Physicians Seek Federal Incentives to Fund EMRs

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WASHINGTON — Several individual physicians and professional organizations urged members of Congress to extend tax credits or deductions and small business loans to physicians who purchase information systems and to require Medicare to offer an incentive payment to physicians who make the move to electronic medical records.

Adopting electronic medical records (EMRs) can make practices more efficient, but the initial expense—both monetary and in staff training—can be devastating to small physician offices, the witnesses told the panel members at a House Small Business Subcommittee on Regulation, Healthcare and Trade hearing.

The lack of reimbursement for using health IT is a major obstacle to its adoption. Some payers are offering financial incentives to those using certified systems.

Subcommittee chairman Charles Gonzalez (D-Tex.) agreed that the federal government should give physicians some kind of financial carrot to invest in health information technology. "Right now there are inadequate incentives for health care providers to adopt many of these technologies," he said.

"Without changes in the way we promote health IT, small physician practices will be left behind the technological curve, and as a result, patients will fail to benefit from the quality of care electronic health records provide," added Mr. Gonzalez, who recently reintroduced his National Health Information Incentive Act. The bill was aimed at assisting smaller practices but would also direct Medicare to make add-on payments for office visits facilitated by EMRs.

The American College of Physicians has called for just such a payment for several years, Dr. Lynne Kirk, ACP president, said at the hearing.

Mr. Gonzalez also noted that the full Small Business Committee recently passed the Small Business Lending Improvements Act of 2007 (H.R. 1332). That bill would let small practices borrow from the Small Business Administration to finance information systems.

Coming up with the capital for health IT is particularly tough for smaller physician groups, Dr. Kirk noted. One 2006 study showed that only 13%-16% of solo practitioners had adopted health IT, she said. Small practices are the lifeblood of internal medicine, she said, adding that 20% of internists are in solo practices and 50% are in practices of five or fewer physicians.

Acquisition costs average $44,000 per physician and yearly upkeep amounts to about $8,500 per physician, according to a 2005 study published in Health Affairs, Dr. Kirk said. To help defray both the initial investment and ongoing maintenance costs, ACP advocates an add-on payment from Medicare scaled to the complexity of the technology. The initial capital costs could be offset by grants, loans, or tax credits from the federal government, Dr. Kirk said.

The lack of reimbursement for using health IT is a major obstacle to adoption, said Dr. Mark Leavitt, chairman of the Certification Commission for Healthcare Information Technology, a publicly funded agency that for the last year has been vetting hardware and software systems.

CCHIT has certified 57 office-based systems, he said. Some payers are now offering financial incentives to physicians who use these certified systems, Dr. Leavitt said. The Hawaii Medical Service Association (Blue Cross and Blue Shield of Hawaii) announced in November 2006 that it was setting aside $20 million to help individual physicians buy EMR systems, though it required those investments to be in CCHIT-certified systems.

Dr. Margaret Kelley, an obstetrician in a two-person practice with her father in San Antonio, said they had spent $100,000 to purchase an EMR system. Initially, the system devastated the practice's efficiency, said Dr. Kelley, who also spoke on behalf of the American College of Obstetricians and Gynecologists.

"It took our practice nearly 2 years to be able to accommodate as many patients as we could before we invested in our EMR system," Dr. Kelley said. Even so, they would not consider returning to their old way of practice, noting that one of the biggest benefits has been the ability to access patient charts 24 hours a day, she said.

Similarly, Dr. David O. Shober said that buying and implementing an EMR system at his two-physician family practice has been draining but beneficial. In 2004, the practice—then comprising four physicians and two offices—spent $200,000 to buy a system. Yearly costs have averaged $50,000-$60,000, said Dr. Shober, who is based in New Castle, Pa. The system has allowed the practice to create more thorough notes, standardize charts, and retrieve records easily and quickly. But the physicians have run into obstacles, including the inability of their system to communicate with radiology centers and labs, and the refusal of many pharmacies in their community to accept an e-prescription, he said.

"The only way to provide incentives for the adoption of health IT is to provide financial assistance," said Dr. Shober, adding that the federal government should make no-interest loans available.

Dr. Kevin Napier, an internist in a nine-physician family and internal medicine practice in Griffin, Ga., said that he and his colleagues had spent $400,000 for the purchase of a system and subsequent training since 2005. The physicians are financing the system at a cost of $1,000 a month each, and their payments will continue for the next 3 years, he said.

There was a huge drop in patient volume and income the first year of implementation, but the benefits have outweighed the risks, Dr. Napier said. ■

POLICY & PRACTICE

CMS Extends Form Deadline

The Centers for Medicare and Medicaid Services has extended the deadline for filing Medicare claims using its new version of claims form CMS-1500, because of formatting errors on the revised form, CMS announced. The original deadline for switching to the new form, known as CMS-1500 (08-05) originally was April 2. But CMS said last month that contractors have been directed to continue to accept the old form until the agency notifies them to stop. In addition, the agency advised physicians who must use the form to use legacy provider numbers as the form cannot accommodate a National Provider Identification (NPI) number.

Oncologist Shortfall Predicted

The United States will have a shortage of 2,550-4,080 oncologists by 2020—roughly one-quarter to one-third of the 2005 supply—as the demand for services increases by 48%, according to a report by the American Society of Clinical Oncology. Meanwhile, the supply of services provided by oncologists is expected to grow by just 14% by 2020, leading to a shortage representing up to 15 million visits per year. Options to fill the shortfall include redesigning service delivery, increasing fellowship positions and the use of nonphysician clinicians, and having primary care physicians provide more care for patients in remission. The report on the final results of the ASCO Oncology Workforce Study based its conclusions on the current age distribution and practice patterns of oncologists and the number of oncology fellowship positions.

Prescription Drug Sales Up

U.S. prescription drug sales grew more than 8% to $275 billion in 2006, fueled by the Medicare Part D prescription benefit, increased utilization of generics within new therapy classes, and new drug launches, said pharmaceutical data firm IMS Health. Total dispensed prescriptions grew at nearly a 5% pace, compared with slightly more than 3% in 2005, the firm said. Part D was a large driver of the upward trend, lifting prescription volume by an estimated 1 to 2 percentage points and pharmaceutical sales by about 1 percentage point. The benefit "increased prescription coverage to the previously uninsured and underinsured, and provided generous plan benefits to seniors," said Diana Conmy, corporate director, IMS Market Insights, in a statement. Meanwhile, drug makers released new generic forms of lipid regulators, antidepressants, and inhaled steroids, resulting in significant growth for those classes of medications. Sales of prescription drugs in the United States are expected to decline in 2007, IMS Health said.

Veterans Bill Introduced

Veterans with service-connected disabilities would be able to go to the hospital or medical clinic of their choice under legislation introduced by Sen. Larry Craig (R-Idaho). The senator said he was concerned about the care lapses documented at Walter Reed Hospital in Washington, but said that he was willing to pit the health care system run by the U.S. Department of Veterans Affairs against private sector providers because he considered the VA system among the best in the nation. "This bill is about my confidence in the VA," Sen. Craig said in a statement. "Let's see where veterans choose to go. It's very simple: If service-connected veterans leave in droves, we've learned something. But, if veterans overwhelmingly stay, and I think they will, we've also learned something."

Medical Debt Increasing

Families are turning to credit cards to pay for medical care as health care costs continue to rise faster than incomes, according to new research by public policy advocacy groups Demos and the Access Project. The groups found that 29% of low- and middle-income households with credit card debt reported that medical expenses contributed to their current balances, and within that group, 69% had a major medical expense in the previous 3 years. Low- and middle-income medically indebted households had, on average, 46% higher levels of credit card debt than those without medical debt. In addition, the medically indebted were almost twice as likely to be called by bill collectors than were the nonmedically indebted. "Congress should address this new and serious consequence of our nation's growing health care crisis before more families go into debt, and risk their financial stability, to get the medical care they need," said report coauthor Cindy Zeldin of Demos in a statement.

Drug Executives Admit Fraud

Four executives from the bankrupt generic drug maker Able Laboratories Inc., pleaded guilty in March to roles in a 7-year scheme to falsify data at the company, which had made 46 generic versions of brand-name, mostly prescription drugs for pain, inflammation, obesity, and cardiovascular conditions. The highest ranking official of the four, Shashikant Shah, vice president for quality control and regulatory affairs, also pleaded guilty to a securities fraud charge. The Food and Drug Administration has said that the company, based in Cranbury, N.J., invented data so its drugs would appear to meet federal standards when in fact they had too much or too little of their active ingredients. This occurred 41 times dating back to 2001, while on nine other occasions, Able failed to issue alerts about impure drugs. Able, which recalled all of its prescription products in May 2005 as part of an agreement with the FDA, filed for bankruptcy protection in July 2005 and liquidated its assets in March 2006.

—Jane Anderson