Policy & Practice

2006 Outlook

Physician payment under Medicare, medical liability reform, access to isotretinoin, and funding for skin disease research will once again top the agenda for the American Academy of Dermatology Association (AADA), the lobbying arm of the American Academy of Dermatology.

iPLEDGE

Starting this March, dermatologists and other prescribers will need to be registered and activated under the iPLEDGE program in order to prescribe isotretinoin. The new mandatory registry program has come under fire from a number of dermatologists who say it is burdensome and will unnecessarily restrict access to the drug. Officials at AADA are continuing to work with the FDA and the iPLEDGE program to make improvements. For example, AADA wants to see written material made available online, more patient kits available to physicians, and less of a lag time between when physicians register and when they can be activated under the program. They are also pushing to make isotretinoin available to the indigent under the iPLEDGE program.

Medical Liability Reform

AADA will also continue to press members of Congress for meaningful medical liability reform, specifically reform that is modeled after California's Medical Injury Compensation Reform Act of 1975 (MICRA). But officials at AADA said that are flexible on the amount of the cap. The House has repeatedly passed legislation capping noneconomic damages at $250,000. But the issue has continued to remain stalled in the Senate.

Reimbursement

Reimbursement for physicians under Medicare is another top priority, according to the AADA. At press time, physicians were facing a 4.4% payment cut under Medicare, although last-minute congressional negotiations were underway for a possible 1% increase. Temporary fixes aside, physicians need a permanent change to the way their payments are calculated, said Dr. Margaret Parsons, AADA's chair of the council on government affairs and health policy and practice. Congress needs to change the way it calculates the Sustainable Growth Rate formula to better reflect the actual cost of providing medical care, she said, adding that a cut in Medicare payments has a much broader impact since the fee schedule used Medicare influences private insurance reimbursement rates. "A lot of us are very concerned about how hard it will hit us across the board," Dr. Parsons said. Dr. Parsons said a cut could limit access by patients as dermatologists choose to limit or drop Medicare patients from their practice. Even if the cuts don't result in a mass exodus from Medicare, fewer students may choose medicine as a career, said Dr. Brett Coldiron, of the University of Cincinnati. And existing dermatologists may convert their practices to concierge practices as a way to escape declining payments from Medicare and private insurers, he said.

Research Funding

Last April, the AADA and the Society for Investigative Dermatology released a report that estimated the burden of skin disease to be about $37 billion. This year, the AADA will continue to seek increased funding for the National Institutes of Health in an effort to boost skin disease research efforts.

Botox Guilty Pleas

Several of the major players in a scheme to distribute counterfeit Botox for use in humans pleaded guilty in federal court last November. The defendants—who include two physicians, two naturopaths, and four companies—are alleged to have purchased more than 3,000 vials of botulinum toxin type A and other ingredients in a formulation design to imitate Allergan's Botox product and sold them to health care providers. Dr. Bach McComb pleaded guilty in November to one count of felony misbranding in violation of the federal Food, Drug, and Cosmetic Act. Later that month, naturopaths Dr. Chad Livdahl and Dr. Zarah Karim pleaded guilt to one count of conspiracy to commit wire fraud, mail fraud, and misbranding, and one count of mail fraud. Dr. Robert Baker also pleaded guilty to one count of mail fraud. In addition, Toxin Research International Inc., Powderz Inc., Z-Spa Inc., and The Cosmetic Pharmacy Inc. all entered guilty pleas to one count of conspiracy. Sentencing for all parties is schedule to take place on Jan. 26, according to the U.S. attorney's office in the Southern District of Florida.

More on Drug-Only Treatment

The number of patients entering treatment for both alcohol and drug abuse problems has declined, but the number of patients getting substance abuse treatment alone has increased, according to data from the Substance Abuse and Mental Health Services Administration. The National Survey of Substance Abuse Treatment Services: 2004 found that of the 1.07 million people enrolled in substance abuse treatment on March 31, 2004, 46% were receiving both drug and alcohol abuse treatment, down from 49% in 1998. Another 34% were in treatment for drug abuse alone, up from 27% in 1998, while 20% were in treatment only for alcohol abuse, down from 24% in 1998. "These data will assist SAMHSA and state and local governments assess the nature and extent of service provided in state-supported and other treatment facilities, and forecast treatment resource requirements," said SAMHSA Administrator Charles Curie.

—Mary Ellen Schneider

CMS E-Prescribing Rule Presents Big Challenge

BY JENNIFER LUBELL
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Without the proper technology, physician practices may find it difficult to participate in Medicare's new "e-prescribing" standards under the Part D drug benefit, physician groups claim.

"Most primary care physicians will be unable to afford to implement this technology on their own, particularly with the projected cuts in Medicare physician payments of 4.4% in 2006 and a cumulative 26% reduction from 2006 to 2011," Neil Kirschner, Ph.D., senior associate for regulatory and insurer affairs with the American College of Physicians, said in an interview.

A physician who adopts e-prescribing now may be 'at risk of purchasing a system that might not integrate' with a future electronic health record system.

The Centers for Medicare and Medicaid Services in a final rule established the set of standards for electronic prescribing, or e-prescribing, of drugs covered by Medicare. The standards were expected to be available for immediate use when the new prescription drug benefit began Jan. 1, according to the Federal Register.

CMS also plans to pilot test initial e-prescribing standards, which may be included in a final rule to be issued by April 2008.

"These standards will allow Medicare, physicians, hospitals, group practices, other health providers, and prescription drug plan sponsors and Medicare Advantage organizations to take advantage of e-prescribing technology to improve medication prescribing for Medicare beneficiaries that participate in the new prescription drug program," said Mike Leavitt, secretary of the Department of Health and Human Services.

For the most part, medical organizations expressed support for the agency's e-prescribing initiative.

"Having standards is good. It will provide a common language for anyone using this method," Dr. Mary Frank, board chair of the American Academy of Family Physicians, said in an interview. E-prescribing would also reduce errors, increase patient safety, and when it is fully interoperable, increase quality in health care as well, she said.

Unfortunately, few practices are currently employing this technology, Dr. Kirshner said. "Surveys vary, but the percentage of practices using it ranges somewhere from 5% to 18%." The number is even lower for the typical small practice, he added.

Only 25%-30% of the AAFP's members have electronic health records, Dr. Frank said. "They are, at present, the only ones who might be able to immediately adopt this approach. I say 'might' because not all EHR systems have the e-prescribing component."

Until there is some financial support to help doctors implement this technology, its use will not be widespread, she said.

Even if a physician does have the money to adopt e-prescribing, "he or she is at risk of purchasing a system that might not integrate" with a future electronic health record system, she said.

Dr. Kirschner noted that the recent release of safe harbor antikickback and Stark exception rules allowing hospitals, group practices, and Medicare Part D drug plan sponsors to provide necessary e-prescribing technology to physicians may help facilitate its use.

E-prescribing as an isolated technology, however, "just won't cut it," Dr. Frank said. "It is only a small piece in the safety-quality continuum." While it may eliminate issues such as bad handwriting and sound-alike medications, it doesn't necessarily address issues such as drug-drug interactions, alerts about possible problems related to existing illnesses, or abnormal lab results.

"We really have to push for a more integrated approach if we really want to improve care," she said.

E-prescribing will be optional for physicians and pharmacies under the new standards, although Medicare will require drug plans participating in the new prescription benefit to support electronic prescribing. Compliance with these standards was required as of Jan. 1, 2006, so that they will be ready for immediate use when the Medicare drug benefit begins.

Jeff Trewhitt, who is a spokesperson for the Pharmaceutical Research and Manufacturers of America, said that PhRMA supported the development of a standardized e-prescribing system. In addition to reducing errors and the administrative costs that are associated with health care, the system would also promote more effective care of drug therapies for chronic conditions.

He agreed, however, that such a system must be designed and implemented correctly. "Keep in mind that the systems needed to convert to an e-Rx system don't even exist yet."

CMS's new standards for e-prescribing include the following technology:

- NCPDP SCRIPT, Version 5.0, for transactions between prescribers and dispensers for new prescriptions, refill requests and responses, prescription change requests and responses, prescription cancellation requests and responses, and related messaging and administrative transactions.
- ASC X12N 270/271, Version 4010 and addenda, for eligibility and benefits queries and responses between prescribers and Part D sponsors.
- NCPDP Telecommunication Standard, Version 5.1, and supporting NCPDP Batch Standard, Version 1.1, for eligibility queries between dispensers and Part D sponsors. ■