Congress Floats Physician Payment Options

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Any legislative approach to fixing Medicare's sustainable growth rate system "would be prohibitively expensive," according to House Ways and Means Chair Bill Thomas (R-Calif.).

Attaining a permanent fix is possible, however, provided that Congress and the Bush administration work on efforts to combine administrative and legislative actions, Rep. Thomas and Nancy L. Johnson (R-Conn.), health subcommittee chair, wrote in a letter to Mark McClellan, M.D., administrator of the Centers for Medicare and Medicaid Services.

Physicians who don't have the technology to participate in the bill's proposed reporting system will see their reimbursement cut even further.

The proposal is one of several ideas floating in Congress that seek to fix the Medicare physician fee schedule, as physicians face a looming 4.3% cut to their reimbursement in 2006. CMS actuaries project negative payment updates of minus 5% annually for 7 years, beginning in 2006, if the flawed sustainable growth rate (SGR) is not corrected.

CMS could do its part by removing prescription drug expenditures from the baseline of the SGR, something it should have the authority to do, the letter suggested. Because drugs aren't reimbursed under the fee schedule, it's illogical to include them in the expenditure total when calculating the schedule's update. The agency should also account for the costs of new and expanded Medicare benefits, which are included in the SGR calculation, the letter stated.

Such actions would "reduce the cost of permanently replacing the physician payment formula with one that accurately reflects the cost of patient care," J. Edward Hill, M.D., president of the American Medical Association, said in a statement supporting the proposal.

On a legislative fix, Rep. Thomas wrote that "the time is ripe" to tie physician payments to quality performance. CMS demonstration projects on performance-based payments in Medicare "will provide us with the experience we need to design appropriate rewards for delivering quality care," he wrote. A spokeswoman for the agency said CMS was reviewing Rep. Thomas' recommendations, but declined to comment further.

Leaders on the Senate Finance Committee have since introduced a pay-for-performance bill, although it appears to fall short of some physicians' expectations.

Applying the notion that Medicare should attain better "value" for its money, the bill from Sen. Chuck Grassley (R-Iowa) and Sen. Max Baucus (D-Mont.) proposes to link a small portion of physician Medicare payments to reporting of quality data and demonstrated progress against quality and efficiency measures. The measures would focus on health care processes, structures, outcomes, patient experience of care, efficiency, and use of health information technology.

Participation in the program would be voluntary. However, those choosing not to report quality data would receive a reduced payment update.

What the Senate bill fails to do is include a fix to the SGR, Mary Frank, M.D., president of the American Academy of Family Physicians, said in a statement. Instead, the legislation "attempts to improve the payment system to physicians without attempting to stem the declining Medicare reimbursement rate."

Physicians could face lower Medicare payments and additional costs under such requirements, Dr. Frank said. While it might increase doctors' costs in order to meet and report specific care standards, the bill "doesn't help them obtain the technology to do so," she said. Without the technology to participate in the bill's proposed reporting system, physicians' reimbursement will be cut even further, hindering their ability to afford the technology. "Sound like a vicious cycle? It is," she said.

The outcome is family physicians may be forced to close their doors to Medicare beneficiaries, Dr. Frank said.

In addition, "tons of implementation questions" aren't broached in this bill, Michele Johnson, senior governmental relations representative of the Medical Group Management Association, told this newspaper.

"Right now, there are no evidence-based, valid scientific measures of efficiency, unless you're talking about clinical measures," Ms. Johnson said. It's unclear how such measures would be developed under the legislation, and how people would physically report these quality measures.

In a summary of the bill, the authors explained that they didn't address the sustainable growth rate because they wanted to limit provisions to quality improvement, value-based purchasing, and health information technology. However, "sense of the Senate" language (nonbinding language that accompanied the bill) did acknowledge that the negative physician update needed to be addressed, based on the "unsustainable" nature of the SGR.

Primary care groups in June had lobbied Senate Majority Leader Bill Frist (R-Tenn.) for a pay-for-performance bill that would provide positive updates to Medicare's physician fee schedule, as well as reverse cuts that would otherwise occur under the SGR.

The American College of Physicians has yet to comment on the Grassley-Baucus bill. "We need to evaluate the final language against our policies and the joint letter we and the other primary care groups sent" to Sen. Frist, Robert B. Doherty, the ACP's senior vice president for governmental affairs and public policy, said in an interview.

If any language from Grassley-Baucus is approved, "it will probably be inserted into 'end of the year must pass legislation,' along with an SGR fix," Ms. Johnson stated. Standing alone, the bill is too risky on the Senate floor because it would provide Democrats with the opportunity to reopen the Medicare Modernization Act.

"They could introduce amendments stating that the government could negotiate prices with the pharmaceutical companies. The Republicans don't want that," she said. ■

Assess Your Practice Needs, Readiness When Choosing an EHR

BY MARY ELLEN SCHNEIDER
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BOSTON — Choosing an electronic health record for your practice involves a comprehensive readiness and needs assessment, according to participants in a congress sponsored by the American Medical Informatics Association.

A group of about 100 physicians, nurse "informaticians," clinical informaticians, pharmacists, consultants, and others met during AMIA's spring congress to brainstorm ideas about how best to select an EHR. Participants in the work group, who had a range of experience with EHRs, contributed their advice, which was then condensed into a short presentation given at the close of the AMIA meeting.

Here are some of the recommendations from the AMIA work group:

Readiness Assessment

▶ Develop an information strategy. The first step is to figure out the organization's information strategy by determining goals, the information needed to achieve those goals, and how the information needs to be accessed.

"If you don't have an information strategy, first and foremost, you're really not ready," said Eric Rose, M.D., a physician consultant for IDX Systems in Seattle, who presented the recommendations from the AMIA workshop on selecting an EHR.

▶ Develop an education strategy. Once an information strategy is in place, the practice needs an education strategy for getting everyone up to speed on the EHR product selection process.

▶ Let everyone in the organization know this is a business transformation process, not an IT project.

▶ Don't try to nail down costs too precisely. While it's important to have a budget, practices also need to recognize that some of the costs will be unpredictable, the group advised.

▶ Assess the capabilities, willingness, and expectations of everyone in the practice.

Needs Assessment

Next, practices should assess their needs in terms of features and functions, the work group concluded.

▶ Focus on "pain points" to uncover functional requirements. "Don't ask people what you want the EHR to do for you, ask people where does it hurt," Dr. Rose said.

▶ Figure out the organization-wide goals and objectives to determine EHR needs.

▶ Assess your in-house IT expertise to determine desirable features. If the practice employs a skilled database analyst, it may not need an EHR with built-in reporting functionality, Dr. Rose said.

▶ Use available resources on successful needs assessment processes. For example, the Healthcare Information and Management Systems Society has an EHR selector at www.ehrselector.com.

How to Write an RFP

Once the practice has taken stock of its needs, they can begin to write a request for proposals (RFP).

▶ Keep it simple. "The more complex your RFP is, the more complex the responses will be," Dr. Rose said.

▶ Address all aspects of the practice's relationship with the vendor in the RFP. An RFP should ask: What training options are available? How much will training cost? How do software upgrades work? How will the vendor work with third-party vendors?

▶ Ask vendors to differentiate themselves from the competition. The RFP is one way to get vendors to tell you what they can offer that is different or better than other companies.

▶ Involve all clinical disciplines in RFP development.

▶ Establish a straightforward, replicable assessment process before sending out the RFP. Practices should be able to redo the RFP in case the procurement process is derailed or one of the key staff members leaves the practice.

Site Visits and Demos

When a practice has narrowed down its choice of vendors, the physicians and administrators may want to begin demonstrations and site visits to test the products.

▶ Consider site visit locations other than those suggested by the vendor. The AMIA group recommended doing your own research to find out who is using a vendor's software. Don't just call the references on a vendor's list, seek out independent sources, the work group reported.

▶ Call ahead when conducting site visits. Practices should try to make the most of the visit by calling ahead and making sure they are visiting a similar organization. The site visit team should collect contact information to bring back for those staff members who couldn't attend the site visit but may want to ask follow-up questions over the phone.

▶ In scripted demonstrations, hold back some portion to be revealed at the time of the demo. The AMIA group suggested that practices ask a few unplanned questions to get around some the lack of transparency in a the scripted process.

▶ Make scoring simple and explicit. ■