Katrina Puts Proposed Medicaid Cuts on Hold

BY JOYCE FRIEDEN
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WASHINGTON — Hurricane Katrina has put many things on hold, including the fate of $10 billion in cuts to the Medicaid program that were proposed by a federally appointed commission.

The Medicaid Commission, which was called for by the fiscal year 2006 federal budget agreement and chartered in May by Health and Human Services Secretary Mike Leavitt, included 13 voting members and 15 nonvoting members representing a variety of interests. It was given a deadline of Sept. 1 to come up with ways to cut the money from the Medicaid budget.

After only two meetings, the commission announced its list of ways to achieve the cuts: changing the reimbursement formula for prescription drugs, tightening rules for asset transfers prior to receiving nursing home care, and allowing states to increase copayments for nonpreferred drugs. But then Hurricane Katrina left hundreds of thousands of people homeless and without a regular source of medical care, and Congress decided the need to reduce the Medicaid budget wasn't so urgent after all.

"There's no doubt that Hurricane Katrina has made it necessary to provide additional resources for the Medicaid program, and we're going to do that apart from reconciliation in the Katrina relief package that's being put together," Sen. Chuck Grassley (R-Iowa), chair of the Senate Finance Committee, said in announcing an indefinite delay. However, he added that the changes would be voted on eventually.

The commission said it would cut money from the Medicaid budget in part by changing the reimbursement formula for prescription drugs.

With regard to the recommendation to reform the long-term care program under Medicaid, Ray Sheppach, executive director of the National Governors Association said at the August meeting that there is a "fairly sophisticated group of lawyers now who are helping people move their assets or income streams to their children or other people so they can [qualify for] Medicaid."

To prevent people from taking advantage of some of the loopholes in the law, Mr. Sheppach said the NGA favored increasing the "lookback" period—the period during which any assets transferred would still be counted as assets for the beneficiary in determining Medicaid eligibility—from 3 to 5 years. "We also think the type of asset should be expanded so we can look at most assets, including trusts and annuities. And although it will be somewhat controversial, we believe that housing—which is an increasingly valuable asset—should also be put on the table."

The "tiered copayments" proposal, which would allow states to implement higher copayments for nonpreferred drugs, also raised a lot of interest.

John Monahan, president of state-sponsored business at WellPoint, the for-profit California Blue Shield plan, said that he favored increased use of generic drugs. "Getting [people to increase] utilization of generics by even 5% would be an incredible savings."

John Rugge, M.D., CEO of the Hudson Headwaters Health Network, in Glens Falls, N.Y., added that "with the psychotropic medications, there's a huge danger in [substituting] one antidepressant for another, one atypical antipsychotic for another; they clearly have to be tailored to the individual. And these are people in most need of service."

Commission vice-chair Angus King, former governor of Maine (I), said he thought the issue could be dealt with because of the ability of the physician to override any preferred drug if it was clinically necessary to do so. He noted that in Maine, such override requests are usually filled within 72 hours.

Commission member Carol Berkowitz, M.D., president of the American Academy of Pediatrics, said she was concerned about how well such an override system would work. Dr. Berkowitz, who practices in Los Angeles, said that "in my experience it's 30-45 days before it gets approved."

At its next meeting, scheduled for late this month, the commission is expected to begin the second phase of its work: making recommendations for long-term restructuring of the Medicaid system. ■

MedPAC: Physician Reviewing Flawed

BY JENNIFER SILVERMAN
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WASHINGTON — The current process for valuing physician services may result in inaccurate pricing and needs to be reviewed, researchers said during a meeting of the Medicare Payment Advisory Commission.

Relative value units (RVUs) are assigned to services in the physician fee schedule to determine how payment rates vary, one service relative to another. The Centers for Medicare and Medicaid Services reviews and modifies the RVUs for selected services based on recommendations from the RVS Update Committee (RUC), a panel made up of representatives of national and specialty medical societies. CMS usually accepts 90% of the committee's recommendations.

By law, RVUs are reviewed every 5 years. The next review is scheduled for completion in 2007.

There are problems with this review process, much of which involves the subjective nature of measuring physician work, Dana Kelley, a research contractor to the Medicare Payment Advisory Commission (MedPAC), told the advisory committee."The physicians themselves are intimately involved in setting the RVUs [but at the same time] have a financial interest in how those services are weighted," she said. This introduces the possibility of biased reporting.

Specialty societies, which have much to gain by RUC decisions, can submit "compelling arguments" that the values are incorrect, Ms. Kelley said. While the RUC has safeguards to make sure that some specialties don't dominate the review process, "specialization remains an important issue."

Physicians who perform a specific service are often surveyed to determine the "weight" of a particular service. In answering these surveys, physicians obviously have a financial incentive to indicate that their service should be highly weighted, she said.

The assumption that current RVUs are accurate ignores the fact that they may change over time, Ms. Kelley said. "Even starting from the premise that it's set correctly, the way a service is performed can change its value."

Also, there is a strong bias in favor of identifying and correcting undervalued codes, she said. "Previous 5-year reviews have led to substantially more increases than decreases in RVUs." This results in passive devaluation of some codes.

Inaccurate payments for physician services can distort the market for health care services, said Kevin Hayes, Ph.D., a MedPAC research director. "It can boost volume for certain services inappropriately, undermine access to care, and make some specialties more financially attractive than others."

A lot of news has circulated "on how maldistribution of payments is affecting the career choices of young physicians," observed Ray E. Stowers, D.O., a member of the commission. "It really does create a long-term problem of decreasing the number of primary care physicians in the country, and eventually affecting the access to care of Medicare beneficiaries and increasing the cost of care to the Medicare system."

While it's easy to criticize the RUC, several MedPAC members cautioned that there are few alternatives to the system. "We have to come up with an alternative. We have a chance of doing something a lot better," Alan R. Nelson, M.D., a member of the commission, acknowledged.

However, even if you can get the pricing "exactly accurate that day," the evidence for inaccuracies isn't going to come for a while, he said. Changes in the way medicine is practiced are going to create some distortion. "It's never going to be perfect because it's a rolling ball game. We need to measure that in our perceived criticism of the RUC."

In light of concerns about inaccurate payments, Dr. Hayes said MedPAC plans to "address the topic of valuing physician services in detail," along with other issues, such as adjusting payments geographically, revisiting the boundaries of payment localities, and determining practice expense payments in the fee schedule.

The RUC plans to make its recommendations on physician RVUs at the end of October, Ms. Kelley said. CMS would then issue a notice of the proposed rule-making next spring on the valuation of physician services, and a final rule would be issued in January 2007, to set values for the following review cycle. ■

Government Attempts to Ease EHR Transition, Level the Playing Field

SAN DIEGO — Government strategies for health information technology will aid physicians by lowering the cost, improving the benefits, and lowering the risks, said David J. Brailer, M.D., Ph.D., national coordinator for health information technology, at the annual meeting of the American Health Lawyers Association.

Information technology "is a tectonic issue for physicians, one that separates old from young, progressive from Luddite, and those who want to be part of a performance-based future from those who want to practice the way they have for years," said Dr. Brailer of the Department of Health and Human Services, Washington.

"We're trying to be nonregulatory, to use a market-based approach, and that means we want to work with the willing. Surveys show that many physicians, at least half today, would do this if they could figure out how to do it," he said.

One barrier to adoption of electronic health records (EHRs) is the variety of products on the market. Certifying a basic, minimally featured EHR system will aid physicians, he said

Another barrier to EHR adoption is the lack of a sound business model. A "pay-as-you-go" financial model is not feasible, and financial incentives will be needed to accelerate the transition, Dr. Brailer said, without specifying any further details. Large physician groups and hospitals are far ahead of small physician offices in adopting EHRs. Jodi Goldstein Daniel, an HHS senior staff attorney who also spoke at the meeting, said more than 50% of large practices have adopted EHRs, but only 13% of small practices have done so. Dr. Brailer's office will monitor the adoption gap annually, to see if it is closing, if certified technologies are being used, and if rural practices and other practices with special needs require a safety net.

"We don't want to see health IT become a strategic wedge between the haves and the have-nots; we want a level playing field so that everyone can participate," he said.

—Elaine Zablocki