



Washington, D.C. update

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Federal Trade Commission again delays implementation of "Red Flag" rule

On Wednesday, July 29, 2009, the Federal Trade Commission announced yet another delay in the implementation of the "Red Flag" rule to protect patient identity theft in medical billing. This is the third delay in implementation for this rule, which is considered a moderate victory for physicians.

Blumenthal addresses Congressional Health Care Caucus

David Blumenthal, MD, National Coordinator for Health Information Technology spoke before the Congressional Health Care Caucus earlier this year. He reviewed the provisions of the American Recovery and Reinvestment Act relating to HIT and meaningful use.

He said the term *meaningful use* is very important because it shows the intent of Congress. The goal is to use HIT to improve patient care. He predicted that the electronic health record will become a core part of a medical practice just like the stethoscope and examining table. Three elements to meaningful use are electronic prescribing, exchange of health information, and reporting of quality data. Blumenthal said the meaningful use standards will change, with the least challenging standards occurring in the beginning and the more challenging standards occurring over time.

Blumenthal also said physicians who are thinking of investing in HIT now should be careful because not all systems will be capable of supporting all of the requirements. He suggested for the time being that physicians could use the meaningful use recommendations as a guide with the HIT vendors.

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2010 Medicare physician fee schedule proposed rule

Physician Quality Reporting Initiative

The Centers for Medicare and Medicaid Services (CMS) proposes to continue implementing quality improvement initiatives for physicians through the Physician Quality Reporting Initiative (PQRI). Among the proposals, CMS will implement provisions of Medicare Improvements for Patients and Providers Act (MIPPA) that would enable group practices to qualify for a 2010 incentive payment based on a determination at the group practice level rather than at the individual level. CMS also is looking to limit the use of claims-based reporting in the future. The agency proposes to begin accepting quality data through electronic health records in 2010.

E-Prescribing

MIPPA authorized the e-prescribing incentive program. To be eligible for the program, the e-prescribing quality measure must apply to at least 10% of the professional's total Part B allowed charges. CMS will report publicly the names of eligible professionals who are successful e-prescribers. The Recovery Act specifies that a professional is not eligible to receive the incentive if an incentive payment is earned under the HIT program under the Recovery Act.

CMS proposes three reporting mechanisms for eligible professionals: (1) retain claims-based reporting used in 2009, (2) implement a registry-based reporting mechanism, and (3) implement an E HR-based reporting mechanism.

Only registries that qualify to submit PQRI measures can submit e-prescribing measures. Registries need to indicate a desire to qualify to submit measures on e-prescribing at the time they submit a self-nominating letter for the 2010 PQRI.

CMS proposes to expand the scope of the denominator codes to Skilled Nursing Facilities and Home Care (99304-99310, 99315, 99316, 99341-99345, 99347-99350 and 90862).

CMS proposes to modify G8443 to indicate that at least one prescription in connection with the visit billed was electronically prescribed. CMS also proposes to eliminate the two remaining G codes (G8445 and G8446). CMS believes this will simplify reporting. E-prescribing quality measure would not apply unless an eligible professional furnishes services indicated by one of the codes included in the measure denominator.

For 2009, e-prescribers had to report the G-codes at least 50% of the time to be considered successful. CMS proposes to revise the criteria to establish a minimum threshold that the measure was reported at least 25 times during the reporting period. CMS wants comments related to: (1) the proposal to change the criteria for determining whether an eligible professional is a successful e-prescriber from requiring reporting of the electronic prescribing measure in 50% of the cases to a count of the number of times the professional electronically prescribed, and (2) the proposed threshold number of 25 times in which an eligible professional would be required to report that he or she electronically prescribed during the reporting period.

Group practices with 200 or more professionals can participate in the e-prescribing program, but participation is limited to those who participate in PQRI. Group practices would be required to participate in both programs.

MedPAC releases June 2009 Report

The Medicare Payment Advisory Commission (MedPAC) released its June report and it contained no specific recommendations. The report maintains that Medicare must change the way it pays health care providers to achieve better care coordination and efficiency because current spending and use trends are not fiscally sustainable.

In the June report, MedPAC examined graduate medical education, Accountable Care Organizations (ACOs), physician resource use measurement, follow-on biologics (FOB), physician self-referral in imaging services, benefit design in traditional Medicare, Medicare Advantage payments, and chronic care management.

Graduate Medical Education

The commission found that formal curricula are not well-aligned with the objectives of delivery system reform. In addition, the commission noted the importance of residency experience in nonhospital and community-based settings because most medical conditions that physician practices confront should be managed in nonhospital settings. Current financial incentives and Medicare regulations primarily confine residents to training within the hospital.

ACOs

MedPAC studied how ACOs have the potential to promote care coordination, increase quality, and lower cost growth. If an ACO achieves quality and cost targets, members could receive a bonus, and if it fails to meet the targets, members could face lower Medicare payments. MedPAC looks at two models: (1) providers volunteer to form an ACO, and (2) mandatory participation.

Physician resource use

The report includes policy principles to guide Medicare's resource use program such as ensuring that physicians are able to actively modify their behavior on the basis of feedback provided, risk adjusting clinical data to ensure fair comparisons among physicians, obtain feedback from the physician community, and adopt a method that is transparent to all physicians.

Imaging services

MedPAC found that self-referral episodes had a higher use of imaging services than nonself-referral episodes. According to MedPAC, use and spending on imaging have grown without a clear link to higher quality.

FOBs

According to MedPAC, establishing a process to approve FOBs is necessary to promote price competition and has spending implications for Medicare. The FDA would have jurisdiction over the approval of FOBs. MedPAC also notes that Medicare as a large payer of biologics has a strong incentive to ensure that it receives value for the money it spends on these products.

Medicare benefit design

Cost sharing may be used as a tool to complement various policy goals such as improving financial protection for Medicare beneficiaries and distributing cost-sharing liability more equitably among individuals with differing levels of health care costs, encouraging use of high-value services and discouraging use of low-value ones, and reinforcing payment system reforms that seek better value for health care expenditures.

Medicare Advantage payment

MedPAC analyzes four options for setting Medicare Advantage payment benchmarks administratively and also discusses an approach to setting benchmarks through competitive bidding.

Chronic Care demonstration programs

The Commission reviewed results of CMS demonstrations and found some modest gains in quality, but no real cost savings (and some increases in spending). MedPAC also found that funding levels for Medicare research activ-

ities are low relative to the overall size of the program. CMS often has constraints on redirecting research funding as program needs and priorities shift, and administrative process requirements are time-consuming.

CMS's estimate for the 2010 physician update is a reduction of 21.5%.