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Medicare payment advisory committee meeting

The situation involving the Sustainable Growth Rate (SGR) is deteriorating, said MedPAC chairman Glenn Hackbarth, as the commission discussed policy considerations for adjustments and alternatives. The commissioners discussed several options from repealing the SGR to recommending a package of changes.

Under the current law, Medicare's fees are scheduled to decline more than 30% over the next several years, as required by the SGR According to MedPAC, a main flaw in the SGR is its inability to differentiate updates by provider. It neither rewards specific physicians or other health professionals who restrain unnecessary volume growth nor penalizes those who contribute most to volume increases. A second problem is that the SGR is strictly budgetary. It has no tools to counter the volume incentives inherent in fee-for-service payment system, or improve quality.

Among the ideas under MedPAC consideration:

- Reset SGR; encourage other reforms
- Freeze/reduce updates; modest increase for primary care
- Malpractice reform
- Prior authorization for high-cost ancillary services
- Funding for accountable care organization (ACO) infrastructure

Hackbarth said the budget score for fixing the SGR is rapidly increasing and his chief concern is the instability in the system, which threatens access to quality care for patients. Confidence in the Medicare program is being undermined. The SGR was discussed again at MedPAC's April meeting. The June report will have a chapter on the SGR. The report likely will not have definitive recommendations, but more clearly point in certain directions.

MedPAC also discussed how Medicare can better motivate and support quality improvement. Commissioners were generally supportive of the following draft recommendations on quality improvement:

- The Secretary should target the substantial majority of technical assistance funding for quality improvement to low performing providers and the remainder should be targeted to community-level quality improvement.
- Congress should allow the Secretary to provide funding for time-limited technical assistance to providers and should require the Secretary to develop an accountability structure to ensure these funds are used appropriately.
- Congress should authorize the Secretary to define technical assistance agents so that a variety can compete to assist providers and to provide community-led quality improvement. Congress should remove requirements that agents be physician-sponsored, serve a specific state, and have regulatory responsibilities.
- Congress should require the Secretary to develop and impose intermediate sanctions for persistently low-performing providers.
- The Secretary should establish criteria for high performance to publicly recognize those providers demonstrating superior quality.

National quality strategy

As required by the Affordable Care Act, the Department of Health and Human Services released on March 21, 2011 its Report to Congress, "National Strategy for Quality Improvement in Health Care." This strategy creates national aims and priorities to guide efforts to improve health care at

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local, state, and national levels. The Strategy has the broad aims of:

- **Better care**—Improve overall quality of care by making health care more patient-centered, accessible, and safe
- **Healthy people and communities**—Improve the health of the US population the United States by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivery of higher-quality care
- **Affordable care**—Reduce the cost of quality health care for individuals, families, employers, and government

To advance these aims, HHS will focus on the priority areas of:

- **Safer care**—Making care safer by reduction of harm caused in health care delivery
- **Patient-centered care**—Ensuring that each individual and family are engaged partners in their own health care, and building patients' perspectives into all performance assessments
- **Coordination of care**—Promoting effective communication and coordination of care; examples of federal initiatives promoting more effective care coordination include: Advancing primary care services, HHS medical home demonstration project, and development of ACOs
- **Prevention and treatment**—Promoting most effective prevention and treatment practices for leading causes of mortality; the first area HHS will focus on will be cardiovascular disease
- **Population health**—Working with communities to promote wide use of best practices for healthy living; the forthcoming National Prevention and Health Promotion Strategy will also align with the National Quality Strategy and provide a more specific plan to improve population health
- **Affordable care**—Foster care strategies that reduce redundant and harmful care; establish common measures to help assess cost impact of new programs and pay systems, along with how well new programs support innovation and effective care; build cost and resource use measurements; reduce administrative burdens; make costs and quality more transparent

Specific performance metrics will be developed for the Strategy through stakeholder input from federal agencies and the private sector. Specific targets and measures will be released sometime later this year. The Strategy will be an evolving plan and will be refined periodically based on emerging best practices, new research findings, and the changing needs of the country. HHS will monitor progress and provide updates annually to Congress and the public. The plan is available at: http://www.healthcare.gov/center/reports.

Federal health information technology strategic plan

The Office of the National Coordinator for Health Information Technology (ONC) has released its strategic plan. The plan outlines ONC's strategy for collaboration with the public and private sector and will guide their efforts for the next five years. The HITECH Act requires that ONC seek feedback from the stakeholder community. Comments were due to ONC on April 22, 2011. The plan has five goals:

- Health information technology (HIT) adoption and information exchange through meaningful use of HIT
- Improve care, improve population health, and reduce health care costs
- Inspire confidence and trust in HIT
- Empower individuals with HIT to improve their health and the health care system
- Achieve rapid learning and technological advancement

The plan for achieving each goal is detailed through strategies that outline current efforts and future work to be completed. Highlights include:

1. **Adoption of electronic health records (EHRs)**—ONC and Centers for Medicare and Medicaid Services (CMS) are conducting an outreach campaign to be implemented over the next two years to communicate the value of EHRs and benefits of achieving meaningful use. Primary care providers will be a primary audience for this strategy. The federal government is also collaborating with professional certification and medical education organizations to have meaningful use requirements incorporated as part of US medical education and accreditation processes. The federal government also will encourage efforts of private payers to align their incentive programs to use meaningful use objectives.
2. **Improve Health System Performance**—Current programs are examining ways to combine more advanced use of HIT and the redesign of clinical care processes to achieve better health outcomes and improve performance of the health care system. The HIT Research Center will make tools such as clinical decision support systems and best practices available to providers as they implement the redesign of clinical care and add more sophisticated HIT to their offices. HIT will be an important tool that will support current demonstration projects and new programs authorized under the Affordable Care Act (ACA) such as bundled payment, medical home pilots, and the National Prevention and Health Promotion Strategy.
3. **Trust in HIT**—ONC is currently working on privacy and security protections that are necessary to ensure trust in the exchange of health care information. This includes developing regulations to establish privacy and security, interoperability, compliance mechanisms for the Nationwide Health Information Network, and rules on restrictions on the disclosure, breach, and sale of protected

health information. ONC will encourage development of privacy and security functions into future EHRs and other HIT and will continue to work on identifying additional functions that can be included in HIT certification and standards for future stages of meaningful use. As part of their outreach, HHS will inform individuals and providers of current privacy and security policies that protect electronic health information.

4. **Engage Individuals**—The HHS outreach strategy will include efforts to help individuals understand the value of HIT and how it can benefit individuals when making informed choices regarding their own health care. HHS is considering how to establish policies that help individuals and caregivers have access to their health information. During the next five years, the federal government will consider advanced features of health information sharing to include standards for consumer HIT applications and applications that enable information to be exchanged through mobile devices. HHS is also examining how patient-generated health information can be incorporated into EHRs and quality measurement, as well as HIT certification and standards processes.
5. **Rapid Learning**—A nation of providers that is achieving meaningful use will create vast amounts of clinical data that can be stored in an electronic and computable format. The vision of the government is to create a learning health system—a system that will use this information and turn it into knowledge that can be used immediately. HHS plans to engage patients, providers, researchers, and institutions in this effort and encourage them to exchange information through the learning health system. ONC is working to ensure that its current work on standards, certification, and governance of exchange of health information support the vision of the learning health system.

The complete plan can be found at: http://www.healthit.gov/buzz-blog/from-the-onc-desk/hit-strat-plan/

Federal tort claims act expansion

Rep. Tim Murphy (R-PA) and Rep. Gene Green (D-TX) have once again introduced the "Family Health Care Accessibility Act of 2011." In the 111th Congress, this legislation passed the House of Representatives by a vote of 417-1, but was not considered by the Senate. This legislation would enhance the number of physicians who provide volunteer care at Community Health Centers (CHCs) by ensuring that physicians who volunteer their services at CHCs are extended medical liability protections offered under the Federal Tort Claims Act. This legislation will both assist CHCs in securing the services of physicians and encourage more physicians to provide their services at CHCs.

Provider shield act of 2011

Reps. Phil Gingrey, MD (R-GA) and Henry Cuellar (D-TX) have introduced the "Provider Shield Act of 2011." The legislation clarifies that participation in quality improvement, resource utilization, continuous certification, or other such programs shall not be construed to establish or influence the accepted standard of care for the purposes of a medical liability case. The legislation does not attempt to limit an individual's ability to pursue recourse for an alleged injury. This is reasonable and responsible policy that further encourages physicians to participate in current or future programs aimed at improving the quality and efficiency of the care they provide.

Healthcare truth and transparency act of 2011 (H.R. 451)

On January 26, 2011, Rep. John Sullivan (R-OK) and Rep. David Scott (D-GA) introduced the "Healthcare Truth and Transparency Act of 2011" (H.R. 451). This legislation would make it unlawful for any health care professional to make deceptive statements or engage in behavior that misleads patients in advertising and marketing efforts about their level of training. This legislation also directs the Federal Trade Commission, which already has authority over these types of issues, to pay particular attention to false and misleading advertising among all health care providers.

HIT policy committee

The HIT Policy Committee is working on clinical quality measures for Stage 2 of meaningful use. This includes determining whether Stage 1 requirements would remain, or whether there should be an alternate approach. One approach mentioned was balancing core measures with specialty measures. Domain areas for measures include clinical appropriateness and efficiency, population and public health, patient and family engagement, care coordination, and patient safety. Other issues that the Committee may consider as they determine Stage 2 measures include the current exchange and interoperability infrastructure, the available infrastructure for patient-reported outcomes, and currently available standards for adoption of measures.

Note: Dr David Blumenthal stated that this process will provide a chance to consider a broader range of measures more representative of the practice of medicine to include specialties.

He noted that the meaningful use framework will become the "raw material" for providers and payers to improve quality through systemic change. Measures should be developed to consider initiatives such as ACOs and medical homes. Measures developed for Stage 2 will be considered

in a way that will enable providers to use them for multiple reporting purposes.

Note: Tony Trenkle of CMS noted that measure development is an evolutionary process and CMS is working to ensure that measures developed for Stage 2 align and harmonize with initiatives such as ACOs.

It is anticipated that Stage 2 measure specifications will be put out for public comment sometime this fall and that this input will inform a proposed rule to be released later this year. Other highlights include:

- **Privacy and Security Tiger Team—**The Privacy and Security Tiger Team is currently examining authentication of users as a potential recommendation on information used in health information exchange. The Committee indicated its preference for a two-factor authentication process for users. Two-factor authentication could include something you have (ie, a password) and something you are (eg, a biometric [such a fingerprint]).

Note: Dr Blumenthal noted the importance of this issue and stated that it is one that the provider community does not know much about.

He noted that as recommendations are developed, they must include a standard that is secure enough to ensure that individuals have trust when their information is shared.