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Budget Backs Physician Fee Fix Tied to Quality Incentives

As a "down payment" to finance a range of health care reforms, the president's budget would establish an initial $634 billion reserve pool, funded by new revenues and by proposed Medicare and Medicaid savings, including competitive bidding for Medicare managed care.

In the fiscal 2010 budget blueprint unveiled late last month, the Obama administration pledged that as part of its health care reform initiative, it would support a "comprehensive, but fiscally responsible" overhaul of the Medicare physician payment system, with incentives for doctors "to improve quality and efficiency, rather than simply furnish more care." But instead of advancing a detailed plan of its own, the administration has signaled it will work with Congress on developing physician payment reform legislation.

The budget would set aside nearly $330 billion over 10 years to permanently fix the Medicare physician fee update formula, the College of American Pathologists reports. The Sustainable Growth Rate (SGR) update formula has triggered steep cuts in recent years, forcing Congress to intervene repeatedly to block them. Lawmakers approved a fee increase of 1.1 percent on average for this year, but a projected SGR cut of 21 percent is scheduled for Jan. 1, 2010 unless Congress rules otherwise.

The budget outline also calls for a shift in Medicare policy to enable physicians to form voluntary groups that focus on coordinated versus episodic care for beneficiaries and to receive performance-based payments for providing coordinated care. For more on the president's health budget goals, see the *Focus*, pp. 4-6.

Obama Picks Sebelius, DeParle for Key Health Care Posts

President Barack Obama has nominated Kansas Democratic Governor Kathleen Sebelius to serve in his cabinet as secretary of health and human services and has named former Clinton administration official Nancy-Ann DeParle to head the new White House Office of Health Reform.

Sebelius became the state's 44th governor in 2003 and was re-elected to a second term in 2006. She served as the state's elected insurance commissioner from 1994 to 2002 and was elected president of the National Association of Insurance Commissioners.

The choice of Sebelius was greeted warmly on Capitol Hill where senators and health care industry groups alike praised her working knowledge of health care and her reputation for working across the partisan aisle as a Democrat elected in a traditionally Republican state.

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If confirmed by the Senate as expected, Sebelius will oversee a mammoth federal department with some 67,000 employees and 11 agencies, including the Centers for Medicare and Medicaid Services, the National Institutes of Health, the Centers for Disease Control and Prevention, and the Food and Drug Administration.

Also, as the one accountable to Congress on health care reform, Sebelius will have to work with DeParle, whom Obama has said will serve as his counselor, to coordinate the administration's effort to reform health care.

DeParle is no stranger to health care issues. Under President Clinton, she was administrator of the Health Care Financing Administration, the predecessor agency to the Centers for Medicare and Medicaid Services, from 1997 to 2000. Before that, she was associate director for health and personnel at the White House Office of Management and Budget. She has also served as Tennessee's commissioner of the Department of Human Services.

DeParle currently is managing director at CCMO Capital, a private equity firm. She serves on the boards of several health care companies and has served on the Medicare Payment Advisory Commission, which advises Congress on Medicare reimbursement issues.

Obama's first pick to run HHS and the White House health reform office, former Senate Majority Leader Thomas Daschle (D-S.D.), withdrew from consideration following revelations that he owed back taxes and penalties of more than $140,000 related to the use of a car and driver provided by a firm he advised. Though he paid the amount owed after being nominated, it did not quell growing criticism. Daschle said he withdrew so as not to become a distraction to Obama's reform agenda.

Health IT Incentive Payments: Pathology Winners, Losers

For independent pathologists who participate in Medicare, the good news in the recently signed economic stimulus law is that they are eligible for up to $44,000 in incentive payments over five years by adopting and using a certified health information technology (HIT) system, including electronic medical records. For early adopters (those who start in 2011 or 2012), the incentive for the first payment year is $18,000.

The bad news for Medicare-participating pathologists and other physicians who are hospital-based is that the law bars them from directly receiving such payments. They are considered covered under separate HIT incentive payments for hospitals. The determination of "hospital-based" depends on the site of service, whether inpatient or outpatient and without regard to any employment or billing arrangements.

The incentive payments are included in the HIT provisions of the American Economic Recovery Act signed by President Barack Obama on Feb. 17. The $787 billion package invests $19.2 billion in HIT infrastructure and Medicare and Medicaid spending to encourage physicians and hospitals to use health IT to electronically exchange patients' information.

"Computerizing America's medical records is a long overdue step to reduce the duplication and waste that costs billions of health care dollars and the medical er-

rors that every year cost thousands of lives," the president said during the signing ceremony. The HIT provisions are estimated to save $12 billion over 10 years (*NIR, Vol. 09, Iss. 4/Feb. 23, p. 1*).

To qualify for the incentive payments, physicians will have to demonstrate that they are "meaningfully" using HIT, including electronic medical records. This can be done through a variety of means, such as the reporting of quality measures, use of e-prescribing systems, submission of claims with coding indicating that an HIT system was used as part of the service, and other alternatives deemed appropriate by the HHS secretary.

Incentive payments may be in the form of a single consolidated payment or in periodic installments as the HHS secretary may specify. They will be phased out over time, and Medicare payments will be reduced for those who do not use certified electronic health records that allow them to electronically communicate with others.

Payment Incentives

The payment incentives to eligible physicians will be capped at a maximum of $44,000 over five years as follows:

- For the first payment year, $15,000. If this year for an eligible physician is 2011 or 2012, the payment is $18,000.
- For the second payment year, $12,000.
- For the third payment year, $8,000.
- For the fourth payment year, $4,000.
- For the fifth payment year, $2,000.
- For any succeeding payment year, $0.

Penalties

The law penalizes those who are not "a meaningful EHR user." They will see their Medicare payments reduced by 1 percent in 2015, 2 percent in 2016, and 3 percent in 2017 and thereafter. For 2018 and each subsequent year, the HHS secretary may make the cut deeper, but not below 95 percent.

An exemption from the payment reduction is allowed, on a case-by-case basis, if the secretary determines that compliance with the requirement would result in significant hardship—such as in a rural area without sufficient Internet access. But in no case may an eligible professional be exempt for more than five years.

No Provision for Other Providers

The economic stimulus law limits direct HIT incentive payments to physicians and hospitals. It does not provide such payments to other providers, including laboratories, skilled nursing facilities, home health agencies, hospice programs, federally qualified health centers, and nonphysician professionals.

Instead, the conference agreement calls for a study to determine whether payment incentives to implement and use qualified HIT should be made available to these providers. The study, due to Congress by June 30, 2010, is to examine such issues as the adoption rates and clinical utility of qualified HIT by these providers, the extent to which they work in settings that might otherwise receive incentive payments, and the potential costs and benefits of making payment incentives and other funding available to these providers. The conference report also calls for a study on open source HIT systems for safety net providers, due Oct. 1, 2010.

focus on: Health Budget Blueprint

Obama Outlines Broad Priorities for Health Care Reform

President Barack Obama and congressional Democrats have moved swiftly since the Jan. 20 inauguration to expand health care coverage to the uninsured through additional Medicaid funding and expansion of the State Children's Health Insurance Program and to help the newly unemployed keep their health insurance by subsidizing their COBRA premiums.

The president wants to sign a comprehensive health care reform measure this year, and congressional Democratic health leaders say this is achievable. The chairmen of three House committees with jurisdiction over health care—Ways and Means, Energy and Commerce, and Education and Labor—told Obama in a March 11 letter that they aim to pass such legislation before the August recess. The Senate Finance Committee is working toward approving separate legislation before the July 4 recess, its chairman Max Baucus (D-Mont.) has said.

Now the president has shifted his sights to realign the health care budget by cutting Medicare and Medicaid payments regarded as excessive and using savings from improved quality and efficiency in health care performance to finance a range of health care reforms, changes that he regards as key to revitalizing the nation's economy.

In his recently released fiscal 2010 blueprint for the Department of Health and Human Services, Obama laid out broad goals for health care reform. While a complete budget is due for release in April, the blueprint illustrates how the president wants to proceed on his ambitious agenda. As a starting point, he proposes to create a reserve fund of $634 billion over 10 years that can be tapped to finance a range of health care reforms.

'Down Payment' on Health Care Reform

The proposed reserve fund would be used to finance fundamental reforms that will bring down costs and expand coverage, according to the budget documents. It would be funded half by tax increases on the wealthiest and half by savings proposals that promote efficiency and accountability, align incentives toward quality, and encourage shared responsibility in HHS programs. But this fund alone will not be sufficient to ensure health care coverage for all Americans, a priority of the administration, so additional funding will be needed for this.

Doubling Funding for Cancer Research

The budget includes more than $6 billion within the National Institutes of Health to support cancer research. This is "central to the president's sustained, multiyear plan to double cancer research," the budget notes. These resources will be committed to have the greatest impact on developing innovative diagnostics, treatments, and cures for cancer. This initiative will build on the $10 billion provided in the economic stimulus law to support new NIH research in 2009 and 2010.

Accelerate Adoption of Health IT

The administration says it will build on the $19.2 billion investment in health information technology (HIT) provided in the economic stimulus package and continue efforts to further support health care provider adoption of certified HIT. The budget notes that incentives are being offered to Medicaid providers, including physicians and children's hospitals, to help with the purchase, implementation, and use of

certified electronic health record technology. In the Medicare program, physicians and hospitals also will be rewarded with payment incentives for HIT adoption (*see related story, p. 2*).

Lower Drug Costs, Improve Food and Medical Product Safety

The budget supports the Food and Drug Administration's new efforts to allow Americans to buy safe and effective drugs from other countries and to establish a new regulatory pathway to approve generic biologics. It also says a substantial increase is needed to strengthen the FDA's efforts to make food and medical products safer.

Competitive Bidding for Medicare Managed Care

Under current law, Medicare pays Medicare Advantage (MA) plans 14 percent more on average than what the program spends for beneficiaries enrolled in the traditional fee-for-service (FFS) program. The higher pay rates were approved by the previous GOP-controlled Congress to encourage private insurers to enter and remain in the Medicare market and offer beneficiaries a choice of coverage alternatives to FFS, including health maintenance organizations, preferred provider organizations, and private FFS plans. MA plans can use the extra pay to reduce or eliminate premiums or copay, establish a reserve stabilization fund, or all of these.

The administration wants to replace the current payment mechanism with a competitive bidding system for MA plans in which plan payments would be based on an average of plans' bids submitted to Medicare, beginning in 2013. This change would "allow the market, not Medicare, to set the reimbursement limits and save taxpayers more than $176.6 billion over 10 years as well as reduce Part B premiums," according to the White House. The savings would go to the health care reform reserve fund.

In defending the competitive bidding proposal, Peter Orszag, director of the Office of Management and Budget, told both the Senate Finance Committee and the managed care trade group America's Health Insurance Plans that the federal government pays $1.30 for each dollar of MA supplementary benefits without any "compelling" evidence that they are producing better quality care than FFS providers.

Orszag said a competitive bidding program would function differently than a system that pays plans 100 percent of what Medicare pays FFS providers because it would account for the cost of providing care in different regions of the country, including rural areas. "It would better align payments with the actual costs of coverage," reiterating that this would enable "the market, not Medicare, to set reimbursement rates." A program in which MA plans received 100 percent of the average bid would not be anti-competitive and would not put the plans out of business, he asserted.

Orszag said he believed managed care plans should compete against each other, not against traditional Medicare FFS. With 80 percent of Medicare beneficiaries enrolled in FFS, it would be "premature and counterproductive and unhelpful to change that system in a disruptive way," adding that the administration is proposing to make Medicare FFS more efficient by introducing more quality initiatives to the program.

Not surprisingly, the proposal to reduce MA payments has raised concerns among several Republican and Democratic lawmakers who fear it could force managed care plans to abandon rural areas they now serve, impede beneficiary choice, and adversely affect plans that are offering Medicare enrollees more generous benefits than traditional FFS.

The Medicare Payment Advisory Commission (MedPAC), meanwhile, has begun its congressionally mandated study of current MA county-level payments and alternatives, including competitive bidding. The panel also is looking at how comparable measures of performance and patient experience can be reported for MA plans and FFS and as a comparison across MA plan types, including those that target special needs populations. In its report to Congress this month, MedPAC said, "We currently do not have a basis for comparing plan performance with the quality of care in FFS." However, MedPAC executive director Mark Miller has pointed out that "that there is an argument for paying managed care plans more" if they offer superior services.

Under the current system, MA plans already bid against county benchmarks, which are limits on payments to provide benefits under Medicare Parts A and B. The benchmarks are set administratively at a high level to encourage plans to enter certain underserved areas. When plans bid below the benchmark, they get to keep 75 percent of the difference between the bid and the benchmark, a factor that keeps payments high. The 2009 national average benchmark is 118 percent of fee-for-service, and payments to plans average 114 percent of FFS.

Reduce Hospital Readmission Rates

Nearly 18 percent of the hospitalization of Medicare beneficiaries resulted in the readmission of patients who had been discharged from the hospital within the last 30 days. Sometimes the readmission could not be prevented, but many of these readmissions are avoidable, the budget says.

To improve this situation, the administration proposes that hospitals receive bundled payments that cover not just the hospitalization, but also the post-acute care provided 30 days after the hospitalization. Hospitals with high rates of readmission would be paid less if patients are readmitted within that 30-day period. This change would save roughly $26 billion over 10 years, the budget estimates.

Expand the Hospital Quality Improvement Program

The budget would link a portion of Medicare payments for acute inpatient hospital services to the hospital's performance on specific quality measures. This will improve the quality of care delivered to beneficiaries, according to budget documents, and the higher quality will save over $12 billion over 10 years.

Comparative Effectiveness Research

In the push to inject more quality into federal programs, the budget notes, it is critical to assess how prevention, treatment, and therapy contribute to improved patient outcomes and which specific procedures do not. For this purpose, the economic stimulus law approved $1.1 billion for comparative effectiveness research, including establishment of a federal coordinating council to oversee the effort. To address criticism that flared in the wake of this approval, the administration notes that such research cannot be used to mandate coverage, reimbursement, or other policies of public or private payers and will also not include national clinical guidelines or coverage determinations.

The HHS Agency for Healthcare Research and Quality will receive $700 million; $400 million must be transferred to the National Institutes of Health to conduct or support such research. In addition, the HHS secretary may allocate $400 million to "fast-track" development and dissemination of research on the comparative effectiveness of health care treatments and strategies.

National Health Care Spending Reached $2.4 Trillion in 2008

Public spending on health care is expected to exceed half of all national health spending by 2016 and reach 51.3 percent by 2018, according to the actuary's report published online by the journal Health Affairs.

Health care spending in the United States rose from $2.2 trillion in 2007 to $2.4 trillion in 2008, while such spending as a portion of the gross domestic product (GDP) is projected to climb from 16.6 percent in 2008 to 17.6 percent in 2009, according to the report released late last month by the Office of the Actuary at the Centers for Medicare and Medicaid Services.

Health care spending is not completely driven by changes in the economy, so its growth is expected to outstrip that of the GDP in 2009 and beyond, CMS said, adding that private and public health care spending is expected to increase at an even greater rate after the projected end of the recession in 2010. By 2018, national spending on health care will reach $4.4 trillion and comprise 20.3 percent of the GDP.

While private health care spending is expected to rise only 3.9 percent in 2009 due to higher unemployment rates and thus fewer Americans with job-based coverage, public spending is expected to grow 7.4 percent, reaching $1.2 trillion, largely as a result of faster growth in Medicaid enrollment and spending.

Medicare spending grew 8.1 percent in 2008, reaching $466 billion, and is projected to again grow 8 percent in 2009. In 2007, the growth was 7.2 percent. The increase in Medicare spending is due largely to higher spending on hospital care, physician services, and the prescription drug benefit, CMS said. The fastest growing component of Medicare spending is on prescription drugs, climbing an average 10.2 percent annually from 2011 to 2018. Its share of overall Medicare spending is expected to rise from 10.9 percent in 2007 to 14.7 percent by 2018.

Medicaid spending grew 6.9 percent, to $352 billion, in 2008, up from the 6.4 percent growth for 2007. In 2009, this spending is expected to grow 9.6 percent as the recession swells the number of program enrollees.

♦ Medicare Claims *Advisory*

Exception Granted for Reporting NPIs for Reference Lab Work

Effective March 27, the Centers for Medicare and Medicaid Services is establishing an exception to the standard reporting of the national provider identifier (NPI) on certain Medicare fee-for-service claims for reference laboratory and purchased diagnostic services (Change Request 6362).

The exception applies when a provider in one contractor jurisdiction bills for a reference lab service on the Part B clinical lab fee schedule that was outsourced to a performing provider in another contractor jurisdiction. In this situation, the contractor that is billed will not have a record of the performing provider's NPI.

To facilitate adjudication of the claim, the billing provider must, in addition to reporting its own NPI (as the billing provider), report its own NPI as the performing provider and annotate the electronic or paper claim with the name, address, and ZIP code of the performing provider. The billing provider also must keep the performing provider's NPI in the clinical records for auditing purposes.

Previously, this reporting convention was discretionary; now, it is a requirement, CMS said. Electronic and paper claims that do not satisfy this convention will be returned as "unprocessable."

Names in the News at CMS

The acting administrator for the Centers for Medicare and Medicaid Services, Charlene Frizzera, on March 12 announced new senior personnel for posts that she said will position the agency to move ahead on President Obama's priorities.

Jonathan Blum, a health policy advisor on the Obama-Biden transition team, has been named director of the Center for Medicare Management and will also serve as acting director of the Center for Drug and Health Plan Choice. He joins CMS from Avalere Health where he served as vice president of Medicaid and Long-Term Care Practice. Prior to this, he was on the professional staff of the Senate Finance Committee, advising the chairman and other members on prescription drug and Medicare Advantage policies.

Amy Hall has been named director of the Office of Legislation and will develop the legislative agenda for the entire scope of CMS programs. She has more than 11 years of experience working for the U.S. House of Representatives in various capacities, most recently as an advisor to the Committee on Energy and Commerce where she drafted major legislative proposals for SCHIP, health reform, and Medicare modernization.

Final ICD-10 Rules Unfazed by Freeze on Rulemaking

The Centers for Medicare and Medicaid Services announced March 5 that "a determination has been made that the effective dates of the two final ICD-10 rules will not be extended and the comment period will not be reopened for either of these rules."

The decision follows the regulatory review required by the Jan. 20 memorandum from White House chief of staff Rahm Emanuel, who requested a governmentwide halt to pending regulations (*NIR, Vol. 09, Iss. 2/Jan. 26, p. 1*).

Accordingly, the compliance date for the final rule replacing the ICD-9 diagnosis and procedure coding system with version ICD-10 remains Oct. 1, 2013, CMS said. The compliance date for adopting the updated standards for electronic health care and pharmacy transactions remains Jan. 1, 2012 (small health plans have an additional year). For more on these rules, see the Jan. 26 issue of *NIR*, p. 3.

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