POLICY & PRACTICE

Nursing Home Fees to Increase

The Centers for Medicare and Medicaid Services has proposed increasing the work relative value units—and therefore the physician fees—for services provided in the nursing home setting. If the increase is included when CMS publishes its final fee schedule on Nov. 1, physicians will see new reimbursement rates beginning on Jan. 1, 2008. Under CMS's proposal, fees for nursing home visits would increase 9%-50%, depending on the service. The changes come after 4 years of work by the American Medical Directors Association and other physician groups aimed at persuading CMS that the work involved in caring for a nursing home patient is similar to the work involved in caring for a hospital patient. "Because patients are moved from more intense settings much more quickly than in the past, patients in nursing facilities are often in very serious condition as they are cared for by their physician," said Dr. David Dale, president of the American College of Physicians in a statement. "These work values are a reflection of this extraordinary responsibility."

ACP Criticizes SCHIP Funding

Funding levels are too low in a Senate bill to reauthorize the State Children's Health Insurance Program, the American College of Physicians told the Senate Finance Committee in July. In addition, the bill to reauthorize SCHIP does not address pending cuts in Medicare physician fees, Dr. Joel Levine, chair of the ACP's board of regents, told lawmakers in a five-point letter. Dr. Levine urged lawmakers to repeal the Medicare physician fee cuts by mandating "at least 2 years of stable, predictable, and positive updates, reflecting increases in physicians' practice costs." He also said that Congress should provide federal grants to support states that redesign their Medicaid and SCHIP programs around the patient-centered medical home, a concept he said already is working in states such as North Carolina. Debate on whether and how to expand SCHIP is expected to intensify prior to expiration of the program's authorization on Sept. 30.

CMS Releases Medicaid Rule

CMS has unveiled a new method of setting limits on what the federal government will reimburse state Medicaid agencies for prescription drug payments. As part of the new regulation, states will be required to collect information from physicians about prescription drugs administered in their offices so that the state can collect any rebates offered by drug manufacturers on those products. The final rule will take effect Oct. 1. The regulation is expected to save states and the federal government $8.4 billion over the next 5 years, but even with the change, the Medicaid program still is expected to spend $140 billion for drugs over the same time period. The change is in part a reaction to a series of reports showing that Medicaid payments to pharmacies for generic drugs were much higher than what pharmacies actually were paying for the drugs. Pharmacies, the reports showed, made the most profit on those generic drugs with the highest markup, creating an incentive to dispense those drugs.

Joint Commission Announces Goals

The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) will require health care institutions to take actions to reduce the risks of patient harm associated with the use of anticoagulant therapy as part of its 2008 National Patient Safety Goals. The new requirement—which applies to hospitals, ambulatory care and office-based surgery settings, and home care and long-term care organizations—addresses a widely acknowledged safety problem with anticoagulant therapy, the accrediting organization said. The 2008 safety goals include a new requirement that addresses the recognition of and response to unexpected deterioration in a patient's condition. Under this requirement, hospitals must select a method for enabling caregivers to obtain assistance from specially trained individuals if and when a patient's condition worsens. Full implementation of both requirements is targeted for January 2009.

Americans Buy Drugs Overseas

More than 5 million Americans adults have recently purchased prescription drugs from another country, such as Canada or Mexico, according to a survey by the Pharmaceutical Research and Manufacturers of America. The vast majority of consumer importers said they were looking for the best price for medicines, but about half decided to buy their drugs in another country because they didn't have a physician's prescription, the survey found. Importers were more likely to be under age 35 years, be Hispanic, live in a southern border state, and to spend more out-of-pocket money on prescription drugs than do nonimporters, PhRMA reported. Most of the drugs imported were to treat chronic ailments. PhRMA President and CEO Billy Tauzin said in a statement that importation increases a patient's risk of being exposed to "dangerous counterfeit medicines."

HHS Expands Vaccine Capacity

The Department of Health and Human Services has awarded two contracts to expand the domestic influenza vaccine manufacturing capacity that could be used in the event of a influenza pandemic. The 5-year contracts were awarded to Sanofi Pasteur ($77.4 million) and MedImmune Inc. ($55.1 million). The contracts fund manufacturing operations and renovation of manufacturing facilities for 2 years, with options for an additional 3 years. Upon completion, these facilities will expand domestic pandemic vaccine manufacturing capacity by 16%, according to HHS. The facilities also will expand vaccine availability for the national stockpile.

—Jane Anderson

Lawmaker's Bill Would 'Wyden' Health Coverage

BY ERIK L. GOLDMAN
Contributing Writer

WASHINGTON — With the introduction of the Healthy Americans Act last January, Oregon Sen. Ron Wyden (D) became the first major political player to launch a proposal for significant health care reform since the early days of the Clinton administration.

Sen. Wyden's plan calls for federally mandated, federally subsidized, portable health insurance coverage for all Americans. The plan is designed to break the nation's reliance on employer-funded health insurance, a dependence that Sen. Wyden believes has become detrimental to the well-being of many American citizens and crippling to American businesses.

Speaking at the fourth annual World Health Care Congress, a conference sponsored by the Wall Street Journal and CNBC, Sen. Wyden outlined his vision for reform, emphasizing that he is most definitely "trying to upset the applecart."

Under the Wyden plan, uninsured individuals would choose health insurance coverage from a variety of plans in their states.

The Healthy Americans Act (S. 334) would guarantee all Americans access to private-sector health plans that provide benefits equal to those currently provided to members of Congress. It would do so without increasing corporate or individual income taxes, and—more importantly—do so without obliging employers to pay any more than 25% of health care costs for employees.

The bill would create incentives for both individuals and health care insurers to bolster disease prevention and wellness programs, Sen. Wyden emphasized at the meeting. He said that he believes this is attainable in a fiscally responsible way that would not require any spending beyond the $2.2 trillion currently spent on health care in America; he projected that his plan would save the government roughly $1.48 trillion over a 10-year period, and that these savings would be reinvested in new prevention-oriented initiatives.

"We're currently spending enough on health care that we could have a doctor for every seven families in the U.S., and pay them $200,000 per year. We're spending more than enough money; we're just not spending it in the right place," the senator said.

Under the Wyden plan, which has support from a diverse group of corporate, labor, and health care leaders, uninsured individuals would choose health insurance coverage from a variety of plans in their states. Federally funded but state-specific Health Help Agencies (HHA) would be created to provide citizens with meaningful comparisons among the various competing plans and to guide them through the enrollment process. The HHAs would also be able to negotiate sliding scale premium reductions to ensure that monthly costs are reasonable and within the reach of working families. HHAs would also provide financial assistance for low-income individuals and families who would not otherwise be able to afford coverage.

People who have employer-financed health insurance through their jobs would undergo a 2-year transition during which their employers would "cash-out" the annual total of the individual's health insurance premiums and pass this on to employees as real wages, which would be tax sheltered once applied to individual or family health insurance policies. After the 2-year transition, employers would begin to make "shared responsibility" payments—meaning they would pay up to 25% of the average premium for essential care—but they would no longer be burdened with having to find and manage health care plans for their employees.

Giving employers an honest exit from the health care arena is fundamental to Sen. Wyden's vision. "There's a general awareness that employer-based health care is already melting like a popsicle on a summer sidewalk. A lot of people in their 50s are just hanging on by their fingernails, hoping that their employers will cover them until they're Medicare eligible. My bill is the first and only bill to cut the line between coverage and employment. Back in the 1940s, we as a nation made the decision to put everything on employers. But that doesn't make sense in 2007."

The aging of the population, the increased burden of chronic diseases, and the emergence of global competition have made employer-based health care increasingly problematic, both for individuals and for the employers themselves.

The other central tenet of Sen. Wyden's vision is to realign the value placed on medical services to support meaningful preventive medicine, disease management, and individual wellness programs.

To this end, the Wyden plan would eliminate individual copayments for all preventive health care services as well as ongoing disease management programs for people with chronic disorders. His plan would encourage insurers to offer financial incentives for participation in wellness programs, nutrition counseling, tobacco cessation, and exercise.

He believes current payment structures unduly favor procedure-based acute care at the expense of primary care, an inequality he hopes to reverse. Under the Healthy Americans Act, primary care physicians would be reimbursed for time-intensive preventive medicine and chronic disease management. The regional HHAs would rate competing health plans, in part based on how well their disease prevention and disease management programs perform.

"Insurance companies will ultimately be competing to keep Americans healthy," the senator said. ■