IMPLEMENTING HEALTH REFORM

The Independent Payment Advisory Board

Tucked within the Affordable Care Act is a provision aimed at reining in health care spending. The provision creates the Independent Payment Advisory Board (IPAB), a panel of 15 experts charged with slowing the growth of Medicare and private health care spending, and improving health care quality. By law, the board's recommendations will automatically take effect unless Congress enacts its own cost-cutting plan that achieves the same level of savings. The board isn't expected to submit its first recommendations to Congress until 2014, but already the medical community is crying foul. Dr. J. Fred Ralston Jr., president of the American College of Physicians, explains some of the issues with the new board.

The sense is that the IPAB provision removes too much congressional authority.

DR. RALSTON

Clinical Neurology News: Everyone agrees something needs to be done to control health care spending, so why is the IPAB so unpopular with physicians?
Dr. Ralston: The ACP is supportive of the general concept of an entity like the IPAB. We believe making complex Medicare payment and budgetary decisions is very difficult within a political process with substantial lobbying pressures, and that a knowledgeable, independent board serving this role would have some protection from this undue influence. Many physician and other provider groups are opposed to this provision because a significant amount of influence is removed from the accessible, elected congressional body by the legislation. The sense is that too much congressional authority is removed, resulting in inadequate opportunity for physicians and other health care providers to express their point of view and influence the actions taken.

CNN: How does the IPAB differ from bodies such as the Medicare Payment Advisory Commission (MedPAC)?
Dr. Ralston: The IPAB, a body whose members must be appointed by the president and confirmed by the Senate, has the authority to have changes made by the Secretary [of Health and Human Services] to the Medicare system to reach a budgetary target. Its recommended changes will take effect unless Congress passes legislation that meets the same budgetary target. Even if Congress passes such legislation, it can be vetoed by the president and the IPAB recommendation would still take effect. MedPAC, as an advisory commission, can only make recommendations, which Congress can choose to enact or not. It has no direct authority to implement change, which differs significantly from the IPAB.

CNN: The ACP and other medical societies have called for changes to how the IPAB is structured. What changes would the ACP like to see?
Dr. Ralston: We'd like:
► A requirement for inclusion of a primary care physician on the IPAB. The perspective of physicians who provide first-contact, comprehensive, and continuous care must be a part of the process.
► Stronger protections to ensure the recommendations to decrease expenditures do not result in decreased quality of care.
► The authority for Congress to reject the implementation of IPAB recommendations with a majority vote, which maintains a reasonable influence in the hands of the elected body.
► Equal distribution of risk for budgetary reductions for all health care providers. Hospitals and certain other provider groups are protected from budgetary reductions over the first several years of the legislation, placing physicians at increased risk of being required to take reductions.

CNN: Which elements does ACP favor?
Dr. Ralston: As mentioned above, the concept of providing a knowledgeable body with some protection from undue influence.

CNN: If Congress eliminated the IPAB, how could it achieve comparable health care savings?
Dr. Ralston: ACP believes the [Affordable Care Act] sets a foundation for many changes that can lead to increased savings. This includes the piloting of integrative payment models rewarding efficiency and effectiveness, as opposed to the current system that rewards only volume. These models include accountable care organizations, increased bundled payments, and gain-sharing arrangements, among others.

Furthermore, data from ongoing demonstrations of the patient-centered medical home care model, which fosters increased care coordination and improved treatment of chronic conditions, indicates a high potential to reduce cost and improve quality.

Finally, the increased development and dissemination of comparative effectiveness information to help inform the decisions of patients in consultation with their physicians also has the potential to significantly reduce costs while improving, or at least maintaining, quality. ■

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EHR Requirements Relaxed in Final Rule on Meaningful Use

BY MARY ELLEN SCHNEIDER

The federal government has released the much-anticipated requirements for how physicians and hospitals can qualify for tens of thousands of dollars in incentive payments to adopt and use electronic health records.

The final rule on the meaningful use of electronic health records (EHRs) eases many of the requirements that officials in the Health and Human Services department had outlined in a proposal published in January. Physician organizations had objected to the initial proposal, saying that it asked doctors, especially those in small practices, to do too much too quickly. Physicians were also critical of the all or nothing framework of the proposal, which required them to meet all 25 objectives for meaningful use or lose out on incentive payments.

Federal officials aimed to address those concerns in the final rule by requiring physicians to first meet a core set of 15 requirements and then meet any 5 of 10 additional requirements. The core set includes requirements such as recording patient demographics and vital signs in the EHR, maintaining an up-to-date problem list and an active list of medications and allergies, and transmitting permissible prescriptions electronically.

"We very much want well-intentioned providers to become meaningful users," Dr. David Blumenthal, National Coordinator for Health Information Technology at HHS, said during a press briefing to announce the final rule.

HHS officials also relaxed some of the thresholds related to the requirements. For example, under the proposed rule, physicians would have had to generate and transmit 75% of their permissible prescriptions electronically to meet the e-prescribing requirement. Under the final rule, the threshold has been lowered to more than 40% of permissible prescriptions. The revision was made so that the requirement would be achievable by average practices in the early years of the program, he said.

The final rule also creates an easier path for physicians to meet meaningful use requirements on electronic reporting of quality data. Under the final rule, physicians will need to report data on blood pressure, tobacco status, and adult weight screening, and follow-up in 2011 and 2012, in order to qualify. Alternatives are available if those measures do not apply to their practices. Physicians also must to choose three other quality measures to report on through their EHRs.

The final rule outlines the steps physicians must take in 2011 and 2012 to quality for the maximum incentive payments through the Medicare and Medicaid programs. The incentives were mandated by the Health Information Technology for Economic and Clinical Health Act (HITECH), a part of 2009's American Recovery Act.

Starting in 2011, physicians who demonstrate meaningful use of certified EHRs can receive payments of up to $18,000 from Medicare. Those bonuses continue for 5 years, with physicians eligible to earn up to $44,000 in total incentives. Physicians can still receive bonuses if they begin their meaningful use of the technology later, but they must start before 2013 to get all the available incentives.

A similar program is in place under the Medicaid program, with physicians eligible to receive up to $64,000 over 6 years for the adoption and use of certified EHRs. ■

The final rule on the meaningful use of EHRs is available at www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf and the final rule on new standards for the certification of EHR technology is available at www.ofr.gov/OFRUpload/OFRData/2010-17210_PI.pdf.

Total Maximum EHR Incentive Payment Amounts

Calendar year	First calendar year for which an eligible professional receives incentive payment				2015 and subsequent years
	2011	2012	2013	2014	
2011	$18,000	—	—	—	—
2012	$12,000	$18,000	—	—	—
2013	$8,000	$12,000	$15,000	—	—
2014	$4,000	$8,000	$12,000	$12,000	—
2015	$2,000	$4,000	$8,000	$8,000	$0
2016	—	$2,000	$4,000	$4,000	$0
Total	$44,000	$44,000	$39,000	$24,000	$0

Note: Incentives were mandated in 2009 by the HITECH Act.
Source: Centers for Medicare and Medicaid Services