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MedPAC recommendations on graduate medical education payment

During its April 1 meeting, the Medicare Payment Advisory Commission (MedPAC) considered recommendations on graduate medical education (GME) payment for inclusion in its June report to Congress. In making these recommendations, the Commission determined that at least a portion of Medicare GME payment should be used as a "lever for change." Because MedPAC staff long has contended that indirect medical education payment is higher than empirically justified, the Commission recommended redirecting these funds to achieve certain objectives, including increasing payment system accountability and transparency. Subject to final modifications, the recommendations include:

- Congress should authorize the Secretary to change Medicare GME funding to support the workforce skills needed in a delivery system that reduces cost growth while maintaining and improving quality. The Secretary should establish standards for redistributing funds after consulting with representatives of accrediting organizations, teaching programs, health care organizations, and other providers. Such standards should specify ambitious goals for practice-based learning and improvement, interpersonal and communications skills, professionalism, and system-based practice including integration of community-based care with hospital care. Training institutions should be paid at levels consistent with their ability to meet the new standards.
- To increase transparency and communication between teaching hospitals and their programs, the Secretary should publish an annual report showing Medicare GME payments to each hospital with certain associated program costs. The report should be publicly accessible and should clearly identify each hospital, indicating direct and indirect payments, the number of residents Medicare supports, and Medicare's share of teaching costs received.
- The Secretary should conduct a workforce analysis to determine the number of resident positions needed to meet national health workforce requirements, both in total and by specialty. This analysis also should examine the optimal level and mix of other health professionals.
- The Secretary should report on how resident programs affect the financial performance of sponsoring institutions and whether all specialty programs should receive the same financial support.
- The Secretary should study strategies for increasing the diversity of the health professional workforce.

During the course of the discussions, several Commissioners noted that the June report should present the third and fifth recommendations in the context of the new Health Workforce Commission created by the health reform law.

Rural Health Information Network Work Group meeting

The Rural Health Information Network Work Group recently convened to provide insight and information about current and emerging health issues to the Rural Assistance Center, which is based at the University of North Dakota and funded by the HRSA Office of Rural Health Policy.

Health information technology

Neal Neuberger of the Institute for e-Health Policy provided an overview of ARRA HIT provisions. He noted that 70%

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of rural hospitals may not be able to qualify for Stage 1 of meaningful use. Members of both the House and Senate are currently circulating letters that request the Centers for Medicare and Medicaid Services (CMS) back off proposed requirements in the final rule on meaningful use of HIT. One item of concern mentioned was the exclusion of hospital-based eligible professionals from the proposed rule. He also noted that there is an overall shortage of HIT workforce. The Department of Labor estimates that there is a need for 200,000 HIT workers overall. *Note:* The AOA is in alignment with these efforts regarding meaningful use. The AOA submitted comments to CMS on March 12, 2010 requesting that the agency scale back the objectives for Stage 1 of meaningful use.

Health Workforce Information Center

The center is a one-stop shop for information on health workforce, which includes information on a variety of health professions. Since its launch in February 2009, the center has received more than 100,000 visits. Popular topics include education and training and interest from health professionals seeking information on licensure. The site has received a lot of interest from physicians on the topic of loan repayment. *Note:* Promotional materials are available to organizations that request it. I would suggest that we ask to receive materials that are available to share information on the Health Workforce Information Center with our members.

Health professions training

Tom Morris, Director of the HRSA Office of Rural Health Policy, provided information on a forthcoming HRSA rural training pilot program. This program, the Rural Training Track Technical Assistance Demonstration program, would provide funding to a consortium of organizations to better understand the challenges that Rural Training Track residency program sites have when recruiting family physicians to train and practice in rural settings. *Note:* Tom Morris has provided to us initial information on this program. We have contacted the agency and requested additional information regarding the program.

Jerry Connolly, who represents the American Academy of Family Physicians, noted that AAFP is working to get a bill introduced for a five-year year pilot program in four sites that would bring training to community sites with the sole purpose of training primary care residents.

Health information technology certifications programs

The American Recovery and Reinvestment Act (ARRA) which was signed into law on February 17, 2009 creates two key concepts to determine whether eligible professionals qualify for electronic health records (EHR) incentive payments—they must make "meaningful use" of health information technology (HIT) and in addition use a qualified or certified EHR. The portion of ARRA that addresses HIT, the HITECH Act, gives the National Coordinator for Health Information Technology authority to establish certification programs for voluntary certification of HIT.

A proposed rule recommending voluntary certification programs for testing and certification of HIT was released by the Office of the National Coordinator for Health Information Technology (ONC) and published in the federal register on March 10, 2010. This rule is the third and final piece of rulemaking on defining meaningful use of certified EHRs. The other two rules on certification criteria and meaningful use were released by ONC and the CMS, respectively, and were published in the Federal Register on January 13, 2010. It is important to note that these rules are closely linked and that CMS and ONC collaborated in the development of these rules. ONC seeks comments on this rule and requests specific recommendations. The complete rule can be accessed at: http://www.access.gpo.gov/su_docs/fedreg/a100310c.html

This proposed rule creates two certification programs under which HIT can be tested and certified for use by eligible professionals and hospitals to meet requirements specified under meaningful use. The first is a temporary certification program. The program would authorize organizations to test and certify complete EHRs and/or EHR modules. A complete EHR is defined as an EHR that has been developed to have all capabilities meeting all applicable certification criteria adopted by the Health and Human Services Secretary. An EHR module is any service, component, or combination that can meet at least one certification criterion. Testing describes the process used to determine whether a complete EHR or EHR module can meet specific, predefined, measurable, and quantitative requirements.

The second program is a permanent certification program that would replace the temporary certification program. The permanent program would differ from the temporary program because it separates processes required for testing and certification, establishes requirements for accreditation, and establishes specific requirements for ONC authorized certification bodies. The National Institute of Standards and Technology (NIST) would be responsible for accrediting testing entities and determining their competency. Organizations in the permanent program would only be able to accept test results from NIST labs when evaluating an EHR for certification. Applicants to the permanent program would need to be accredited before submitting an application for consideration. Organizations would be required to renew their status every two years. In addition to certifying complete EHRs and EHR modules, participating organizations may be able to certify other types of health information in the future. This may include personal health records and networks to exchange information.

ONC expects that the permanent certification program will be operational by 2012. Any organization or a consortium of organizations that can demonstrate competency under internationally recognized standards can apply for the certification programs. Because of the high level of expertise required, it is anticipated that a small number of applicants will apply to these programs.

Comments are due by April 9 for the temporary certification program and by May 10 for the permanent certification program. ONC anticipates issuing two separate final rules for each of the programs.

Practicing Physicians Advisory Council meeting

The Practicing Physicians Advisory Council (PPAC) held its meeting last week. PPAC member Joseph Giaimo, DO, was in attendance. Among the topics discussed were the Provider Enrollment and Chain, Ownership System (PECOS), EHRs, and fraud and abuse.

EHR update

Tony Trenkle, CMS director of E-Health Standards and Services, and David Hunt, MD, of the Office of the National Coordinator provided an overview of the EHR incentive program and EHR adoption and implementation. The AOA submitted comments to CMS regarding the proposed rule. Dr. Giaimo reiterated some of the concerns of the Association regarding the proposed rule. Dr. Giaimo said the Stage 1 requirements are too aggressive and will deter participation. PPAC adopted his recommendations that CMS remove the numerator/denominator measurement calculations until the EHR systems can do automated calculations. He also recommended that CMS develop a feedback mechanism so that physicians will know that they transmitted the data successfully and are meeting the criteria. One of the criticisms regarding the Physician Quality Reporting Initiative is that physicians do not know if they are meeting the reporting criteria until after the reporting period has ended. By that time, they have no opportunity to make corrections. In addition, Dr. Giaimo expressed support for the Physician Consortium for Performance Improvement in developing physician quality measures. Other PPAC members recommended that CMS modify the requirements so that hospital-based physicians are eligible to participate.

PECOS

James Bossenmeyer, CMS director of the Division of Provider/Supplier Enrollment, gave an update on PECOS. He noted that CMS has postponed its plans to reject claims of ordering/referring physicians until next January so that physicians have more time to enroll or update their enrollment in PECOS. PPAC members said CMS needs to do tremendous outreach to the physician community until next January.

Fraud and abuse

Kimberly Brandt, CMS Director of the Program Integrity Group, described the agency's initiatives such as the DME Stop Gap Plan and HEAT. Under the stop gap plan, CMS identifies highest-risk DME suppliers, highest-ordering physicians, and highest-using beneficiaries. The agency conducts data analysis, interviews physicians to validate their NPI, and verifies clinical relationships. The hot spots for DME fraud are New York, North Carolina, Florida, Michigan, Texas, Illinois, and California. CMS revoked 265 DME suppliers. CMS is also working with the American Medical Association on how to help doctors bill correctly for DME supplies. PPAC recommended that CMS show that physicians represent the extreme minority in fraud and abuse cases. There are HEAT Strike Forces in Miami, Los Angeles, Houston, Detroit, Brooklyn, Tampa, and Baton Rouge. The Strike Force teams investigate and prosecute fraud across all benefit types.