



Wednesday, March 7, 2012

Discussions on Permanent Sustainable Growth Rate Formula Fix Begin Again

With a 10-month Medicare physician payment patch passed on February 17, physicians are now scheduled to face an estimated 32 percent payment cut on January 1, 2013 unless Congress again acts to intervene. At a February 28 House Ways and Means Committee hearing on the Department of Health and Human Services' (HHS) fiscal year 2013 budget blueprint, Health Subcommittee Chairman Wally Herger (R-CA) questioned why \$429 billion was included in the HHS budget for a 10-year physician pay fix without proposing full budgetary offsets.

In an effort off of Capitol Hill, the Society of General Internal Medicine announced the formation of the Commission on Physician Payment Reform in order to identify recommendations for reforming the physician payment system with approaches geared toward lowering health care costs.

Steven Schroeder, former president of the Robert Wood Johnson Foundation, will chair the 12-member panel, which also includes physicians, policy experts, business leaders and health care industry representatives. Former Senate Majority Leader Bill Frist will serve as honorary chairman. The Commission is to review existing research on physician payment models, including accountable care organizations (ACOs), patient centered medical homes and value based purchasing, and will present its recommendations in early 2013.

The American Medical Association (AMA), meanwhile, continues to urge Congress to repeal the SGR permanently. In addition, it has recommended a three-prong approach to reforming the flawed physician payment system:

- (1) Repeal the SGR;
- (2) Implement a five-year period of stable Medicare physician payments that keep pace with the growth in medical practice costs; and
- (3) Transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs.

Read more about the AMA's recommendations [here](#).

CMS Releases Proposed Stage 2 Criteria for Electronic Health Records Meaningful Use

On February 23, the Centers for Medicare and Medicaid Services (CMS) issued a 455-page proposed rule outlining its recommended criteria for eligible providers and hospitals to demonstrate in meeting Stage 2 "meaningful use" of certified electronic health records (EHRs) and qualify for Medicare and Medicaid financial incentives under the Health Information Technology Economic and Clinical Health (HITECH) Act.

According to CMS, the proposed rule is largely based on recommendations from the Office of the National Coordinator for Health Information Technology's Health Information Technology Policy Committee and based upon providers' experiences in implementing Stage 1 meaningful use criteria. The proposed rule includes the same core and optional objectives structure for the program as Stage 1. It would require eligible professionals to meet 17 core objectives and three of five optional objectives, and would require eligible hospitals to meet 16 core objectives and two of four optional objectives.

The proposed rule outlines new EHR objectives for specialists, including access to imaging results and the capability to identify and report cancer cases to a state cancer registry. Additional new criteria in the proposed rule include increasing requirements for the electronic capture of health information in a structured format, enhancing requirements for the exchange of clinically relevant information between providers at care transitions, and providing payment adjustments for providers and hospitals.

The rule proposes changing some of the Stage 1 criteria, including replacing the requirement on "exchange of key clinical information" with a "transitions of care" objective, which CMS says is more robust, and replacing the objective to "provide patients with an electronic copy of their health information" with an "electronic/online access" objective.

The proposed rule also formally extends the Stage 1 timeline so that providers who attested to meaningful use in 2011 have until 2014 for implementation of Stage 2 criteria – a year later than initially planned. *(Continued on page 2)*

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CMS Releases Proposed Stage 2 Criteria for Electronic Health Records Meaningful Use (cont'd)

CMS has estimated that eligible professionals will spend approximately \$54,000 to purchase and implement a certified EHR and \$10,000 annually for ongoing maintenance. For eligible hospitals, the range is from \$1 million to \$100 million.

This year the Department of Health and Human Services (HHS) is expected to release several additional proposed regulations related to health information exchanges, a final rule on Health Insurance Portability and Accountability Act (HIPAA) privacy and security policies, and guidance on participation in the Nationwide Health Information Network.

Reactions from physician and hospital associations on the proposed Stage 2 criteria thus far have been positive. The proposed rule is published in the March 7 *Federal Register*, and comments will be due 60 days after publication.

Click [here](#) to read the proposed rule.

House Energy and Commerce Subcommittee on Commerce, Manufacturing and Trade Holds Hearing on Prescription Drug Diversion

On March 1, the House Energy and Commerce Subcommittee on Commerce, Manufacturing and Trade held a hearing entitled, "Prescription Drug Diversion: Combating the Scourge," to address the rising number of prescription drug overdoses in the U.S.

More than 5 million people in the nation are estimated to abuse narcotic painkillers, and the Centers for Disease Control and Prevention (CDC) classifies prescription drug abuse as an epidemic. Lawmaker attention on the need for supply chain improvements in curbing prescription drug abuse has peaked with the Drug Enforcement Administration's (DEA's) case brought last month against Cardinal Health, accusing the company of endangering the public by selling excessive amounts of oxycodone to four Florida pharmacies.

The Subcommittee hearing included testimony from leaders within the Office of National Drug Control Policy (ONDCP) and the Drug Enforcement Administration (DEA); state attorneys general; and representatives from the Healthcare Distribution Management Association (HDMA), National Community Pharmacists Association (NCPA), National Association of Chain Drug Stores (NACDS), Pharmaceutical Research and Manufacturers of America (PhRMA) and Generic Pharmaceuticals Association (GPhA).

The broad consensus of the Subcommittee was that there is a prescription drug abuse problem and blame for the problem lies across the distribution chain. Much of the hearing was related to the need to address prescription drug diversion through measures such as stopping pill mills and "doctor shopping", enhancing provider education and providing for safe drug disposal through take-back programs.

Although the hearing did not generally focus on wholesaler issues, DEA Deputy Assistant Administrator Joseph Rannazzisi said that the core of the prescription drug abuse problem is diversion from the supply chain and holes within that system.

Rannazzisi also noted that DEA would continue to exercise its authority to go after distributors that are not living up to responsibilities of the law, and that it would "vigorously pursue criminal, administrative and civil actions against registrants who fail to comply with all aspects of the Controlled Substances Act and its implementing regulations as required."

While none of the Subcommittee members seemed hostile to industry representatives, Chairwoman Mary Bono Mack (R-CA) did press all the industry witnesses to admit that there is a supply chain problem and that they all could do more about solving this problem.

In response to lawmaker questions regarding his testimony, John Gray, President and CEO of HDMA, noted that distributors are not compensated for drug monitoring systems that have been put in place at the expense of millions of dollars; that guidance from DEA needs improvement; and that distributors' hope is to work collaboratively with DEA to address this issue.

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House Energy and Commerce Subcommittee on Commerce, Manufacturing and Trade Holds Hearing on Prescription Drug Diversion (cont'd)

View video of the hearing [here](#).

House Panel Votes to Repeal Medicare Independent Payment Advisory Board

On March 6, the House Energy and Commerce Committee voted to approve the Medicare Decisions Accountability Act (H.R. 452), which would repeal the Independent Payment Advisory Board (IPAB) created under the Affordable Care Act (ACA).

Approved by voice vote, the Committee's support of the repeal legislation follows the February 29 House Energy and Commerce Subcommittee on Health's 17-5 vote in support of the measure. The House Ways and Means Committee held a hearing on the controversial board on March 6, and the Committee is expected to approve the bill as well during its March 8 scheduled markup.

Set to begin in 2014, the IPAB would include 15 members to be appointed by the president and subject to Senate confirmation. In years when Medicare's costs increase faster than target rates, its members are to put forth program cost-cutting policy that would become law unless Congress intervenes. Under the ACA, Congress cannot consider any amendment to IPAB's proposal that does not meet the same cost-reduction goals unless both houses of Congress and three-fifths of the Senate vote to waive this requirement.

In debating the IPAB repeal measure, many members of Congress say the IPAB would allow an unelected panel to create Medicare reimbursement policy that Congress would be challenged to overturn. Other members believe the IPAB would help curb Medicare spending and that repealing IPAB is yet another attempt to dismantle the health reform law, and that critics have not offered a way to pay for repeal, which is expected to increase the federal deficit by \$2.4 billion.

Energy and Commerce Health Subcommittee Chairman Joseph R. Pitts (R-PA) said dangers of the IPAB include that its recommendations will be difficult for Congress to overturn; there is no requirement for it to submit proposals for public comment before issuing recommendations; and its actions will not be subject to judicial review. In addition, Rep. Allyson Schwartz (D-PA) led a bipartisan letter last year in support of repealing IPAB, which describes IPAB as a "flawed policy that will risk beneficiary access to care."

In a February 27 letter to the Subcommittee leadership, the American Medical Association (AMA) also urged support of repeal legislation, saying "Major changes in the Medicare program should be decided by elected officials... Adding additional formulaic cuts through IPAB is just not rational and would be detrimental to patient care, especially as millions of baby boomers enter Medicare."

In a February 29 blog post, Deputy White House Chief of Staff Nancy-Ann DeParle defended the IPAB, saying it will help reduce Medicare spending and strengthen the program.

Although repeal legislation is expected to gain wide support in the House, this legislation is likely to face more opposition with the Democrat majority in the Senate.

Experts Discuss Medicare Cost Drivers, Options for Lowering Health Care Costs

On February 28, Centers for Medicare and Medicaid Services (CMS) chief actuary Richard Foster testified before the House Budget Committee that controlling cost growth is the major challenge to Medicare's financial stability and that neither Republicans' support for a premium support system nor cost-cutting initiatives from the Obama administration provide all the solutions.

Foster said that the chief contributors to Medicare's cost rate growth are its volume of services, a preference for newer and more expensive health technologies, and economic inflation. *(Continued on page 4)*



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Experts Discuss Medicare Cost Drivers, Options for Lowering Health Care Costs (cont'd)

He said that Affordable Care Act (ACA) programs such as bundled payments and accountable care organizations (ACOs) are able to reduce Medicare cost levels but not its overall growth rate, and that a premium support plan, such as that proposed by House Budget Committee Chairman Paul Ryan (R-WI) and Sen. Ron Wyden (D-OR), may lower costs and provide greater competition but would be unlikely to lower the cost growth rate as well.

The following day, several leading economists testified before the Senate Budget Committee on how to control overall U.S. health care spending. The economists were David Cutler, an economist at Harvard University; Len Nichols, a health economics and policy professor at George Mason University; and James Capretta, a fellow at the Ethics and Public Policy Center. They agreed that the best way to control health care spending is to move from a fee-for-service payment system toward a system that rewards results and promotes competition, but they disagreed on specific approaches and whether the ACA will help efforts to move in that direction.

Cutler said the U.S. accumulates nearly \$750 billion in wasted medical spending each year, attributing approximately \$400 billion to unnecessary services, inefficiently delivered services, or missed prevention opportunities. The remaining \$350 billion, he said, is spent on excessive administrative costs (\$190 billion), inflated prices (\$105 billion) and fraud (\$75 billion). To help lower wasted spending, he called for the aggressive use of bundled payments and health information technology in Medicare and Medicaid.

Nichols praised the ACA's new payment model initiatives and called for additional reforms, including malpractice reform and a permanent Medicare physician payment fix. Capretta, meanwhile, said the ACA will hinder efforts to lower health care costs – saying that its initiatives to create more cost-effective care delivery through ACOs and other Medicare pilots, comparative effectiveness research and the Center for Medicare and Medicaid Innovation only duplicate other previous plans attempted over the years “to change the dynamic in the traditional fee-for-service program that have failed.”

Even if consensus on a new payment system for Medicare were to be reached, moving to a new system would face numerous legislative and political hurdles, particularly during an election year.