States Can Expand Medicaid Before Mandate

BY MARY ELLEN SCHNEIDER

One of the cornerstones of the health care reform law is a massive expansion of the Medicaid program.

Starting in 2014, all states will be required to expand eligibility of their Medicaid programs to all adults at or below 133% of poverty, regardless of whether they have children or are disabled. And beginning last month, states could choose to open up programs to these new enrollees early.

This is the first time in the history of the Medicaid program that states can receive federal funds for providing coverage for adults based solely on income levels.

In April, officials at the Centers for Medicare and Medicaid Services released the first details on how the new eligibility requirements will work. States that choose to begin enrolling these newly eligible adults before 2014 will receive federal matching payments at the regular Federal Medical Assistance Percentage (FMAP) rate. Starting in 2014, they will receive an increased matching rate for certain people in the new eligibility group, according to the CMS. The agency plans to issue separate guidance on this issue later.

The immediate impact on states will probably vary based on whether they are already covering some of the newly eligible adults with their own funds. In those states, the new federal money will mean an immediate savings. States that don't already offer expanded coverage will be spending new money to pick up their share of covering new beneficiaries.

Another question is how the expansion of the Medicaid program will impact access to care. In many states, Medicaid pays physicians at rates well below Medicare levels, and some estimates suggest that only about half of primary care physicians accept new Medicaid patients.

Under the Health Care and Education Reconciliation Act passed as part of health reform, Congress raised Medicaid payments up to Medicare levels for primary care providers starting in 2013 and 2014.

A survey of 944 primary care physicians conducted by UnitedHealth Group found that 67% think that new Medicaid patients will struggle to find a suitable primary care physician if the Medicaid expansion is not accompanied by other reforms, such as payment increases. If payment is increased to at least Medicare levels, about half of physicians (49%) said they would be willing to take new Medicaid patients.

"Having a Medicaid insurance card is not the same as having a primary care doctor that will treat you," Simon Stevens, executive vice president of UnitedHealth Group and chairman of the UnitedHealth Center for Health Reform and Modernization, said at a news conference to discuss Medicaid expansion. "Unfortunately, that disconnect between Medicaid benefits and health care access has in some places been growing."

UnitedHealth Group estimates that the cost to permanently boost Medicaid payments to physicians would be about $63 billion from 2013 to 2019, with about $50 billion of that cost currently not funded by the health care reform law.

What needs to be avoided, Mr. Stevens said, is a new Medicaid "doc fix problem" in which the federal government or the states temporarily make adjustments to Medicaid physician payments after 2014 in the same way they have been heading off payment cuts in Medicare in recent years. ■

Quality Guru Nominated As Next CMS Administrator

BY ALICIA AULT

The White House announced on April 19 that it has nominated Dr. Donald M. Berwick to lead the Centers for Medicare and Medicaid Services.

The nomination of Dr. Berwick, a pediatrician who is president and chief executive officer of the Institute for Healthcare Improvement, had been rumored for weeks.

In a statement released by the White House, President Obama said, "Dr. Berwick has dedicated his career to improving outcomes for patients and providing better care at lower cost. That's one of the core missions facing our next CMS Administrator, and I'm confident that Don will be an outstanding leader for the agency and the millions of Americans it serves."

'I would welcome the opportunity ... to help extend the effort to improve America's health care system.'

DR. BERWICK

The American Medical Association praised Dr. Berwick's "visionary leadership efforts" in quality and patient safety in a statement given by Dr. Nancy H. Nielsen, the AMA's immediate-past president. "Upon confirmation, we look forward to working with Dr. Berwick at CMS on implementation of the new health reform law and on ensuring that physicians can continue to care for seniors who rely on Medicare."

With the recent passage of health reform and the continuing lack of a permanent solution for the fee cuts threatened by Medicare's sustainable growth rate (SGR) formula, Dr. Berwick will have a full plate if he is confirmed by the Senate.

Physicians, hospitals, insurers, consumers, and pharmaceutical and medical device manufacturers all are hoping to influence how the law is implemented.

The medical device industry lobby, AdvaMed, issued a statement praising Dr. Berwick's "compelling vision," but reminded him also of what he will be taking on. "There is perhaps no more important job in health care," said Stephen J. Ubl, president and CEO of AdvaMed. "The decisions made by Dr. Berwick will affect the lives of America's seniors and every health care provider, and CMS will play a pivotal role in implementing the comprehensive health reform program recently enacted by Congress."

For his part, Dr. Berwick said in a statement that he felt "flattered and humbled" at his nomination. He added, "If confirmed by the U.S. Senate, I would welcome the opportunity to lead CMS because it offers the chance to help extend the effort to improve America's health care system—the very vision that led to the founding of the Institute for Healthcare Improvement."

Dr. Berwick is a member of the adjunct staff in the department of medicine at Children's Hospital, Boston, and is a consultant in pediatrics at Massachusetts General Hospital. He is an elected member of the Institute of Medicine, and previously chaired the National Advisory Council for the federal Agency for Healthcare Research and Quality. He also served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry in 1997 and 1998. ■

ABIM, ABEM Agree on Critical Care Certification Pathway

BY ALICIA AULT

In a long-awaited move, the American Board of Emergency Medicine and the American Board of Internal Medicine have agreed to cosponsor a pathway to certification in Internal Medicine Critical Care Medicine.

The landmark agreement comes after decades of effort to find an appropriate mechanism for emergency physicians to receive certification in the subspecialty of critical care medicine.

Emergency physicians have been receiving advanced training through critical care fellowships since the late 1980s, but there was never a pathway to board certification, Dr. Eric Holmboe, the ABIM's chief medical officer, Quality Research and Academic Affairs, said in an interview.

Many of those critical care fellows have gone on to take an examination through the European Society of Intensive Care Medicine. In general, some hospitals accept that overseas exam certification as a surrogate due to the lack of an equivalent U.S. examination, said Dr. Lillian L. Emlet, chair of the Critical Care Medicine section of the American College of Emergency Physicians.

The impact of the new certification is unclear, but "it's a very exciting thing for all of us," Dr. Emlet said in an interview. At a minimum, it should facilitate additional communication between the ABEM and the two other boards that currently certify in adult critical care medicine, the American Board of Surgery and the American Board of Anesthesiology, said Dr. Emlet, of the University of Pittsburgh.

But the availability of a 2-year fellowship and subsequent U.S. certification will also help produce more U.S.-trained intensivists, Dr. Emlet said.

Currently, about 20 emergency medicine residents enter a critical care fellowship each year, Dr. Emlet said, adding that there's a natural affinity between emergency medicine and critical care medicine. A recently published survey of emergency physicians in a critical care medicine fellowship found that of those who had completed their fellowship, 49% (36 of 73) were practicing both specialties (Acad. Emerg. Med. 2010;17:325-9).

The number of emergency physicians who have completed critical care fellowships has risen from 12 over the 1974-1989 time period to 43 in 2000-2007, according to the survey.

Even so, Dr. Debra G. Perina, ABEM president, said that there is a continuing shortage of critical care physicians in the United States—a problem discussed in a 2006 report by the Institute of Medicine called "The Future of Emergency Care in the United States Health System."

The current boards are not supplying enough specialists to meet the demand in critical care medicine, Dr. Perina, an associate professor at the University of Virginia, Charlottesville, said in an interview.

A 2005 white paper—published by the ACEP, the Council of Emergency Medicine Residency Directors, the Emergency Medicine Residents' Association, the Society of Academic Emergency Medicine, and the Society of Critical Care Medicine—urged an expansion of training to allow emergency physicians to become certified in critical care medicine.

The new certification program still requires approval from the American Board of Medical Specialties. At this point, "we're not aware of any issues that would keep this from coming to fruition," Dr. Perina said.

She and Dr. Holmboe said they expected the first certification exam to be offered in 2012. ■