as presently constituted, we see it [as] basically another target for physicians to meet – potential double jeopardy, with an SGR as well as the pronouncements from this body."

The panelists also asserted their belief that whatever plan chosen should be physician led, with financial support of the government. "It would be helpful if physicians could get better financial support in their own payment system to enable them to lead all of those efforts," said Dr. Mark B. McClellan, director of the Engelberg Center for Health care Reform and former administrator of the Centers for Medicare and Medicaid Services. ■

Electronic Health Records Deemed Good for the Earth

BY FRANCES CORREA

FROM HEALTH AFFAIRS

Greater use of electronic health records would cut greenhouse gas emissions, energy use, waste and toxic chemical production, and water consumption, according to a study by Marianne C. Turley, Ph.D., and her associates at Kaiser Permanente.

Even after factoring in the additional energy consumption from the increased use of personal computers, the overall net effect on the environment would be favorable, the researchers concluded based on an analysis of the impact of the Kaiser Permanente EHR system, which covers 8.7 million beneficiaries.

Annually, the use of the Kaiser EHR system eliminated the use of 1,373 tons of paper by discontinuing the use of paper medical charts, x-ray jackets, and administrative forms. The system also decreased annual gas consumption by an estimated 3.3-10 million gallons by cutting the number of visits by 4-13 million.

Patients who were registered online could correspond with their providers about nonemergency concerns through secure e-mail messages, the investigators reported (Health Aff. 2011;30:938-46).

Switching from desktop to laptop computers saved 89,300 megawatt hours and digitizing x-rays eliminated the waste of 203 tons of plastic and 79 tons of toxic chemicals.

VITALS

Major Finding: The use of electronic health records cut Kaiser Permanente's use of paper by 1,373 tons annually. The system also decreased energy use by 3.3-10 million gallons of gasoline by reducing medical visits.

Data Source: Based on a 2011 internal analysis.

Disclosures: All seven researchers are employees of Kaiser Permanente.

Using the Environmental Protection Agency's greenhouse gas equivalencies calculator, Dr. Turley and her associates estimated that Kaiser's efforts reduced greenhouse gas emissions by 9,200 tons.

Results were based on data from regional operational reports, paper-purchasing records, and internal pharmaceutical reports. Travel distance was estimated by calculating the distance from patient addresses to Kaiser-participating primary care buildings and aggregating them by region.

With a growing emphasis on health technology, the Kaiser study showed that "the use of electronic health records can both change the face of health care and help reduce its environmental footprint," the researchers wrote.

Despite these findings, Dr. Turley and her associates said that the environmental impact of switching to electronic health records will vary from system to system. As the Affordable Care Act calls for implementation of electronic systems, they said further analysis is necessary to determine the impacts of widespread implementation.

Although 51% of office-based physicians are currently using an electronic system, only 10% of practices reported their systems as being fully functioning, according to the most recent evaluation from the Centers for Disease Control and Prevention. Regardless, implementation of electronic systems will probably increase as provisions in the American Recovery and Reinvestment Act of 2009 create incentives for providers who invest in electronic systems. Public and private investment in these systems is expected to reach $40 billion in the next several years, according to the investigators. ■

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