Practice Costs Expected to Rise

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sizing procedures and reduce the time they spend counseling patients.

Neurologists may also consider early retirement, he said, or cut down on the number of Medicare patients they see, since many physicians lose money treating these patients.

Dr. McClellan said the proposed cut to Medicare reimbursements would come on the heels of small pay increases during the last few years. Physicians received a 5.4% cut in Medicare reimbursement rates in 2002; since then, Congress has provided an update of approximately 1.5% each year.

If the projected cuts don't change, physicians will face total reimbursement cuts of 26% over the next 6 years, as projected in the 2005 Medicare Trustees Report, J. Edward Hill, M.D., president-elect of the American Medical Association, said at a press conference sponsored by the organization.

The consequences of such cuts could be dire for Medicare patients, he said, noting that the trustees' report also found that the costs of running a medical practice are slated to rise by 15% during the same period.

"If these predicted cuts take place, physicians will be forced to think twice about taking Medicare patients into their practice. That news should send chills down the spines of seniors in Medicare—and it should be even more alarming for Americans who are going to be entering the Medicare program in the next few years," Dr. Hill said.

The AMA surveyed 5,400 physicians nationwide in February and March and found that if the projected 4.3% cut takes place next year, 38% of respondents would decrease the number of new Medicare patients they accept, and nearly two-thirds would defer purchasing new medical equipment.

This projected 4.3% cut in reimbursement is due in part to larger than expected increases in Part B expenditures, Dr. McClellan said. Spending on Part B services in 2004 increased by about 15%. Most of the increased spending can be attributed to more office visits, more minor procedures by physicians and physical therapists, more frequent and complex imaging, more laboratory tests, and increased utilization of prescription drugs in physician offices.

"We want to look carefully at what we're getting in terms of health improvement for this increase in utilization," Dr. McClellan said.

'If these predicted cuts take place, physicians will be forced to think twice about taking Medicare patients into their practice.'

While these types of services can help prevent complications from serious chronic diseases and help keep costs down, Dr. McClellan said, there is also a lot of variation in the use of the services that are responsible for the biggest spending increases. These variations occur from area to area and among similar medical practices, he said.

CMS plans to address some of these issues by working with the physician community to develop measures for quality and efficiency by individual physicians and group practices. The agency plans to follow through on a recommendation from the Medicare Payment Advisory Commission to share information on quality of care and resource use with individual physicians.

For example, CMS could use claims data to provide physicians with information on the frequency and complexity of minor therapy procedures, imaging procedures, lab tests, and visits for patients with chronic illness. The idea is that the information could be used to help physicians make their practices more efficient.

In addition, CMS is moving forward with pay-for-performance pilot projects.

"We must get more for our health care dollars," Dr. McClellan said. ■

Joyce Frieden, associate editor for practice trends, contributed to this story.

EHRs' Lack of Compatibility Challenges Physician Users

BY MARY ELLEN SCHNEIDER
Senior Writer

BOSTON — Interoperability is key to the success of electronic health records, but there are barriers to sharing data between systems, said David Brailer, M.D., national coordinator for health information technology.

The major challenges include standards harmonization, unclear data control policies, a lack of uniform security practices, the inability to ensure that products perform as advertised, and the lack of a business model around interoperability, he said.

"At the very basis of this—kind of the DNA of the interoperable electronic health record—is the emergence of harmonized standards," Dr. Brailer said at a congress sponsored by the American Medical Informatics Association.

There are many organizations involved in developing and approving standards, but there isn't a process for harmonizing two conflicting standards.

In addition, there is no unified maintenance or release schedule for standards so that the industry can know what's coming and build investment plans around it, Dr. Brailer said.

Further, there is no means of providing input into the standards process, he said. For example, there isn't a mechanism for taking a problem in health care and distilling that into requirements that could be used by organizations that develop standards. "Problems don't come well packaged into a standard," he said.

Harmonized standards are at the core of interoperability, but even with standards there are many other factors in achieving interoperability, he said.

One less well-known obstacle to interoperability is the lack of clear policies about data control. Health care right now lacks even a vocabulary to talk about the control of data, Dr. Brailer said. Deciding on a set of terms and their meanings will be essential to figuring out who decides if information flows from point A to point B, in what way, and who will be notified.

Security standards pose another set of problems, Dr. Brailer said. Currently, it's possible for any two health care organizations to be compliant with the Health Insurance Portability and Accountability Act of 1996 and still have security practices that render their data unable to be shared.

For example, one organization may adopt user names and passwords for authentication while another organization uses a biometric thumbprint.

Some solutions are being developed to bridge the different levels of security. For example, security brokers or other third parties could navigate between two systems. And some states have talked about creating more requirements for uniformity of security practices.

"I think this is a profound barrier to our ability to be interoperable, and standards won't address it," Dr. Brailer said.

Physicians also need to be able to know if the system they purchase will be able to deliver on the vendor's promises of interoperability. The industry is taking a step in that direction with the formation last year of the Certification Commission for Healthcare Information Technology, a group that will certify that EHRs and other products meet minimum standards.

This work is important not just so that EHRs will one day become "plug and play" technology, Dr. Brailer said, but also because it will take some of the risk out of the marketplace.

But ultimately, interoperable EHRs can't become successful without a viable business model. The industry is just starting to experiment with the value drivers in this area, such as research, clinical improvement, and transaction simplification compared with paper.

"The government's not going to tell you what the business model is," he said.

The challenge is not just what the business benefit is but who receives it, he said. And Dr. Brailer predicts that this interplay of costs and benefits will lead to new relationships between providers and payers and other entities. ■

State Laws on Who May Perform Imaging Vary Greatly

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

Although the recent spotlight has been on what the federal government will do to rein in the rising numbers of medical imaging procedures, states also are doing their part.

In Maryland, state law requires that only licensed radiologists perform advanced imaging procedures such as CTs, MRIs, or PET scans. Radiologists say that laws like this help decrease the use of inappropriate imaging, which they say is done largely by nonradiologists who use the equipment in their offices.

"We believe Maryland's law is a model that we would like to see in other states," said Josh Cooper, senior director of government relations at the American College of Radiology, in Reston, Va. Florida has a similar law, but it is not as restrictive as Maryland's, he said.

Another way states are trying to manage the use of imaging equipment is through "certificate of need" laws that require physicians and others setting up imaging facilities to obtain a certificate of need to document that there is a demand in the community for such a facility. Rhode Island has such a law, Mr. Cooper said.

While the radiologists and their college are keen to support state and federal laws that limit imaging utilization, other physicians say the radiologists are just trying to keep the business for themselves.

"The radiology community … claims that growth in imaging is due to 'self-referral' by physicians who own their imaging equipment, and that the quality of images and interpretations by nonradiologists is inferior to those by radiologists," the Lewin Group, a Falls Church, Va., consulting firm, said in a report for the Coalition for Patient-Centered Imaging, a coalition of medical specialties that wants specialists to be able to perform in-office imaging procedures.

"Our findings suggest that self-referral is not the primary driver of growth in imaging services. Some of the fastest-growing imaging services, such as MRI and CT scans, are primarily done by radiologists."

State legislatures are seeking fresh approaches to the issue. A bill currently in the California legislature would exempt only radiologists and cardiac rehabilitation physicians from a ban on physician self-referral.

The California Medical Association (CMA) is opposed to the bill, according to spokeswoman Karen Nikos. The group's opposition is based on its self-referral policy, adopted in 1993, which states: "While CMA recognizes that there is nothing inherently wrong when a physician invests in a facility or when a physician refers a patient to a facility in which the physician has an ownership interest, CMA recognizes that serious ethical questions are raised when referrals are made purely for a profit motive.

"CMA has a responsibility to create policy and support legislation that would prevent abusive practices such as overutilization and overcharging." ■