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Keith Studdard, Marcelino Oliva, DO, FACOFP

Medicare Physician Payment Fix Signed Into Law

After the Senate passed standalone legislation reversing the 21% cuts to Medicare physician pay on June 18, 2010, House Speaker Nancy Pelosi (D-CA) threatened to stall House action on the bill until the Senate moved forward on the larger "extenders" package, which would address a number of expiring tax provisions, including the research and development tax credit. Pelosi ultimately allowed a House vote on the bill (HR 3962, the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010"), which passed on June 24, 2010 by a vote of 417 to 1. The bill, which replaces the 21% cut with a 2.2% update until November 30, 2010, was signed into law by the President the next morning.

On June 18, the Centers for Medicare and Medicaid Services (CMS) began processing claims for services provided on or after June 1, 2010 at the reduced rate. The agency has indicated that for claims filed after June 1 that have been paid at the reduced rate, it is prepared to adjust these claims per the legislation's retroactive effect. For claims filed after June 1 that have not yet been paid, they will be held and paid after July 1, 2010 at the increased rate once new pricing files have been tested and distributed.

May 2010 HIT Policy Committee Meeting

The HITECH Act requires that the Office of the National Coordinator for HIT (ONC) update the Federal HIT Strategic Plan. At the May HIT Policy Committee meeting, the Strategic Plan Work Group outlined a strategic framework for the plan in four key areas. *Note:* It is anticipated that the plan will be finalized for Committee endorsement at the June meeting. It will then be forwarded to ONC to be published sometime this fall. ONC will be developing tactics and metrics to support the goals of the plan. Highlights of the draft include:

- **Policy and technical infrastructure**—Establish policies, standards, implementation specifications, and certification criteria that incrementally enhance the interoperability, functionality, utility, reliability, and security of HIT that support its meaningful use. This should include identifying and prioritizing types of data for transmission that facilitate improvement in national health priorities to include research, public health, quality reporting, performance measurement, etc.
- **Privacy and security—**Develop, promote, and enforce privacy and security laws and appropriate policies for all aspects of information management, HIT, and health information exchange. Assess and implement as appropriate federal laws and policies relating to key privacy and security issues for the broad use of health information and communication technologies among all parties that access or exchange health data for individual and population health.
- **Meaningful use of health IT—**Work toward the use of an electronic health record (EHR) for each person in the United States by 2014. Capture, manage, and meaningfully use health information to improve the health and health care for individuals and to reduce disparities. Use national health priorities for which effective use of HIT has demonstrated impact to guide selection of future criteria for meaningful use of HIT. Develop, monitor, and maintain a progressive meaningful use roadmap. Actively support primary care and other smaller providers—rural and safety net providers—to achieve meaningful use of certified EHR technology.
- **Learning health system—**Facilitate creation of knowledge through policies, standards, and methods that leverage networked information. Engage public and private stakeholders to facilitate the advancement of care delivery and the use of clinical decision support tools, align-

Corresponding author: Keith Studdard, 330 E. Algonquin Road, Arlington Heights, IL 60005.
E-mail address: kstuddard@osteopathic.org.

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ment of payment with outcomes, elimination of waste, enhancement of public health, etc.

Meaningful use work group

A key tenet of proposed meaningful use criteria put forth by the Committee is in the area of patient and family engagement. On April 20, 2010, the Workgroup held a patient and family engagement hearing. Several key themes emerged from the hearing:

- Patients are demanding universal and immediate access to their data. Patient-generated data should be incorporated into the EHR.
- There should be greater engagement with the public on meaningful use. Consideration should be given to reorienting meaningful use criteria to include what is meaningful to patients. *Note:* Dr. David Blumenthal noted that ONC is in the process of developing a consumer survey on EHRs.
- There should be more of a focus on patient outcome measures vs traditional process measures.

Note: The Work Group is planning to hold several additional hearings in the next few months. Potential subject areas are disparities, care coordination, and population and public health. I have contacted ONC seeking additional information about opportunities to participate.

A tentative proposed timeline for the Workgroup's forthcoming work:

September—Discussion of preliminary meaningful use Stage 2 and Stage 3 new objectives. *Note:* A recommendation was made that the Committee should incorporate the thinking of stakeholder groups when thinking about Stages 2 and 3 meaningful use. I have inquired at ONC to ask specifically how this will be done.

October—The Meaningful Use Work Group will present proposed new objectives to the HIT Policy Committee.

November/December—New objectives recommended to ONC/CMS.

Winter 2011—Release of request for information for public comment on proposed Stage 2 objectives and measures.

We will continue to monitor this issue and provide updates. Detailed information can be accessed under the Federal Advisory Committees section of the HHS website (http://www.hhs.gov/healthit).

MedPAC: "Focusing Graduate Medical Education Financing on Educational Priorities"

During its April 1, 2010 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 have contended that indirect medical education (IME) 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 the following:

- 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; 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.

HHS announces $250 million investment in primary care

On June 16, 2010, HHS Secretary Kathleen Sebelius announced $250 million in new investments to strengthen the

primary care workforce. Made possible by the Patient Protection and Affordable Care Act (Affordable Care Act), these investments will help train 16,000 new primary care professionals over the next five years. According to the Secretary, the investments will help address the shortage of primary care practitioners and the declining number of medical students choosing primary care, while increasing access to care, preventing disease and illness, and reducing health care costs.

The investments announced today are the first allocation from a new $500 million Prevention and Public Health fund for fiscal year 2010, created by the Affordable Care Act. Consistent with the announcement, half of the funds—$250 million—will be used to enhance the supply of primary care physicians and other primary care professionals. The new funds will be used to create more than 500 new primary care residency slots by 2015 and encourage states to anticipate and address health professional workforce needs through innovative strategies designed to expand the state's primary care workforce by 10% to 25% over the next 10 years.

Investment monies also will be used to support physician assistant training in primary care, encourage students to pursue full-time nursing careers, and establish 10 new nurse practitioner–led clinics to train nurse practitioners while providing comprehensive primary care services to populations in medically underserved areas.

According to HHS, these investments are one part of a comprehensive strategy for encouraging and training more primary care professionals. Key components of this strategy include:

- **Increasing access to health care professionals in underserved areas** by providing $1.5 billion in Affordable Care Act funding over five years to expand the National Health Service Corps. Along with existing funding, this investment is expected to result in an increase of more than 12,000 primary care physicians, nurse practitioners, and physician assistants by 2016.
- **Focusing on career training** by providing job training grants to community colleges, workforce investment boards, and training venues serving underrepresented minorities to build or expand pathway programs in the health care sector.
- **Expanding tax benefits to health professionals working in underserved areas** by excluding from taxes the value of student loans that are repaid or forgiven because the individual worked in certain health professions including primary care. This benefit, retroactive to 2009, will make available approximately $10 million in tax refunds to health care professionals who practice medicine in underserved areas.
- **Building primary care capacity through Medicare and Medicaid** by redistributing unused resident slots to primary care residencies in underserved areas. Teaching hospitals that receive additional slots must maintain their current number of primary care residents and at least 75% of the new slots in primary care or general surgery. In addition, the rates Medicaid pays to primary care physicians will be increased in 2013 and 2014 to at least 100% of associated Medicare rates.
- **Providing financial assistance for students** by increasing the federal government's funding of Pell Grants by $40 billion, thereby increasing the number of eligible students awarded a grant and increasing awards in future years.
- **Making health care education more accessible** by expanding existing income-based student loan repayment programs for new borrowers after July 1, 2014, by capping payments at 10% of their discretionary income (down from 15%) and forgiving loans after 20 years (rather than 25 years as currently).