New State Relicensing Policy Being Considered

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Physicians, even those holding permanent board certificates, could face increased requirements when renewing their state medical licenses under a draft model policy currently being evaluated by the Federation of State Medical Boards.

Under the draft policy, relicensure would become more comprehensive and would require that physicians demonstrate continuing skills and knowledge in their area of practice. As proposed, the maintenance-of-licensure process would closely mirror the requirements that the American Board of Medical Specialties has in place for maintenance of certification. The draft policy is a model that state medical boards could use, but individual states would determine whether or how it would be implemented.

Over the last 5 years, the Federation of State Medical Boards (FSMB) has been considering how individual state boards could change these policies to ensure that licensees are competent. Earlier this year, the organization's house of delegates approved guiding principles for developing maintenance-of-licensure processes, and called for additional research on the effect that the new requirements would have on state medical boards and licensed physicians.

The best way to ensure that the process does not impose new burdens on physicians is to align it with the existing requirements for certification.

Once that research is complete, the draft maintenance-of-licensure policy would likely be considered by the FSMB's house of delegates at their meeting next May, said Carol Clothier, vice president of strategic planning and physician competency initiatives for the FSMB.

"Nobody wants to create more work for physicians," she said.

The idea is to try to take advantage of activities that physicians already are doing to demonstrate their competence, and to use those to satisfy state licensure requirements, she said.

For their part, state medical boards are feeling pressure from the public to ensure that physicians are competent in light of rapidly changing science and technology. And the current requirements, which vary but generally include some continuing medical education, don't match up with public expectations of the oversight of physicians, she said.

If the maintenance-of-licensure policy is accepted by the FSMB's house of delegates, it still would be a model policy only, Ms. Clothier said. It would be up to individual states and territories to decide if they wanted to adopt, revise, or ignore the model policy. And that decision and its timing are likely to vary widely, based on the politics involved in each state, she said.

"I think it's just inevitable that this will probably happen," said Dr. Larry R. Faulkner, executive vice president and CEO of the American Board of Psychiatry and Neurology (ABPN).

The current state licensing requirements, which mainly involve completing a certain number of hours of continuing medical education, are unlikely to stand up to public scrutiny, said Dr. Faulkner, and that will likely drive this process. But when and how fast these changes occur is unknown. Much could depend on whether there is a case of negligence on the part of a physician that draws significant media attention and drives states to beef up requirements for relicensure. The important thing is to keep any possible maintenance-of-licensure process from being onerous. The states should develop something that promotes quality, but doesn't impose an undue burden on physicians in terms of time and money, Dr. Faulkner said.

The best way to ensure that any maintenance-of-licensure process does not impose new burdens on physicians is to align it with the existing maintenance-of-certification requirements, said Dr. Ralph F. Jozefowicz, a neurology director for ABPN and a professor of neurology and medicine at the University of Rochester (N.Y.) However, each state would still have to create a general maintenance-of-licensure process for physicians who are not board certified.

Neurologists with lifetime board certification could choose to either follow this more general relicensure route or participate in ABPN's maintenance-of-certification process. Dr. Jozefowicz, who holds a lifetime certificate, said he has taken the recertification exam and gone through the other maintenance-of-certification modules and found the experience to be "very educational and rather pleasant."

Pursuing maintenance of certification may also be an attractive option for lifetime certificate holders in neurology because they can be tested in their area of expertise, not through a general exam that could include clinical questions on subjects they haven't studied in many years, like obstetrics and gynecology, Dr. Faulkner said.

Dr. Myles Abbott, a pediatrician in Berkeley and Orinda, Calif., who holds a time-limited certificate from the American Board of Pediatrics, said he is skeptical that the states will act quickly enough to affect many permanent certificate holders who may be considering retirement in the next several years. And because this process will play out in state legislatures for the most part, it's possible that some states could end up issuing "grandfather" exceptions for those physicians who hold permanent certificates from their boards.

However, that doesn't mean that permanent certificate holders who want to continue in practice won't need to at least consider maintenance of certification, Dr. Abbott said. It's likely that before the states tackle licensure changes, hospitals, universities, and payers may require physicians to be able to verify that they are up to date on their knowledge and skills, he said. ■

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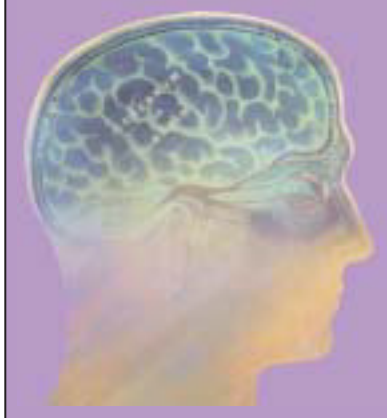

Society for Neuroscience

Gerontological Society of America

Radiological Society of North America

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American Epilepsy Society

Cognitive Services May Benefit

Fee Rule *from page 1*

in the Federal Register on Nov. 19. In the final rule, the CMS estimates that total Medicare spending on the physician fee schedule for 2009 will reach $61.9 billion, up about 4% over 2008 projections.

Without the intervention by Congress over the summer, physicians would be facing a deep payment cut come January. As part of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which was enacted in July, Congress eliminated a 10.6% pay cut scheduled to go into effect in July and another 5.4% cut scheduled for January.

By law, CMS officials are required to adjust physician payments according to the sustainable growth rate (SGR) formula, which calculates physician payments based in part on the gross domestic product. Over the past several years, Congress has stepped in to eliminate scheduled pay cuts under the formula. However, since the SGR formula has not been altered, over time physicians will face even more significant pay cuts unless Congress acts to change or replace the SGR. In addition to the payment update and incentives provided in the final rule, the CMS is also making a technical change to how it calculates the statutorily required budget neutrality adjustment.

Previously, the CMS has applied budget neutrality to work relative value units (RVUs); but, under a mandate in the MIPPA, the agency now will make the adjustment to the conversion factor.

This change is expected to benefit primary care providers and others who provide cognitive services since increases to work RVUs were implemented in 2007 and 2008. However, the change is expected to result in lower payments for services with a significant practice expense element such as imaging and in-office procedures.

To realize the incentive payments outlined in the physician fee schedule final rule, physicians will need to successfully participate in the Physician Quality Reporting Initiative (PQRI) and meet requirements for being a successful electronic prescriber.

The new e-prescribing initiative is similar to, but separate from, the PQRI, according to the CMS. To earn an incentive payment for e-prescribing, physicians will need to report on Medicare's e-prescribing measure in at least half of applicable cases. In addition, physicians need to use a qualified system that: is able to generate a medication list; allows health care professionals to print and transmit prescriptions electronically and conduct safety checks; provides information on lower-cost alternatives; and provides information on formularies and insurance authorization requirements.

Dr. Zuckerman, who also serves on the practice and technology committee for the American Academy of Neurology, said that although people worry about the cost of e-prescribing, low-cost or no-cost systems are available in some states and from some payers.

"I think the bigger factor is the minor change in work flows that come with e-prescribing. People get into habits. There's a learning curve. But after you do that, it's so much faster to write refills and prescribe things" with an electronic system, he said.

"The only problem is when you have controlled substances. The [Drug Enforcement Agency] is being unreasonable" by not allowing such drugs to be prescribed via electronic systems. "That's one of the larger stumbling blocks."

Physicians who are able to meet the e-prescribing requirements can earn a 2% incentive in 2009 and 2010. The incentive will drop to 1% in 2011 and 2012, and 0.5% in 2013. And starting in 2012, the CMS will begin reducing physician payments by 1% for failing to use e-prescribing.

The physician fee schedule final rule also includes increased incentives for participating in the PQRI from 1.5% to 2% of covered professional charges. In addition, the CMS has added 52 new quality measures for a total of 153 available measures in 2009. The new measures are related to the management of osteoarthritis, rheumatoid arthritis, back pain, coronary artery bypass graft, chronic kidney disease, melanoma, oncology, coronary artery disease, hepatitis, and HIV/AIDS.

The final rule also includes some additional benefits for patients under Medicare and expanded coverage for preventive services recommended by the U.S. Preventive Services Task Force. ■