IT Leaders Set Goals for Personal Health Records

BY MARY ELLEN SCHNEIDER
Senior Writer

Over the next year or so, leaders in the health information technology community will work on ways to make medication history and some general demographic information available to consumers in a portable health record.

Experts at a Webcast meeting of the American Health Information Community agreed that this is the "low-hanging fruit" that could eventually pave the way for widespread access to portable, consumer-controlled personal health records. The American Health Information Community is an advisory committee to the Department of Health and Human Services.

Today, most patients feel they own their own medical record, but when they go to get lab results from their physician, it can take days or weeks.

The development of portable electronic demographic information, or registration information, would be a way to do away with the medical clipboard, HHS Secretary Mike Leavitt said.

"The timeliness of access to medical information is critical to patients," said Nancy Davenport-Ennis, CEO of the National Patient Advocate Foundation and a member of the American Health Information Community.

Today, most patients feel they own their medical record, but when they go to get lab results from their physician, it can often take days or weeks, she said.

But one of the major hurdles in creating secure and portable patient health records is authentication, said Dr. Reed Tuckson of UnitedHealth Group, who presented information to the group. Other obstacles include the inability to locate patient information across multiple settings, segmentation of the consumer market, privacy concerns, low levels of consumer trust, few electronic health records to connect to, and the lack of an established business model.

But there have been some successes, said David Lansky, Ph.D., of the Markle Foundation, who presented information to the group. For example, the Department of Veterans Affairs set up a patient portal, and the Department of Defense has a similar program. And some health plans offer pre-populated personal health records.

"We're not starting with a blank slate," Dr. Lansky said.

Providing medication history electronically to patients is something that could be done quickly, Dr. Lansky said.

The Markle Foundation was one of the groups that helped spearhead efforts to do just that with www.katrinahealth.org, which allowed certain physicians to access drug histories for hurricane evacuees.

It's helpful that the public already recognizes the value of using this type of information in an emergency situation, Dr. Lansky said.

Providing electronic access to general demographic data or registration information holds the potential for increasing convenience for patients and improving accuracy when sharing information. But privacy issues would need to be addressed and there is the potential for replicating errors, he said. ■

Feds Offer Warning on Design Of Patient Assistance Programs

BY MARY ELLEN SCHNEIDER
Senior Writer

Some Medicare beneficiaries may still qualify for extra help in purchasing drugs through patient assistance programs, despite the new Medicare Part D drug benefit that started Jan. 1.

But pharmaceutical manufacturers that offer assistance will have to tread carefully to avoid running afoul of the federal antikickback statute, according to a special advisory bulletin from the Department of Health and Human Services' Office of Inspector General.

In the bulletin, Inspector General Daniel R. Levinson said that it would raise serious concerns if the manufacturer of a drug covered under the Part D program were to subsidize cost-sharing amounts for its product.

In the meantime, drug manufacturers that operate patient assistance programs do not need to rush to disenroll all their Medicare Part D beneficiaries. During the first year of the Medicare drug benefit, OIG officials will take into consideration whether the assistance program is taking "prompt, reasonable, verifiable, and meaningful steps to transition patients who enroll in Part D to alternative assistance models, such as independent charities."

OIG said the practice of pharmaceutical company–sponsored programs offering assistance to Part D beneficiaries could steer patients to particular drugs, increase costs to Medicare, provide a financial advantage over competing drugs, and reduce beneficiaries' incentives to use less expensive alternatives.

The OIG bulletin also raised questions about the practice of bulk replacement in which drug makers donate their products to pharmacies, health centers, clinics, and other facilities.

Such programs would need to be evaluated on a case-by-case basis, according to OIG, but these arrangements could potentially violate the antikickback statute if the recipient of the free drugs is in a position to generate federal health care program business for the drug maker.

Alternative program designs could allow Medicare beneficiaries to continue to receive assistance. For example, a pharmaceutical manufacturer could donate its products to an independent, bona fide charity that provides cost-sharing subsidies for Part D drugs.

This action would raise few, if any, concerns under the antikickback statute as long as the patient assistance program was not functioning as a conduit for payments by the drug maker and did not unduly influence beneficiaries' drug choices.

Patient assistance programs are also less likely to run into legal trouble if the patients are not receiving Medicare Part D benefits at the same time, OIG said.

To eliminate the potential for fraud and abuse in such a case, the patient assistance program would need to notify the Part D plan that the drug is being provided so that no payment would be made and the cost of the subsidized drug would not be counted toward the beneficiary's true out-of-pocket costs. ■

Recovery Audit Contracts Raise MD Hackles

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Members of the Practicing Physician Advisory Council wanted to know why a new demonstration program from the Centers for Medicare and Medicaid Services rewards contractors financially for finding money owed to the Medicare program, but not for finding money that Medicare has underpaid to physicians.

Under the Recovery Audit Contractors program, three contractors hired by CMS look for overpayments and underpayments made by Medicare to physicians and hospitals, and try to recover the overpayments. The program, which began last spring, operates in the three states with the largest Medicare beneficiary populations: California, Florida, and New York. The three contractors, who work on a contingency basis, are PRG-Schultz International (California), Health Data Insights (Florida), and Connolly Consulting (New York). Contractors review claims that are at least a year old.

Although the contractors are paid a percentage of what they collect in overpayments, there is no similar incentive for finding underpayments. That's because it would require Medicare to pay money over and above the amount of the underpayment, "and that's money going out of the [Medicare] trust fund, not going back in," Gerald Walters, director of the financial services group at CMS, told PPAC members at a council meeting.

Council member Dr. Peter D. Grimm, a radiation oncologist in Seattle, said he would gladly give some of the underpayment money he was due back to the contractor.

Mr. Walters said that idea had been suggested to him before, but under the terms of the demonstration program, "if even one person says, 'I'm not going to pay, give me my money,' I can't do it."

Council member Dr. Barbara L. McAneny, a clinical oncologist in Albuquerque, noted that there is a "cottage industry" of companies that volunteer to review physicians' claims, find examples of undercoding, and help the physicians resubmit the claims for more money. "If you sell this as a service, it would be a reasonable business thing to do," she said.

Council chair Dr. Ronald D. Castellanos, a urologist in Cape Coral, Fla., said he had spoken with one of the contractors who "definitely had sent out demand letters [to providers], but had not found any underpayments." Mr. Walters said that CMS "believes it has found a way to incentivize" the contractors to target underpayments, but he did not elaborate further. Once an underpayment has been identified, the contractor must notify the appropriate Medicare carrier, which will adjust the claim and pay the provider.

Dr. Castellanos said he was happy that CMS officials had met with hospitals and physician organizations to explain the program, but he was concerned that the agency had not yet met with any carrier medical directors. The council passed a resolution urging CMS to meet with them. CMS will share data on the program with PPAC at a future meeting, and also will issue a report to Congress about the program, Mr. Walters said. ■

INDEX OF ADVERTISERS