

# Inside CMS

exclusive news on the most powerful agency in health care

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## **Baucus Floats Delivery System Reform Options; Doc Pay Fix Draws Fire**

Senate Finance Committee leaders Max Baucus (D-MT) and Charles Grassley (R-IA) this week unveiled health reform policy options that aim to improve care by fostering better provider coordination and value-based purchasing, but the options' lack of a permanent physician fee fix immediately drew fire from physicians. The lawmakers also called for investments in tools that would boost productivity and reduce prices as well as ways to make the Medicare Advantage (MA) program more efficient and combat fraud.

The options also suggest a need to boost reimbursement for primary care and eliminate conflict of interest associated with physician self-referral.

The provider reaction to signals that lawmakers will continue to patch Medicare's sustainable growth rate formula (SGR) used to pay doctors was negative, and other than the medical home provisions, physician-related support was lukewarm. "We're disappointed on the fee fix," said a specialty society lobbyist. "The primary care provisions — the intent is good — but I don't think it is a significant enough investment." However, the lobbyist added, "We like the prominence of the medical home" policy.

Health care economist Harold Luft, director of the Palo Alto Medical Foundation Research

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## **No permanent fix irritates physicians BUDGET COMPROMISE REQUIRES PAYGO FOR SENATE MEDICARE DOC PAY FIX**

The House and Senate budget resolution agreement allows for a Medicare physician payment fix without immediately requiring an offset on the House side, but anything sent to the Senate would have to be deficit neutral unless that chamber has 60 votes to waive pay-as-you-go (paygo) rules, a key congressional aide says. Unilaterally addressing the Medicare sustainable growth rate (SGR), however, isn't the only option as there is an "expectation" in Congress that the physician payment issue will be dealt with as part of broader health reform, a source tells *Inside CMS* (see related story).

But a physician source says the budget language shuts down the

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## **SENATE HEALTH REFORM ROUNDTABLE HEARS CALL FOR STATE FLEXIBILITY**

Senate health committee members were urged to give states flexibility to launch innovative health reforms during a roundtable Tuesday, where those testifying showcased a variety of reforms underway around the country. Lawmakers were particularly interested in Massachusetts' health insurance "connector," eyed as a possible model for a cross-state insurance model. While that program has significantly reduced the number of uninsured, it has not controlled health care costs, nor was it supposed to, said state officials.

Lawmakers were urged to avoid prescribing an overarching health reform approach that would pose a roadblock to state innovations. "Please be careful that your efforts don't undermine what's been done in the states. One size does not fit all," said Harry Chen, a Burlington, VT-based emergency physician

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## **Dominoes: Grassley could leave Finance, reform focus SPECTER'S SWITCH MAY GIVE HIM CHAIR ON APPROPRIATIONS HEALTH PANEL**

Pennsylvania Sen. Arlen Specter's announcement April 28 that he will run for re-election as a Democrat could shake up future health care leadership in the Senate, given the five-termers' relative high seniority, sources say. Specter currently serves as the Republicans' ranking member on the Judiciary Committee and, importantly for health care reform efforts, as the ranking Republican on the Appropriations' Labor and HHS subcommittee. The lawmaker will get to keep all his seniority when the committees are altered after the 2010 election, Senate leadership has said.

Should three things hold true — Specter is re-elected, seniority is fully

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## SEARCH FOR CMS ADMINISTRATOR CONTINUES AS WOLTER DROPS OUT

The much ballyhooed Montana pulmonologist Nick Wolter, who heads The Billings Clinic as CEO, tells *Inside CMS* that he is no longer in the running for the top job at CMS.

Citing “obligations and commitments as the CEO of Billings Clinic,” Wolter said through a spokesman that he has decided “not to pursue this opportunity at this time.” He plans, however, to continue “to play a role nationally in helping shape health care policy and health care reform.”

Wolters, in town for a speaking engagement, tells *Inside CMS* that the Chief Financial Officer job at Billings is vacant right now and he cannot leave the clinic at present.

In an April 10 editorial, the *Billings Gazette* essentially endorsed Wolter for the job, writing that he would be an excellent choice to head CMS. “He understands the challenges of rural and regional health care, but he also has considerable experience with national health care policy. Wolter’s years of working where policy meets practice combined with his outside Washington perspective may be just what this nation needs to move forward on improving health care for all Americans - starting with the 90 million who rely on Medicare, Medicaid or CHIP.”

Wolters said he didn’t know who else was in the running for the job. With his withdrawal, the field for CMS administrator remains wide open. — *Brett Coughlin*

## NEW HHS OFFICE FORMED TO WATCH STIMULUS CASH, DELIGHTING THE HILL

The announcement this week that HHS will create an Office of Recovery Act Coordination to monitor the dispensing of stimulus funds marks the beginning of a massive effort to shepherd money and publicly report on expenditures anticipated to reach \$137 billion, according to the agency.

The Office of Recovery Act Coordination (ORAC), which reports to the HHS Office of Resources and Technology, will be led by Dennis Williams, who will serve as HHS’ Deputy Assistant Secretary for Recovery Act Coordination. Williams has previously served as deputy administrator of HHS’ Health Resources and Services Administration and as acting assistant secretary in the Office of the Assistant Secretary for Management and Budget.

Praise for ORAC’s creation included support from Senate Finance ranking Republican Charles Grassley (IA), who expressed delight over the new program to oversee stimulus dollars.

“Taxpayers have a lot on the line with the deficit spending that’s been approved this year, and the federal agencies distributing that money owe it to taxpayers to make sure the money isn’t wasted or lost to fraud,” Grassley told *Inside CMS*. Last week, Grassley demanded answers from CMS on an HHS Inspector General memo from last November that found \$754 million in uncollected over-payments to durable medical equipment (DME) suppliers and other businesses (see *Inside CMS*, April 17).

To date, HHS has distributed more than \$3 billion in stimulus funds to programs from Community Health Centers to Medicaid. With the agency “committed to moving quickly and carefully to distribute Recovery Act funds in an open and transparent manner,” said HHS Spokeswoman Jenny Backus, this new office “will enhance and streamline our efforts to get critical resources and potential new job opportunities to the American people during tough times.”

A large part of that open and transparent disclosure will include tracking HHS activities funded through the Recovery Act at [hhs.gov/recovery](http://hhs.gov/recovery). The site already includes weekly reports of spending, declarations of grant and contract opportunities and state allocations of Medicaid funds and \$155 million dedicated for creating 126 community health clinics. A link is also available to send the inspector general reports of fraud and abuse.

To follow through on various stimulus package requirements and OMB guidance — such as making sure reporting due dates are met and performance outcomes are tracked — the ORAC will get a dedicated staff to prepare reports and compile official Recovery Act material.

According to the official language creating the office, the ORAC is also “the authoritative source for accurate and up-to-date information for all communications” to the Office of Management and Budget, Congress and the public.

“By convening meetings and workgroups of senior HHS program and business managers and by working in close collaboration with existing business management and program offices,” the reorganization language reads, “the ORAC ensures that funds are awarded in a prompt, fair and reasonable manner; that recipients and users of all funds are transparent to the public (and) that projects and activities funded under the Recovery Act are achieved while mitigating risk.”

**ORAC includes four sub-groups:** the Immediate Office of the Recovery Act Coordination and the divisions of Management and Performance; Planning and Presentation; and Project Coordination.

Work already undertaken by HHS to dispense stimulus funds includes cumulative disbursements for Medicaid FMAP funding of \$13.2 billion through April 17, according to the agency. (In just fiscal year 2009’s third quarter, CMS issued \$778.5 million in supplemental Medicaid grant awards.) April 17 was also the date of publishing — a

day before the Recovery Act's prescribed deadline — guidance on technologies and methodologies to secure health information. This guidance builds on existing requirements of the HIPAA Privacy and Security Rules, which are unchanged, HHS said.

On April 10, HHS' Administration for Children and Families announced \$1 billion for the community service block grant. And OMB has completed its review of several other HHS spending plans; once necessary documents are prepared, those funds will be released or funding opportunities will be made public, the agency said. — *Seth Freedland*

## **PROPOSED 2010 HOSPICE WAGE INDEX ESTIMATES 1.1 PERCENT PAYMENT CUT**

CMS is moving ahead with the phase-out of the budget neutrality adjustment factor (BNAF) for hospices, which includes 75 percent of the entire reduction for fiscal 2010, according to the proposed hospice wage index rule released April 21. The rule also adopts a Medicare Payment Advisory Commission (MedPAC) recommendation on physician certification and recertification of patient illness.

The BNAF phase-out began last year with a 25 percent reduction for the 2009 wage index. The plan was to phase it out by 25 percent in 2009, 50 percent in 2010 and the final 25 percent in 2011. The 2009 decrease was delayed by the stimulus act, but according to CMS the legislation did not address the continued BNAF phase out, therefore the hospice industry will be hit in 2010 with a 75 percent reduction of the BNAF, which provided hospice with roughly 4 percent additional payment over the market basket.

The agency estimates that 2010 hospice payments will decline by \$340 million as a result of the 75 percent BNAF reduction, according to CMS in the proposed rule (to be published in the *Federal Register* April 24). But, CMS says in the rule that "[t]his estimate does not take into account any hospital market basket update, which is currently estimated about 2.1 percent for FY 2010."

Phase-out of BNAF over two years is expected to save Medicare \$2.9 billion over five years. In 2010 hospice payments are expected to be about \$13 billion.

CMS said in an announcement of the 2010 hospice wage index proposed rule that Medicare payments to hospice are estimated to decrease by 1.1 percent, which is the result of the 3.2 percent reduction in BNAF that is offset by the estimated 2.1 percent market basket update.

As for the certification and recertification of hospice patients, CMS took MedPAC's recommendation that stemmed from unexplained variation in patients' length of stay in hospices and an increasing number of stays past 180 days. The changes in patient stays under hospice care raised concern that physicians were certifying or recertifying patients for hospice who were no longer eligible.

CMS is proposing in the rule, as MedPAC recommended, that physicians certifying or recertifying patients as eligible for hospice care must submit a narrative on the certification form explaining the clinical evidence supporting life expectancy of six months or less.

The proposed rule also solicits comments on the proposal to require a physician or nurse practitioner to visit the hospice every 180 days that a patient is on Medicare for the benefit. CMS is trying to determine whether that move would improve accountability of the certification process.

The agency is also seeking comment about different methods of calculating the hospice aggregate cap. Comments are due June 22. — *Ashley Richards*

## **AHA, AHCA, OTHERS RAMP UP OPPOSITION TO FALSE CLAIMS ACT CHANGES**

A host of business, insurance and health care groups delivered twin letters this week to the House Judiciary Committee and the full Senate requesting them to scrap a pair of bills that would expand both the scope of liability and breadth of financial penalties under the embattled False Claims Act.

The House letter was targeted to Judiciary Chair John Conyers (D-MI) and Ranking Republican Lamar Smith (TX), urging them not to report the False Claims Correction Act of 2009 (H.R. 1788) out of committee. Both letters were dated April 21 and included signatures from the American Health Care Association, American Hospital Association, American Insurance Association, Association of American Medical Colleges and the U.S. Chamber of Commerce, among others.

The organizations told lawmakers that the FCCA's clause imposing liability for failure to disclose over-payments even when the failure isn't known was a "radical departure" from the False Claims Act, which only penalizes "knowing" conduct. This addition would "unfairly impose treble damages and penalties on those who act merely negligently," the groups wrote.

This over-payment provision would have an echo effect, wrote the coalition, with False Claims Act litigation injected into many federal procedures that Washington uses to reconcile under- and over-payments.

Also a concern for the AHA, the AHCA and their allies was the bill's boosting of the financial damages. H.R. 1788 would allow third party "administrative beneficiaries" to recover damages in addition to the government's

losses, leading to “windfall recoveries” for the federal government, according to the letter. The bill also would “improperly protect the interest of relators at the expense of the harmed third party, by providing that the relator’s share is paid before amounts are returned to the injured third party,” the groups added.

**Drawing ire as well is the bill’s inclusion of retroactive application**, the constitutionality of which the groups threaten to challenge in the courts for years to come.

“We believe these amendments are unnecessary and will impose enormous burdens on non-profits, universities, hospitals, and small businesses,” the 16 groups wrote, adding that the bill could discourage participation in federal programs or completion for government business.

The Senate letter attacks S. 386, the Fraud Enforcement and Recovery Act of 2009, which also disappoints the groups by including some retroactive language. But the coalition said they were “encouraged” by an amendment to come from Sen. Jon Kyl (R-AZ) that would tweak some FCA language. The amendment would clarify that an actionable “obligation” would not include a requirement to pay penalties or fines, and only imposes liability for knowing and improper “retention” of an overpayment, as opposed to mere “receipt” of an overpayment.

**Both letters make direct reference to last June’s Supreme Court decision *Allison Engine v. U.S.*, which legal observers viewed as a potential undermining of the government’s ability to win false claims suits.** But the letter-writers claim there is “no need for the proposed changes” prescribed in the FCCA and FERA, which they say attempt to do away with *Allison Engine*’s core “intent” requirement.

In *Allison Engine*, the Supreme Court took on the False Claims Act, which has emerged as the primary tool to battle Medicare and Medicaid fraud by subjecting civil penalties to those who knowingly submit false or fraudulent claims for governmental payment. In 2007, the federal government recovered \$2 billion in settlements and judgments in FCA cases — more than 75 percent of which came from health care entities (see *Inside CMS*, June 12).

However, the Supreme Court narrowed the available scope of action by striking down an FCA claim against a defense subcontractor that the justices found did not intend to defraud the government. And so the court ruled that a false claims suit prosecutor has to prove the defendant intended for government itself to pay the false claim, as opposed to a CMS claims processing contractor, for example.

Advocates who proclaimed then the extreme difficulty with most Medicare fraud to prove a company intended for CMS to pay the false claim found support in a November Congressional Research Service (CRS) report that agreed that the *Allison Engine* decision makes it harder to prosecute fraud of both Medicare and Medicaid (see *Inside CMS*, Nov. 27).

In response, the FCCA as introduced by Rep. Howard Berman (D-CA) on March 31 would strengthen the FCA by clarifying that fraud claims for non-taxpayer funds under governmental control are actionable under the law.

Support for strengthening FCA has also come from President Barack Obama, who on April 20 issued a Statement of Administration Policy (SAP) on the FERA, saying the bill “would provide Federal investigators and prosecutors with significant new criminal and civil tools and resources that would assist in holding accountable those who have committed financial fraud.”

The FERA would make sure the FCA “remains a potent and useful weapon against the misuse of taxpayer funds,” the SAP continues. “In general, this legislation would benefit U.S. taxpayers by both addressing existing fraud and deterring waste, fraud, and abuse of public funds. Moreover, S. 386 would provide needed resources to strained law enforcement agencies and prosecutors that would enable the [Justice] Department and its partners to advance the pace and reach of the enforcement response to the current economic crisis. These additional resources will provide a return on investment through additional fines, penalties, restitution, damages, and forfeitures.”

Weeks earlier, Joseph White, president of Taxpayers Against Fraud, told the Judiciary committee that the FCA in its current state was “allowing a ‘finders’ keepers’ regime to flourish when it comes to the overpayment of federal funds,” according to his testimony. “Specifically, the knowing retention of over-payments is a tremendous problem in government health programs and government procurements,” White added during the April 1 hearing.

The legislation “is needed to plug a gaping loophole that is currently draining our public [finances] and undermining the long-term viability of our government health care programs,” White said. — *Seth Freedland*

## GRASSLEY PUSHES FOR ANSWERS ABOUT UNCOLLECTED DME OVERPAYMENTS

Senate Finance ranking Republican Charles Grassley (R-IA) is quizzing CMS on a little-noticed HHS Inspector General memo released last November that revealed \$754 million in overpayments to DME suppliers and other related businesses over a two-year period has gone uncollected.

As Congress looks for funding to pass pending health reform legislation, this money could be useful. Grassley’s inquiry also comes as CMS is focused on implementing an already-delayed competitive bidding program for DME suppliers, and fraud fighters continue to rack up wins against DME company owners in South Florida. A CMS report in December suggested that payments to more than 1,100 DME suppliers in Miami-Dade County, FL, and Los Angeles County, CA, whose billing privileges were revoked totaled \$265 million from the Medicare program in 2006 and 2007.

The November Office of Inspector General report suggested that DME supplier and home health agency owners

have formed intertwining ownership structures and flown under the radar of CMS by falsifying enrollment forms. These business relationships, which allow owners of different companies to co-mingle their funds, may deserve increased CMS oversight, the OIG and Grassley suggest.

Referring to the 17-page “early alert memorandum,” sent to CMS the day before Thanksgiving 2008, Grassley wrote to acting CMS Administrator Charlene Frizzera that the report reveals “tremendous losses to the taxpayer” from “Currently Non Collectible” debt owed to the federal government by home health agencies and DMEPOS suppliers (see *Inside CMS*, Dec. 12, 2008).

Grassley asked Frizzera if potential home health agencies or DME suppliers are required to disclose “any relationship with other companies currently in default to the Medicare program?” He also inquired about CMS policy regarding recoupment of losses after a default and documents about that policy. Finally, the Iowa Republican asked if CMS has any new “enhanced authorities ... to protect the program” from DME abuse.

Grassley points to the “staggering debts of \$352 million and \$402 million which DMEPOS suppliers and other related business owed to the Medicare program in 2005 and 2006.” These monies are overpayments that the DME suppliers are not eligible for that have been written off by the Medicare program as bad debt and turned over to Treasury Department officials for recoupment.

**“My staff has been advised that CMS has no mechanism in place to recover these losses which represent significant costs to the American taxpayer,”** the Iowa senator wrote in the April letter to CMS. Grassley, formerly the chair of the Finance Committee, has long been hawkish on DME fraud fighting.

CMS officials were unable to immediately respond to questions about the CNC policy. Treasury Department officials did not return telephone calls about CNC recoupment efforts.

The OIG memo, sent to CMS Nov. 26, 2008, suggests that DMEPOS suppliers in debt may be able to hide behind “front” businesses operated by “business associates, family members, or other individuals posing as owners” of other companies that bill Medicare, HHS Inspector General Daniel Levinson wrote citing anecdotal information culled from OIG investigators and assistant US Attorneys.

The memo points out the limitations of the investigation and said there is no evidence to suggest these shady business ownership arrangements are prevalent. The Inspector General chose at random 10 DMEPOS suppliers in Texas, each with a Medicare CNC debt of at least \$50,000.

The investigators detected “networks of associated businesses that existed both before and after CMS deemed the sample DMEPOS suppliers’ over payments to be CNC.” Of the 10 DMEPOS suppliers targeted, six were associated with 15 other companies (eight other suppliers and seven home health agencies) that received Medicare payments that totaled \$58 million from 2002-2007, the report indicates.

**Of the 15, 11 filed enrollment applications that did not list the name of at least one owner or manager, a violation of federal regulations, Grassley pointed out in his letter to Frizzera.**

Levinson wrote in November that, “although the associations among DMEPOS suppliers with CNC debt and their associates that received Medicare payments are not, taken alone, sufficient to establish improper or illegal activity, CMS may determine that such associations justify enhanced oversight, e.g., comparison of ownership and management information provided by HHA providers and DME suppliers to information in public records and following up on apparent inconsistencies.”

The report indicates that CMS “deems a Medicare overpayment to be CNC if an overpayment to a DMEPOS Supplier remains uncollected 210 days after the date of the first demand letter despite recovery attempts by CMS contractors.”

Texas, along with South Florida and Los Angeles, has been, apparently, a hot-bed of DME abuse (see *Inside CMS* Sept. 11, 2003). When CMS announced jointly with the OIG the “Operation Wheeler Dealer” program to crack down on wheelchair fraud, the first target was Harris County, TX. Officials said at the time that the “most egregious problems” with fraud centered in the county and pointed to sales of wheelchairs there that jumped from 3,000 in 2001 to more than 31,000 the following year. Many of these chairs were never delivered and other prescriptions were filled without a face-to-face visit between a physician and a patient.

DME fraud in Miami-Dade County, FL has been so rife that it has permanently bumped up the Medicare Advantage benchmark in the county, which rose by 13 percent this year. Medicare Payment Advisory Commission researchers explained that fraud in the county has inflated the fee-for-service spending there by hundreds of millions of dollars. Because FFS spending is used to set the county benchmarks, MA spending in the county will increase by \$150 million to \$200 million more than if the benchmark had been set based on the national growth rate of FFS spending.

The U.S. Attorney for South Florida, Alexander Acosta, told House Ways and Means Health subcommittee Chair Pete Stark (D-CA) in early 2007 that his office had a 97 percent conviction rate and the number of prosecutions is up 30 percent from 2006.

The home health and DME industry have largely welcomed the effort to root out fraud, but have suggested that much of what they do is simply filling prescriptions from doctors that they have no interaction with. However, the groups have strongly lobbied in Washington to delay implementation of the competitive bidding program, which is slated to move forward (see related story). — *Brett Coughlin*

## SCHUMER, ROBERTS ASK CMS TO SCRAP TEACHING HOSPITAL IME CUTS

A push by medical colleges to stave off a planned elimination of Medicare capital indirect medical education (IME) payments worth \$375 million has spurred a pair of Finance Committee members to urge the Obama administration to revisit the policy. Finance members are also zeroing in on a solution to primary care workforce shortages and subsidies for training in non-hospital (ambulatory) settings.

CMS is gearing up to slash the capital IME payments to medical schools Oct. 1, prompting Sens. Chuck Schumer (D-NY) and Pat Roberts (R-KS) to circulate their sign-on letter addressed to acting CMS Administrator Charlene Frizzera asking that the policy be withdrawn from the pending inpatient prospective payment system (IPPS) proposed rule.

A similar letter is circulating in the House. The number six ranking Democrat on the House Ways and Means Committee, Rep. Richard Neal (MA), along with Ohio Republican Rep. Patrick Tiberi, who also sits on the committee, have addressed their letter to President Obama. Staff in Neal's office declined to share how many members have yet to sign onto the letter.

The pending cuts "would result in nearly \$375 million in aggregate annual losses to U.S. teaching hospitals," the senators wrote in the March 31 draft letter that is still circulating. The senators suggested that the capital IME cuts could put some teaching hospitals out of business and noted that these hospitals provide "critical health services" unavailable elsewhere to large numbers of Medicare patients.

The teaching hospitals won a partial reprieve thanks to a provision that Schumer was able to place in the stimulus bill blocking a 50 percent reduction in the capital IME. Schumer and House Ways and Means Committee Chair Charles Rangel (D-NY) have been the industry's top champions in Congress.

More than one quarter of the Senate — 27 members — have signed the letter, including eight lawmakers on the Senate Finance Committee (including Schumer and Roberts). Also signed on are Senate health committee Chair Edward Kennedy (D-MA) and Senate Budget Committee Chair Kent Conrad (D-ND).

**The different recipients of the House and Senate letters may be a result of the fact that a permanent political appointee to head CMS has not yet been named, complicating efforts to lobby the agency for policy changes.**

Association of American Medical School (AAMC) officials tell *Inside CMS* that while they have asked Frizzera to repeal the IME capital cuts, action is likely to await the appointment of a permanent agency chief, the identity of which remains in question (see related story). Many important policy decisions are being delayed by the vacuum of leadership at CMS, various health care lobbyists complain.

CMS initially cut back on the IME capital payments due to concerns that the margins these teaching hospitals made on Medicare payments were high, AAMC officials said. But once you take away the capital payments, the AAMC officials suggested, those margins are flat.

AAMC, the American Osteopathic Association (AOA) and other primary and specialty society also are poised to address a similar issue through stand-alone provider workforce bills that could give Finance Chair Max Baucus (D-MT) numerous policy choices as he crafts a broader health reform bill.

After recent testimony by prominent primary care physicians and researchers about the falling numbers of these physicians, Baucus said he intends to address workforce issues in his bill. It remains to be seen how he would address the IME issue if the Obama administration refuses to budge on the funding. Obama has also not embraced prior recommendations to remove the cost of drugs from the sustainable growth rate update formula.

**Another issue, of major concern for primary care physicians, is the current policy on medical students who are trained in an ambulatory, not hospital, setting.** In 1999, CMS moved from paying essentially all of the costs for students who trained in a physician office, as opposed to a hospital, to paying "substantially all" of the costs (see *Inside CMS*, Sept. 7, 2006).

Primary care specialties have said for years that this is the wrong policy at the wrong time, as the ranks of internists, family physicians and gerontologists shrink. This policy is wrong-headed and counterproductive to the effort to encourage more medical students to go into these specialties, they say.

According to the AAMC the policy has had a "chilling effect on ambulatory training."

**A Finance Committee member has introduced a bill to resolve the situation and address the Medicare policy on ambulatory training.** The bill, introduced by Sen. Jeff Bingaman (D-NM), would create a National Health Work Force Commission and modify Title 7 provisions to provide debt relief for medical students who practice within the National Health Service Corps. It would also provide money to the potential medical school enrollees to prepare for training.

Bingaman introduced the bill April 2 and it follows recommendations by the Council on Graduate Medical Education to focus on primary care. It boosts primary care residency slots and increases pay by 10 percent, focusing on direct (DGME) grants for training of family medicine, general surgery, geriatrics, general internal medicine,

general surgery, and ob/gyn and other “high risk” specialties.

The Health Access and Health Professions Supply Act of 2009 (S 790) would widen enrollment in the still pending Medicare medical home demonstration project and create a “pilot program for 1,000 primary care practices that work in interdisciplinary teams.”

“These clinicians will provide the highest quality medical care using the best health information technology, and personalized, coordinated, and accessible care,” Bingaman states in a written release.

Sen. Maria Cantwell (D-WA), also on Finance, likewise is working on a bill to spur federal grants addressing primary care workforce issues, *Inside CMS* has learned. The issue could be broached in the upcoming health reform legislation. — *Brett Coughlin*

## **PHYSICIAN PAY “PATCH” QUESTIONED . . . begins on page one**

Institute, said he was impressed by the “openness to experimentation” indicated in the delivery system reform proposal. The “different ways to pay providers and bundling payment for services ... is a piece that can really be transformative,” Luft told *Inside CMS*.

**The paper released from Senate Finance Committee has two options for physician payment.** The first would allow a flat 1 percent update for 2010 and 2011, followed by a freeze in payment at those levels in 2012. Then current law would kick back in beginning in 2013 and the clawback methodology of the SGR would call for payment cuts.

The second option is identical except in the out years. In 2014, the second option comes with a negative 3 percent floor and “the fee schedule updates for localities with two-year average fee-for-service growth rates at or greater than 110 percent of the national average” would be hit with a negative 6 percent floor.

A draft sign-on letter from physician groups calls for the SGR to be addressed more broadly. The letter, distributed by the American Medical Association and signed by 40 other medical specialty and group practice organizations, specifically calls for expanded health insurance coverage, but says that policy will not ensure access to care if payment isn’t boosted.

“We believe that the safety net provided by public programs needs to be maintained and strengthened, and that payment levels must be sufficient to cover provider costs.

**“The Medicare physician payment system, in particular, must be fundamentally reformed to eliminate the sustainable growth rate (SGR) formula that has required repeated congressional intervention to prevent steep annual payment cuts.** In addition, Medicare’s current financing structure needs to be revised so that providers in a particular program category can receive appropriate recognition for savings they are able to achieve in a different part of the program.”

Wednesday, Finance senators and staff walked through the policy options, allowing time for members who have not been working on the legislation to ask questions. Senators discussed the options with Congressional Budget Office staff, with whom Baucus has said repeatedly he has been working to hash out ways health reforms could achieve a positive budget score, and Mark Miller, executive director of MedPAC. CBO has signaled a willingness to relax a policy that did not score savings for investments aimed at boosting fraud and waste detection, Baucus said (see related story). Staff said during a background briefing with reporters after the meeting that much of the five to six hour discussion was taken up by explanations of the options. Finance staff also said that while Part D reforms were not included in this proposal, there are options there being considered.

**Value-based purchasing.** The Finance document promotes payment reforms and options to establish value-based payment systems in the hospital, home health and skilled nursing facility industries. These include improvements to the physician quality reporting initiative, transparency and evidence-based decision making for imaging services, and quality reporting for inpatient rehab and long-term acute care facilities. The document also discusses the possibility of provider bonus payments for primary care physicians and general surgeons.

**Chronic disease management.** Better management of chronic disease has been under discussion for some time and the policy options include creation by CMS of a Chronic Care Management Innovation Center that would test and disseminate payment innovations that foster patient center care coordination for the costliest patients.

**Medicare Advantage reforms.** MA reforms suggested by the paper include options to link payment to quality and set benchmarks based on plan bids.

**Delivery system reform tools.** Tools that could enhance the delivery system include increased use of health information technology, comparative effectiveness and greater transparency.

**Physician workforce.** Several options for boosting the physician workforce — including greater flexibility in training programs and redistributing unused graduate medical education slots to increase access to primary care

physicians — are also included.

**Fraud and abuse.** The committee also proposes a more robust effort to combat fraud and abuse. Options include implementing a screening process for Medicare provider and suppliers, creating a data base that would expand data-sharing capabilities across federal agencies and increasing certain penalties.

**The 52-page set of options, other than the physician payment fix, received quick kudos from some stakeholders.**

Chip Kahn, president of the Federation of American Hospitals (FAH), said the options move the nation one day closer to comprehensive health reform becoming a reality, and identify key building blocks that will help develop effective, durable delivery reforms. “The plan laudably includes a critical investment in a quality infrastructure that calls for partnership among consumers, employers, labor, patients, providers and payers (public and private alike); various efforts to promote preventive, primary and coordinated care, and the prospective elimination of self-referral and the conflict of interest which it breeds,” he said.

AARP was pleased with the inclusion of a transitional care benefit. The proposal would provide Medicare reimbursement for physicians who provide care management, including in-person care assessment and management, coaching, education and self-management support. The transitional care benefit also rewards physicians for keeping chronically ill patients from being readmitted after a hospital stay.

“This important policy would help people safely return to their homes after a hospital stay by improving the follow-up care they receive,” said David Sloane, AARP senior vice president of government relations, in an e-mail statement. “That care will not only help keep people healthier, but also reduce hospital readmissions that are driving up the cost of health care.”

The reform options also drew early praise from the National Partnership for Women & Families. Delivery system reform is critical to getting us to where we want to go, which is creating a quality-based affordable health care system for everyone — but we can’t get there without transformational changes, said Debra Ness, president of the group. She called the options a terrific starting point for the conversation on how to reach the shared goal.

The lawmakers’ decision to float “options,” she added, recognizes that there need to be multiple paths in play to reach health reform goals.

She applauded the focus on primary care, chronic care management, prevention and increased ability to address needs of highest risk, most-vulnerable patients who often fall in cracks and cost the most. She also praised the inclusion of alternate payment strategies that would move toward integrated and collaborative care and shared accountability. Plus, she applauded the document’s call to expand incentives for health information technology beyond the physician’s office as well as its focus on performance measures.

Ness echoed the concerns of the physician lobby regarding the lack of reforms aimed at physician payment. “I think what they’ve done is create some room and time to learn about better models but that still looms,” she said, referring to a 21 percent cut in payment to physicians scheduled for January.

All in all, she said she was impressed. “I want to stand up and cheer,” she said. “We’re not all the way there, but this is a great starting point.” — *Inside Health Policy*

## COMMENT REQUEST FOR MENTAL HEALTH PARITY LAW LISTS CMS’ UNKNOWNNS

A request for public comment from CMS, HHS and other governmental entities on last year’s mental health parity law spells out what governmental questions remain in the wake of the bill’s passage, with curiosity remaining on increased cost exemptions and out-of-network coverage.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was enacted in October 2008 and created new requirements to the Mental Health Parity Act of 1996 (MHPA) and added a definition of substance use disorder benefits. The comment request, published in the *Federal Register* on April 27, comes from the departments of Treasury and Labor, as well as HHS, CMS and the IRS.

Those agencies are looking for a better understanding of the costs and benefits, including the expected trouble that would come with record-keeping, reporting and third-party disclosures, according to the request for information.

In the 2008 law, group health plans — and health insurance coverage offered with group health plans — are required to ensure that financial requirements aren’t worse for mental health or substance use disorder benefits than they are for medical and surgical benefits. The treatment limitations, such as number of visits or days of coverage, can’t be different either.

Similarly, if a plan provides medical/surgical benefits provided by out-of-network providers, that plan must also provide mental health/substance abuse benefits. The law does exempt group health plans of employers who manage fewer than 50 employees from the requirements of the group market mental health parity provisions.

Another exemption to requirements of the group market mental health parity provisions eliminates any application of those provisions that result in an increase for the plan year involved of the actual total costs of coverage with

respect to medical/surgical benefits and mental health/substance use benefits by an amount that exceeds 2 percent for the first plan year in which the law applies and 1 percent for each subsequent plan year.

Though a sunset provision in the MHPA 1996 had since been amended, the 2008 law deleted it, leaving its requirements in place.

Comments requested on the economic analysis and paperwork issues are fairly broad. They namely ask for the policies, procedures or practices of group health plans and health insurance issuers that could be impacted, and for any “direct or indirect costs or benefits,” including paperwork burdens.

But the regulatory guidance shines some light on what CMS is still trying to figure out with the act, by asking the public to provide feedback on two terms: “financial requirement” — defined in the statute as including deductibles, copayments, coinsurance and out-of-pocket expenses, but excluding an aggregate lifetime limit and an annual limit — and “treatment limitation,” which curtails frequency of treatment, number of visits and days of coverage. CMS asks if any plans have other definitions, and if plans vary coverage levels within each class of benefits.

Other feedback CMS hopes to gain include what clarifications would be helpful and what information on medical necessity determination criteria made under plans for mental health/substance use benefits is available by the plan. CMS also asks what information on reasons for denial exist and to whom any of this information is made available, and how it’s made available.

The public is also asked how such coverage is the same as or different than out-of-network coverage provided for medical and surgical benefits; what aspects of the increased cost exemption, if any, require additional guidance; and if model notices would be helpful to facilitate disclosure to federal and state agencies, participants and beneficiaries regarding a plan’s or issuer’s election to implement the cost exemption.

Comments can be submitted by going to the federal eRulemaking portal, [regulations.gov](http://regulations.gov). — *Seth Freedland*

## **BLUE DOGS, LEADERSHIP VOW TO USE PAYGO . . . begins on page one**

possibility of a permanent SGR fix as part of health reform (see related story).

A Medicare physician payment solution as part of health care reform legislation would give the Senate flexibility even if there aren’t 60 votes to waive paygo rules, as Congress would then have 11 years to budget in offsets, the source says.

Physicians face a 21 percent cut in their Medicare reimbursement in 2010 if the SGR is not addressed by Congress this session. A tentative agreement announced hours before the final budget resolution was reached touted a two-year SGR fix without an offset, but the congressional aide said that was only on the House side and the Senate at no point agreed to do away with paygo rules for SGR.

A health care lobbyist told *Inside CMS* that the House pushed for a permanent SGR fix with no offset required in the first two years with the possibility of falling back on just a temporary two-year resolution. Senate Budget Chair Kent Conrad (D-ND) said at a conferee meeting April 27 that there remained “a number of outstanding issues” in the House and Senate budget agreement, including parts of paygo rules. Ultimately, the two chambers still differ in their budget requirements for offsetting a Medicare physician payment solution.

A lobbyist representing physicians said the proposal for a permanent fix with no initial offset seems to come down to semantics and it appears Congress “wants the docs to be grateful and keep quiet about anything else.”

The House Blue Dog Coalition, Speaker Nancy Pelosi (D-CA) and Majority Leader Steny Hoyer (D-MD) signaled their support this week for finding a pay-for when addressing the Medicare physician payment issue.

**Blue Dogs introduced on April 27 the Fiscal Honesty and Accountability Act of 2009 (HR 2116) that would establish statutory paygo and “give pay-as-you-go rules full force of law,”** according to a statement from the office of Blue Dog Rep. Henry Cuellar (D-TX). There are likely to be waivers and exceptions to the statutory paygo bill, Cuellar told *Inside CMS*, but the Blue Dogs want to limit that. In order to get Blue Dogs to go along with the budget resolution agreement, the leadership agreed to work with the coalition on statutory paygo, Cuellar said.

“Part of the negotiations was to make sure that the House leadership that the president and the Senate work with us on passing legislation for reinstating statutory pay-as-you-go,” Cuellar said, adding that Blue Dogs acknowledge statutory paygo could present obstacles when passing legislation to increase spending in key areas like health care.

In any case, Cuellar said, “We’ve got to find a way to start bringing down the deficit spending that we have. . . . That’s going to make it difficult for some of the votes we have next time but we just feel very, very strongly that we do have to start working on bringing down the budget deficits which are just tremendous right now.”

Pelosi and Hoyer publicly indicated their support for statutory paygo in a letter to budget conferees in which the House leadership emphasized the need for statutory paygo, as the White House requested. The April 28 letter said the House would attach statutory paygo to any Medicare SGR legislation (as well as to alternative minimum tax, estate tax and middle-class tax cut bills).

While Senate Budget Chair Kent Conrad (D-ND) maintained in the Senate resolution a requirement to follow paygo rules (which also allows waiving the rules) for the Medicare SGR, the budget hawk’s skepticism on statutory

paygo for health care contrasts the House's commitment to it. Conrad's public statements and responses to reporters on April 27 about a Senate agreement to such rules indicated he agrees with statutory paygo in most situations, but felt it's more difficult to require with health care.

Statutory paygo would give control of the baseline of a program in future years to the White House Office of Management and Budget (OMB) instead of the Congressional Budget Office (CBO). But the significant differences in health care baselines between OMB and CBO raise concerns, Conrad said.

**The American Medical Association lashed out against the budget agreement for failing to reach a concrete agreement to fix SGR**, saying the budget doesn't "ensure a long-term solution to the Medicare physician payment problem."

"Continued uncertainty about future Medicare payments will divert attention from important health reform issues, and the role physicians play in successful patient-centered reforms," AMA board Chair Joseph Heyman said in an e-mail statement to *Inside CMS*.

Heyman applauded President Barack Obama's budget and the original budget resolution adopted by the House that "created a pathway to permanent reform of the broken Medicare physician payment update formula."

"The AMA appreciates that the House-Senate conference agreement on the budget resolution apparently makes some allowance for the House to address this issue; however, physicians still face the prospect of steep cuts after that protection ends," Heyman said.

Freezing what physicians call a flawed SGR is estimated to cost \$285 billion over 10 years. The original House budget resolution designated \$87.5 billion over five years and \$285 billion over 10 years to address the physician payment scheme and language in the resolution also exempted the fix from paygo rules. The Senate also included a provision for fixing the SGR, but that budget resolution required budget neutral offsets for the reform (see *Inside CMS*, April 2).

A Washington insider said House leadership pushed hard for entirely rebasing SGR, and the two-year fix without paygo was the compromise. Another health care observer said to be disappointed about the budget resolution agreement is understandable but it's premature to invest too much into its meaning, as the budget resolution isn't binding.

According to the final budget resolution agreement, for any Medicare physician payment legislation in the Senate that would freeze payment at current levels, provide a positive update in payment or reform physician Medicare payment, the Senate must comply with Sec. 301(a) or Sec. 301(b), which require deficit-neutral health care reforms.

**The agreement allows the House to rebase by \$38 billion above the Congressional Budget Office baseline for Medicare spending levels**, treating it as a "current policy adjustment before evaluating the costs of legislation affecting Medicare physician payments for compliance with House budget rules." The House would be allowed to go above the baseline up to \$38 billion to maintain 2009 physician payment rates in effect through 2010, 2011 and part of 2012, but the agreement "does not intend" for the SGR paygo waiver to be "a reflection of future policy."

But the House is only allowed to rebase by \$38 billion using the "current policy baseline" for SGR if statutory paygo is attached to the non-offset bill sent to the Senate or if the House has already sent a statutory paygo bill to the Senate, according to the letter to budget conferees from Pelosi and Hoyer. For it to pass through the Senate, paygo rules would have to be followed or that chamber would need 60 votes to waive the rules, otherwise it's "back to the drawing board," the congressional aide said.

Pelosi and Hoyer said in the letter that the House will not consider conference reports, any SGR bill or a report from the Senate if it doesn't also incorporate statutory paygo, unless "the bills are fully offset under traditional scorekeeping, or statutory paygo has already been enacted into law." — *Ashley Richards*

## **CMS AGAIN OPENS DECISION ON CAROTID-STENTING PROCEDURES COVERAGE**

After issuing a pair of rejections over the last two years, CMS has decided to take a third crack at potentially expanding coverage of carotid artery stenting, announcing that new published evidence may be enough to change the agency's mind.

In October 2008, CMS drew ire of advocates by declined to allow coverage of the carotid stenting for a wider range of high-risk patients two weeks before the planned decision date. Advocates entreated CMS to not announce its decision early in order to allow the results of cardiology journal studies to be published.

In the decision, CMS wrote that it was aware of the data still pending publication but didn't believe it would be enough to have an impact on the decision.

Now, based on an internally generated request, CMS will reconsider for a third time its national coverage determination (NCD) for percutaneous transluminal angioplasty (PTA) of the carotid artery concurrent with stenting, factoring in those and other studies. The first rejection came in May 2007.

According to the tracking sheet posted to CMS' Web site on March 18, "New data have recently been published that examine outcomes in patients for whom coverage is currently limited to participation in clinical trials and

postapproval studies.”

Specifically, the agency will be examining if coverage should be expanded to beneficiaries who are at high risk for carotid endarterectomy (CEA) due to anatomic risk factors with asymptomatic carotid stenting of at least 80 percent. Under the current policy, patients at high risk for CEA who have symptomatic carotid artery stenosis of at least 70 percent are covered. CMS also currently covers carotid stenting in patients with high risk for CEA with lesser degrees of symptomatic stenosis — from 50 percent to 70 percent — and patients at high risk for CEA with asymptomatic stenosis.

Cardiologists saluted CMS’ re-opening of the coverage determination, praising new data from two-post market studies published in March in *Circulation: Cardiovascular Interventions* as critical information to win the wider coverage. This Medicare expansion would provide new treatment options for a larger group of patients who are at real risk for stroke, according to the Society for Cardiovascular Angiography and Interventions (SCAI).

The data shows CMS has met or surpassed all of the American Health Association’s 30-day death and stroke rates for carotid endarterectomies in high-surgical-risk patients, said William Gray, director of Endovascular Services at the Center for Interventional Vascular Therapy, New York-Presbyterian Hospital and Columbia University. The studies represent the largest prospective data set for any carotid-specific therapy ever, Gray added.

The two *Circulation* studies prove what was found in that October 2008 survey that CMS wouldn’t wait for, say SCAI leaders. That survey, known as the Stenting and Angioplasty with Protection of Patients with High Risk for Endarterectomy (SAPPHIRE) trial, was published in *Catheterization and Cardiovascular Interventions* and found that 30 days after treatment, high-surgical-risk patients who received CAS had similar results to patients who received surgery.

“These studies demonstrate that CAS should be considered an appropriate option to treat patients with carotid stenosis and increased surgical risks,” said SCAI President-elect Steven Bailey. “We applaud the CMS for revisiting its decision on expanding coverage of CAS, and we hope CMS will agree that patients and physicians should have a wider range of treatment options to best suit each patient’s specific condition.”

SCAI was one of four groups to request the second decision in December 2007, along with the American College of Cardiology, the Society of Vascular and Interventional Neurology and the Society for Vascular Medicine.

Public comment will be accepted until April 17, with the proposed decision memo expected for Sept. 18. Final completion of the analysis is slated for Dec. 17. — *Seth Freedland*

## **ENZI CHALLENGES KENNEDY ON PROCESS . . . begins on page one**

who helped to craft the state’s reform policies.

“The best way for the federal government to be involved is to respect the starting point of each individual state,” echoed Utah Speaker of the House David Clark (R). Clark challenged the federal government “to take no action that would further reduce the ability of states to develop creative solutions by reducing health care spending and expanding coverage.”

He added, “The willingness of states to experiment should be encouraged and their ability enhanced by allowing reasonable exemptions, or waivers, to some of the federal laws or regulations that constrain innovations right now.” The “invisible hand of the market place, rather than the heavy hand of the government, is the effective means whereby reforms should take place,” said Clark.

The health committee’s ranking Republican, Sen. Michael Enzi (R-WY), said during his opening remarks that the state’s are “mini labs” that find successes, and failures, and it is “crucial to hear from people across the country about state reforms.” He said the hearing wouldn’t follow the normal Washington protocol “where the Chairman invites four people and I invite one, then both sides show up to beat up on everybody.”

Instead, Enzi said, “this is actually about what you know: What you did, how you did it, what the effect was.”

**One state, Vermont, said its wellness initiative bumps up against CMS rules.** The Vermont legislature passed bills allowing insurance carriers in the state to offer monetary incentives in their different products for people who adhere to wellness initiatives, according to Susan Besio, director of Vermont Health Access, Human Services Agency.

The state has allowed for the creation of integrated medical home pilots that reward providers and patients for ordering or adhering to evidence-based protocols. Health information technology that cuts down on duplicative tests is heavily subsidized, and the state legislature is debating legislation that would allow pilot testing of accountable care organizations in different areas of the state, Besio told the panel.

“But Medicare is not at the table. We cannot get Medicare at the table. So we’ve got Medicaid and our three primary insurers all agreeing to provide the same monetary incentive to providers for evidence-based care, all paying for these community care teams and ... so, in the future, if those show that they are cost effective” Vermont can take the taxpayer savings, invest it and expand the policies statewide, she said.

“But we can’t afford to do it without Medicare’s involvement,” Besio said. She criticized the “rigid” rules for

demonstration projects at the agency and “their approaches to states” (see *Inside CMS*, Dec. 11, 2008)

“We can’t get their involvement because we need to enroll in a ‘singular Medicare demonstration project.’ Which makes no sense when you’re at a provider level trying to manage care for your entire patient panel,” she said.

**Utah’s Intermountain Health Care study adds weight to ACOs, leaders there said.** Intermountain Health Care’s Brent James said the health system has recently completed a study that will be published soon in a major medical journal with findings that suggest that 50 percent of the health care delivered in the country is “technically waste.”

“I think that is where the real solution lies,” said James, who is a retired clinical oncologist. Incentives for value-based care, Accountable Care Organizations — which all seven panelists agreed was a good solid policy that should be pursued — and eliminating waste were all policies James supported.

**Massachusetts’ Connector shows that the individual mandate is expensive,** said Jon Kingsdale, the executive director of Commonwealth of Massachusetts’ Health Insurance Connector. He said that the state had in place adjusted community rating, guaranteed issue, guaranteed renewal, along with four other states, prior to institution of the health connector. This ended up “shrinking the market” and older sicker people were forced to purchase expensive insurance products, Kingsdale added.

Now, with the connector, nearly everyone in the state (except for 7.6 percent of adults and 2.6 percent of children) are insured, but the costs of health care continue to rise.

“The thing about the individual mandate is it’s expensive; it’s definitely expensive, because you’re trying to get everyone insured, that’s expensive,” Kingsdale said. “You have to subsidize people with a lower income. But it does create what an underwriter or an actuary calls a statewide credible risk pool” including the young and healthy, driving down premiums, he explained, meaning patients are feeling some relief, but the costs of individual treatments and procedures remain largely unchanged.

“We have more than doubled the size of our non group market in just the first year of reform, so it’s expensive ... but that’s the challenge of getting universal coverage,” he said.

He suggested that the connector has not “exacerbated the cost issues” but “everybody now recognizes in Massachusetts that near universal coverage is simply not sustainable financially unless we do address health care costs.”

“We took on access with a nod toward cost containment, but the real battle on cost has yet to be fought in Massachusetts,” he said, adding: “There is clearly a major piece still to be dealt with.”

Then Kingsdale explained the stance of many on the left who believe that covering everyone is simply the right thing to do. “I think we confront that issue from the moral high ground. The moral commitment to access,” he said.

**Enzi said that universal coverage is simply not sustainable financially unless we can control costs.** Sen. Bernie Sanders (I-VT) said that the policy he hears about repeatedly when he talks to doctors and other providers is single-payer, which would cut costs by eliminating the double-digit administrative costs of private insurers, cut down on red tape for health care workers and control costs, which he dubbed “the theme of the hour.” — *Brett Coughlin*

## SENATE FINANCE, HEALTH GOP LEADERS IRKED BY RECONCILIATION MEASURE

The ranking members of the Senate Finance and health committees called it “disappointing and alarming” that Democratic leaders in Congress and the White House agreed to support reconciliation as an option for moving health reform should a bipartisanship approach fail by Oct. 15. Senate Budget Committee Chair Kent Conrad (D-ND) confirmed on Monday (April 27) that it was due to pressure from the administration and Democratic leaders that budget resolution conferees decided to put reconciliation language in their final budget deal.

The GOP lawmakers, who have been working with Democrats to craft reform legislation, said it would be an “injustice” if the bipartisan efforts of the Democratic committee chairs were undercut by congressional leaders and White House strategists. “We hope that any plans for using budget reconciliation to jam a partisan health care bill are scrapped in favor of a bipartisan approach that serves Americans for decades to come,” they said in a joint press release.

Conrad, however, said he did not think that the fast-track process would be needed. “I don’t believe health care reform will be written using reconciliation,” he emphasized repeatedly during the House and Senate budget conferee meeting. “I believe health care reform will be done under regular order and we have until Oct. 15 to do so.”

“It’s there as an insurance policy,” Conrad added, prompting Budget Committee ranking Republican Sen. Judd Gregg (NH) to respond: “A gun would be more accurate than an insurance policy.”

Conrad also told reporters following an open meeting on the budget that he has consistently opposed use of reconciliation for health care reform legislation. However, “when you’ve got the president of the United States, the majority leader and the speaker all wanting it, at some point it becomes clear. The changes that we got that I think are significant are an Oct. 15 date, which gives more time to do it in regular order. But more than that one reason I believe health care will not be done in reconciliation is I think, as we’ve debated this and discussed, it’s become more

clear to people that it just doesn't work well for health care. Now, it could it be at the end of the day there's just no cooperation and so you have to resort to it, yeah."

Senate HELP Committee ranking top member Sen. Mike Enzi (WY) and Finance Committee ranking GOP member Sen. Charles Grassley (IA), like Conrad and Gregg, are members of the so-called "board of directors," a group of bipartisan senators on the committees of jurisdiction who have been meeting regularly to discuss health care reform legislation. They stated in a joint press release: "The negotiations are in good faith, and there's a lot of hope that they will succeed."

"That's why it's very disappointing and even alarming to hear about a wedge potentially being driven into that productive effort by Democratic leaders in Congress and the White House. Cutting off Senate debate and deliberation with the budget reconciliation procedure would shortchange legislation with enormous impact," they add.

Enzi also did not shy from challenging health committee Chair Edward Kennedy (D-MA) on budget reconciliation during a health reform roundtable the panel held Tuesday (see related story). Enzi said reconciliation would "cut off most avenues for real debate in the Senate and is intended as a tool to reduce the deficit." If the leadership does try and "jam the health care reform through the Senate, they would be sending a clear signal that they are not interested in a truly bipartisan effort. I hope that's not true," he said.

Kennedy, added, "I'll let that comment, that you aimed at the Democrats, go by. It's very early in the game." The committee chair recounted his committee's focus on health legislation, including Medicare, Medicaid and CHIP. "We know now that we have important work to do and we are very, very hopeful that our committee will be able to deal effectively in these areas as we have in some of the others," Kennedy said.

In a written statement, the ailing senator said that health reform "continues to be the cause of my life. It is my number one priority in the United States Senate. So many on this committee and around the country are working tirelessly to reach our goal. And this time we will not fail." — *Inside Health Policy*.

## **HARKIN CITES REID SUPPORT . . . begins on page one**

honored, and committee ratios remain as they are today — Specter would be handed the Appropriations health subcommittee, currently chaired by Sen. Tom Harkin (D-IA).

But asked to respond to the possibility of Specter taking on that critical panel, Harkin spokeswoman Kate Cyrul flatly dismissed the very idea, telling *Inside CMS* that there have been "no discussions with Senator Harkin about this prospect."

**Harkin "has a long history with the Labor-HHS Appropriations subcommittee and plans to maintain his chairmanship as long as congressional Democrats maintain their majority in the U.S. Senate," Cyrul said.**

Senate Majority Leader Harry Reid has reportedly backed Harkin, who told *Dow Jones* that Reid "assured me that nothing's changed and I will continue to maintain my chairmanship," according to the newswire. Specter in speaking to the press on Tuesday, however, said that the Labor/HHS panel issue isn't "worked out yet."

The Appropriations chairmanship is also within Specter's reach, pending decisions from two senior senators. If Appropriations Chair Daniel Inouye (D-HI), who will be 86 years old after the next election, chooses to give up that gavel, Sen. Patrick Leahy (D-VT) would be next in line. Leahy would then choose between the Appropriations chair and his current chairmanship of the Judiciary Committee, giving Specter the other, a health care lobbyist tells *Inside CMS*.

**Term limits self-imposed by the GOP will force Finance Ranking Republican Charles Grassley (IA) out of that role at the end of this Congress, but the domino effect of Specter could move up that timeline** — a leadership transition that could remove Grassley from his famously good relationship with Finance Chair Max Baucus (D-MT) as the committee works on health care reform.

With Specter out as the Republican's ranking member on Judiciary, attention would normally turn to Sen. Orrin Hatch (R-UT) but because of those Republican conference rules — which stipulate that after a senator serves six years as chair of a committee, he can't serve as ranking member of that same committee — Hatch is not an option. Next in line would be Grassley.

This gives the Iowa Republican a tough call: Either he can stay the senior Republican on Finance, which carries great power this year with the health reforms on deck but is a role he will lose at the end of 2010 — or he could take the top GOP spot on Judiciary. Grassley's office did not return a request for comment.

Coincidentally, Hatch currently serves as the senior Republican on Finance, allowing for the possibility of Grassley stepping down as Finance ranking member early and swapping with Hatch to take over as ranking Republican on Judiciary. This outcome shouldn't throw too big a wrench in reform efforts, as Hatch is seen as supportive of the reform push, said a health policy analyst. "Hatch is no Enzi," the analyst said, referring to Finance Republican Michael Enzi (WY). "I think his vote can be had."

But the dominoes won't fall too soon, the analyst added: "This is going to take at least a couple weeks for them

to figure all this out,” he added, referring to the political process.

**Grassley has stated an affection for the Judiciary job**, as he mentioned in an interview with *CQ* before the Specter switch. Knowing the GOP term limits will disallow him to continue as Finance ranking Republican, Grassley said just last week he would allow Specter to keep the Judiciary spot. At the time, it seemed most likely that Grassley would succeed retiring Sen. Judd Gregg (R-NH) as top Republican on the Budget committee.

“From my heart, I’d rather have Judiciary than Budget. But out of respect for Specter, I might take Budget,” Grassley told *CQ* then.

The after-effects don’t end there, of course. Specter will outrank every Democrat on the Veterans’ Affairs Committee, including Chairman Daniel Akaka (D-HI).

**Unless the Senate adopts a new organizing resolution, Specter’s committee seats — which also include roles on Environment & Public Works and Special Aging — will not be changed before the new Congress.** So Specter will caucus with the Democrats but will occupy Republican seats.

In response to the Democrats’ likely 60th vote — assuming Al Franken (D) is seated once former Sen. Norm Coleman (R) ceases his legal efforts — Reid only issued a modest statement, calling Specter a “man of honor and integrity, and a fine public servant.” Specter has said he will continue to promote funding for medical research and the National Institutes of Health as a Democrat.

The two men “have had a long dialogue about his place in an evolving Republican Party,” Reid said. “We have not always agreed on every issue, but Senator Specter has shown a willingness to work in a bipartisan manner, put people over party, and do what is right for Pennsylvanians and all Americans. I welcome Senator Specter and his moderate voice to our diverse caucus, and to continuing our open and honest debate about the best way to make life better for the American people.”

A well-placed insider tells *Inside CMS* that reaching middle ground on the Employee Free Choice Act will be a significant product of Specter’s party switch and spoke of negotiations between key lawmakers, including Sen. Bob Casey (D-PA) and Pennsylvania Gov. Edward Rendell (D), to make the transition.

Sen. John Cornyn (R-TX), chairman of the National Republican Senatorial Committee, described Specter’s decision as “the height of political self-preservation” in light of polling data in the lead-up to the 2010 election.

“While this presents a short-term disappointment, voters next year will have a clear choice to cast their ballots for a potentially unbridled Democrat super-majority versus the system of checks-and-balances that Americans deserve,” Cornyn said. According to Senate leaders’ statements after the news broke, Specter’s party switch landed him a clear Democratic primary in Pennsylvania, though some Democrats including Rep. Joe Sestak (PA) said they weren’t so sure. President Barack Obama has pledged his support to Specter.

GOP Chairman Michael Steele body-slammed Specter as a “craven politician,” compared him to Benedict Arnold and called the Democrats’ proposals an “Obama-Pelosi-Specter agenda.”

“Facing defeat in Pennsylvania’s 2010 Republican primary due to his left-wing voting record, and an end to his 30 year career in the U.S. Senate, he has peddled his services — and his vote — to the leftist Obama Democrats who aim to remake America with their leftist plan,” Steele said.

Conversely, the addition of Specter to the Democratic caucus delighted Sen. Robert Byrd (D-WV), who said that it would give the majority “not only a numerical boost, but also an intellectual shot in the arm.” — *Seth Freedland*

## **SPECIALTY, PRIMARY CARE DEBATE RESURFACES WITH MEMBERS’ LETTER**

A letter circulated by two House members seeking support to block cuts to specialty physicians’ Medicare reimbursement as a way to bump up primary care doctors’ pay has highlighted the ongoing tug-of-war between medical specialties and primary care. Emphasizing their continued cooperation to achieve health care reform, stakeholders are treading carefully on both sides of the issue and insist they’re not trying to fuel a turf war over Medicare Part B physician payments.

Rep. Shelley Berkley (D-NV), a member of the Ways and Means health subcommittee, and Rep. Mark Kirk (R-IL), a member of the Appropriations Committee, sent a dear colleague letter asking other members to back a letter to House Speaker Nancy Pelosi (D-CA) and Minority Leader John Boehner (R-OH) to protect specialty physicians’ Medicare reimbursement.

While the draft letter hasn’t been sent to Pelosi and Boehner, the American Association of Family Physicians (AAFP) is already on the defensive, telling *Inside CMS* it is “far too premature to disregard any option” to pay for additional Medicare payment for primary care physicians. Broad recognition that primary care is “undervalued” makes it important to keep every option open for reforming primary care payment, the AAFP official said.

But at the same time the AAFP official said: “The notion that this should be balanced on the backs of the subspecialties is not one we support.” Support for boosting primary care is only fragmented when there is concern that physicians payment reform must be budget neutral only within Part B, the official said.

Primary care physician associations have suggested reforming the budget neutral calculation to improve primary

care payment without cutting into specialties. The proposal suggests using savings primary care doctors say they can achieve in other parts of Medicare, such as within Part A by reducing hospital admissions that could be handled by a primary doctor.

**Kirk told *Inside CMS* that he and Berkley “feel that the voice of the specialty physicians is not strong enough yet, hence the letter.”**

“Obviously older Americans need doctors most,” Kirk said. “They have the most chronic and long-term issues for obvious reasons, so we want to make sure they’re protected because they have little place to go but Medicare.”

Asked about primary care, Kirk said, “I’m for it,” but specialty care should be protected as well. The letter, which Kirk expects to receive much more support now that Congress has returned from recess, is intended to demonstrate there is bipartisan backing for finding a fix to the sustainable growth rate and protecting specialty and primary care, Kirk said.

An aide to Berkley told *Inside CMS* her office is trying to “find a way to satisfy both needs” and cutting specialty physician payments to bolster primary care would harm beneficiaries in need of those services. Berkley’s husband, Lawrence Lehrner, is a specialty doctor, practicing as a nephrologist in Las Vegas, according to the congresswoman’s personal biography.

The Berkley aide said the letter, which calls on the House leadership to stop the upcoming 21 percent physician payment cut as well as reform the payment system to provide access to primary and specialty doctors, doesn’t pit primary doctors against specialty doctors. Instead, the aide said, it indicates the House members are trying to “find ways to get around that requirement to offset” payment reform.

A lobbyist for physician interests said a new budget neutral calculation would satisfy Congress’ desire for a win-win situation, but the lobbyist was skeptical it would pan out. Renewed talk about the six “bucket” system, proposed in the 2007 Children’s Health and Medicare Protection Act (CHAMP) that passed the House, indicates some support for allowing primary care to grow at its own rate while letting other practice areas “take the brunt of the cuts,” the physician lobbyist told *Inside CMS*.

Neurological surgeons are among those working with Berkley and Kirk on the issue. An official representing surgical groups said the surgical medical sector supports improving primary care, but is “absolutely opposed” to doing that “in a budget neutral manner within the physician payment pool of dollars.”

“There may be other places to look for extra financing, but we are not specifying how this is done,” the surgeons representative said about the specialty’s work with Congress on the payment reform. — *Ashley Richards*

## **BAUCUS CITES NEW FLEXIBILITY FOR CMS AS PART OF HEALTH REFORMS**

Senate Finance Committee Chair Max Baucus (D-MT) recently said that CMS will have to be retooled and given new authority to nimbly adapt to health reform changes. “We’re going to have to, probably have to, breathe new life into CMS ... they’re not that great at design and we have to give them more flexibility, more power. We have to make it more exciting to work at CMS, frankly,” he told reporters April 24.

Asked by *Inside CMS* whether the Congressional Budget Office is relaxing its rule not to allow dynamic scoring — the idea that savings could be scored for policies such as coordination of care and comparative effectiveness in the face of convincing data — Baucus said it is an ongoing process.

“It’s hard to get numbers on that” but a number of groups, including Geisinger Health System, Intermountain Healthcare and Kaiser Permanente, have focused on quality care that improves outcomes and seem to have some data to quantify that effort, he said.

“Every group that’s pursued this, finds that result. So our job is to transfer that” to Medicare, he said.

Baucus said CBO is “relaxing its rules” about scoring savings from efforts to fight fraud, waste and abuse apparently recognizing the very high return on investment the Justice Department and the HHS Office of Inspector General see when investigators discover and successfully prosecute fraud or detect waste or abuse.

The HHS Office of Inspector General has seen a return on investment (ROI) of \$117 for every \$1 spent on OIG audits, evaluations, investigations and other activities. The Medicare Integrity Program had an ROI of \$37 for every dollar spent on the Medicare Secondary Payer program (see *Inside CMS*, Dec. 1).

“We’re pushing on scoring,” he said. “As I say to CBO, the lack of information is a double-edged sword. Lack of experience is a double-edged sword.”

**Another “hot-button” issue is a public plan option, which drew questions from the health press after he suggested the policy may not be a focus right now.**

“Some people will say ‘Take the public option off the table!’ Uh, uh,” Baucus said. “The public option is on the table. Now the public option may be on the side of the table, but it’s still on the table.”

Pressed by a reporter from *The Hill* about more details, he said: “We will get into it a little bit, but we don’t have to decide it yet.” Baucus said the public plan option will be taken up after the next roundtable discussion that focuses

on coverage. Baucus said he has intervened with groups lobbying for and against the public option and persuaded them to “cool it.”

But he kept returning to the issue that is facing them to re-tool the fragmented fee-for-service Medicare program through delivery system reforms. “Delivery system reform is huge,” and practice patterns that drive volume should be replaced with evidence-based treatment regimens, Baucus said.

“So the idea is that we focus on quality, comparative effectiveness, health IT and more transparency. So people will know where the quality is and where the waste is,” he said.

Baucus asked the stakeholders involved in the process — and they are a diverse group, often at odds — to “keep their powder dry” and “suspend judgment” even if it’s only for a “nanosecond.”

“Your initial reaction might be modified or ameliorated by something else you see here,” he said.

A major reform he talked about would create a health exchange to increase the size of risk pools and boost the numbers of the insured. “We’ll set up a system similar to Massachusetts where the individual looking for health insurance can go to the exchange and get health insurance similar to FEHBP ... we’ll make sure there are good benefits and it’s affordable,” he said.

He said the Massachusetts “Connector” has gone over budget because the health exchange did not come with delivery system reforms, which his plan will have. “I think that is, in part, because they didn’t attempt delivery system reform; they really couldn’t. They’re one state. Too small,” he said.

The system Baucus envisions would include self-insured companies, ERISA companies, that keep their own plans and continue to manage health insurance. He said he doesn’t plan to change the way self-insured companies organize their health care products.

He stressed that patients, at the end of the process, will be able to keep their current plan

The plain-spoken Montanan said that when he ran into now Secretary of State Hillary Clinton a few months ago, he asked her why the 1994 attempt at reform failed and she told him it was because the committees of jurisdiction failed to cooperate. He said he has “bent over backwards” to make sure that doesn’t happen this year. — *Brett Coughlin*

## CMS EXPANDS MEDICARE COVERAGE FOR PET SCANS, DELIGHTING INDUSTRY

CMS this week issued a long-awaited final national coverage determination (NCD) on positron emission tomography (PET) for beneficiaries treated for tumor cancers, concluding that the scans are “reasonable and necessary” for initial treatment. The decision to cover PET coverage for the majority of cancer patients spawned praise from industry societies like the American College of Radiology, which called the move a “victory for seniors.”

Medicare coverage of PET since 2005 has been tied to a mandate that providers collect clinical data about how the scans affect doctors’ treatment decisions. That information was collected via the National Oncologic PET Registry (NOPR). But with this week’s decision, the clinical study is no longer required when the PET scan is used to support initial treatment or diagnosis of most solid tumor cancers.

In addition to initial diagnosis and treatment scans, CMS will also allow expanded coverage of PET scans for follow-up testing for those with cervical cancer, ovarian cancer or myeloma. For these cancers, NOPR data collection will no longer be required, CMS said.

“Expanded CMS coverage for PET is a tremendous step forward for cancer care in this country,” said James Thrall, chair of the ACR Board of Chancellors. “The NOPR is a shining example of how the medical community can interact with government on research that can ultimately save and extend patients’ lives.” The ACR co-manages the NOPR along with the American College of Radiology Imaging Network (ACRIN).

**CMS’ decision will allow Medicare patients access to at least one baseline PET scan for an initial treatment strategy evaluation.** This new coverage stemmed from data generated as a result of CMS’ 2005 move to require NOPR reporting for most cancer PET scans. This decision is the first time that CMS has reconsidered its 2005 coverage policy due to evidence developed from the Coverage with Evidence Development (CED) program, CMS said.

CMS’ CED program lets the agency develop evidence about how a certain medical technology is used in clinical practice so that the agency can consider future changes in coverage and make recommendations to patients on the technology.

CMS considered published studies that accumulated data from more than 41,000 NOPR cases and found that results of PET scans led physicians to change their original cancer management plans in 36 percent of patients. And in about three quarters of cases in which a biopsy was the initial pre-PET recommendation, the biopsy procedure was ultimately avoided as a result of PET scanning, according to an April 2008 study.

PET — a test that uses a radioactive chemical to depict the function of cells to indicate healthy tissue and diseased tissue — will only serve to more accurately guide and track a patient’s treatment, said Ilyse Schuman, managing director of the Medical Imaging & Technology Alliance (MITA). This week’s announcement has to be seen

as a “major step forward in the war on cancer,” added Schuman.

“PET scans have revolutionized the diagnosis and treatment of cancer,” Schuman said. “CMS’ decision to expand PET coverage for many cancer indications gives oncologists 20/20 vision when deciding on the proper treatment for their patients.”

**In 2004, a group of 37 senators of both parties signed a letter that called PET “an incredibly powerful tool” and called on CMS to remove the scans’ non-coverage status** and dismiss the need for more research. With such political headwinds, NOPR leaders told *Inside CMS* late last year that they were confident CMS would ultimately reconsider the NCD. Back then one of the biggest concerns was that pressure might come from insurance companies that had worried that patients would ask for the expensive scans when they weren’t medically necessary. But CMS took solace in NOPR findings that showed an increase in utilization of 10 percent of the Medicare population, which it said was not significant enough to keep coverage curtailed.

**The use of evidence to make the decision delighted advocates.** “Our organization supports all evidence-based medicine and believes PET scans are a proven method for ovarian cancer patients when it comes to treating women who need restaging and or monitoring for recurrence or response to treatment,” said Cara Tenenbaum, senior policy director of the Ovarian Cancer National Alliance. — *Seth Freedland*

## COMMUNITY PHARMACISTS PUSH FOR E-PRESCRIBING, ENHANCED CARE ROLE

Pharmacies are not yet fully integrated cogs in the health care system and any reform proposal should provide the infrastructure and financial incentives to connect pharmacists into that wider effort, the National Community Pharmacists Association are telling lawmakers in a detailed list of policy recommendations.

To become better incorporated into the health care system, the association this month sent a mass e-mail to lawmakers urging them to include a method for pharmacy information in personal health records, which would allow pharmacists access to electronic medical records. This development, the NCPA wrote, would allow pharmacists to use patient diagnoses as well as other information to better aid patients.

E-prescribing would improve medication compliance through easier prescription refills, helping prevent more than two million adverse drug events, the group wrote. In noting recent Part D efforts to facilitate adoption of e-prescribing, the NCPA wrote that, though doctors don’t pay transaction charges to send e-prescriptions to pharmacies, the pharmacies pay charges to receive them and to send that prescription to a pharmacy benefit manager (PBM) or plan for payment.

Lawmakers should create a temporary incentive program for independent community pharmacists who can’t afford the charges to defray the transaction costs to get Part D e-prescriptions, the association wrote. Only about half of independents can receive e-prescriptions, they said.

**Another recommendation from the NCPA asks Congress to incorporate educational services that focus on how patients manage their drugs into all treatment approaches.** Despite prescriptions’ critical role in the treatment of chronic disease, they improve health only with appropriate patient use. Pharmacists have long supported medication therapy management (MTM) services and education to improve outcomes, reduce hospitalizations and save money. These management services should be part of “any standard health care benefit package” as well as incorporated into the medical home model, the group wrote.

The NCPA would also like the quality measures developed by the Pharmacy Quality Alliance, created by CMS in 2006, to be incorporated into the MTM programs. The measures could also be used by health insurance plans and other payers to differentiate among pharmacies based on outcomes. The NCPA also floated the idea of paying pharmacies differently based on the data.

**NCPA’s focus on maximizing clinical skills, especially with chronic care, pleases Claudia Schlosberg, policy and advocacy director for the American Society of Consultant Pharmacists (ASCP).** Pharmacists have needed expertise that CMS currently does not fully respect, Schlosberg said.

“It’s critically important that folks who are writing health care reform legislation understand the role that medications play and the need for appropriate medication therapy,” Schlosberg said. “With pharmacists, the biggest problem is we don’t value their high level of clinical skills. We only pay pharmacists to dispense pills and the more you dispense the more you get paid. The anomaly there is feeding into the misuse or mismanagement of medication.”

Because of a fragmented system with multiple prescribers, a systematic response to the \$177.4 billion spent every year on complications due to adverse drug reactions couldn’t be more needed today, Schlosberg said. With much of that attributable to those over 65 years old, what’s needed is to “focus on the high cost and utilization of services of those with chronic illness — that’s something we really need to get a handle on.”

According to the NCPA, for every dollar spent on prescription medications, at least one dollar is also spent to

treat mostly-preventable adverse drug events from prescription drugs.

Other requests mirrored those from other professional societies, such as a demand to reform the Medicaid payment system for multiple source drugs. With average generic drug costs — about \$25 — weighing in at one-fifth of brand-name drugs, attention must be paid to how generics are paid for, the NCPA wrote to Congress.

**Implementation of the Average Manufacturer's Price (AMP)-based system for Medicaid generic drug reimbursement — under legislative moratorium until October, in addition to a court injunction — would kill retail pharmacies**, according to the society. So the group backs changes to the methodology to assure that only prices paid by retail pharmacies are included in the calculation of AMP; that the Federal Upper Limits for generics are set at 300 percent of the weighted average AMP; and that “AMPs are not made public so that the market place is not distorted by reporting of inaccurate or misunderstood AMP data,” the group wrote.

Long a source of ire for pharmacists are the PBMs, which NCPA wrote have “no consistent regulatory structure or oversight.” Reform legislation needs to create a mechanism to federally regulate the PBMs and allow for greater transparency of financial relationships, according to the pharmacists. — *Seth Freedland*

## **MEDPAC: SELF-REFERRERS' INCREASED IMAGING HAS NO LONG-TERM SAVINGS**

Congress' Medicare payment commission has found that physician self-referral of diagnostic imaging leads to increased use of imaging in an episode, which in turn has not led to downstream savings but instead has resulted in higher overall episode costs — a break from earlier studies. The findings led commissioners to reassert calls for the issue to be addressed both in congressional health care reform legislation as well as in reforms to CMS' fragmented physician payment system.

The findings, included in a study released at the Medicare Payment Advisory Commission's April meeting, directly answer questions that Commission Chair Glenn Hackbarth has been asked during congressional hearings about self-referral. “People have claimed, well, yes, we're doing more of this, but it's reducing total episode cost and so don't worry about it,” Hackbarth said during the April 8 meeting, “(So) I would point out that the work here is very relevant.”

That self-referral leads to more imaging is not in doubt, according to MedPAC researchers. Noting that the volume of imaging services per beneficiary has grown faster than other physician services — between 2002 and 2007, cumulative growth of imaging was 44 percent against 23 percent for all physician services, MedPAC staff used migraine episodes as an example of diagnostic imaging to drive the point home. Fourteen percent of migraine episodes with a self-referring physician resulted in an MRI, as opposed to only 9 percent of migraine episodes without a self-referring physician who had an MRI.

“The general point is that we have several studies over a period of 20 years,” said MedPAC researcher Jeff Stensland. “The studies used different data sets, some from private insurers and some from Medicare. They used different methodologies and different definitions of self-referral. But the results from these various studies are all consistent with what we are representing today: Self-referral is associated with more imaging.”

MedPAC's focus confronted previous literature that found imaging in specific circumstances prevents surgeries and reduces hospital costs, leading some to wonder if this trend translates into broader savings for the entire episode of care. There has been some evidence that imaging can prevent surgeries and reduce hospital costs, through CT scans that detect appendicitis or acute stroke. This would mean increased imaging — and thus increased imaging spending — would have lower total costs, with broader savings for an entire episode.

**And yet MedPAC's results found that more imaging is directly associated with greater use of all services during an episode, with imaging spending leading to more total spending on procedures**, MedPAC staff said. This conclusion differs from previous research because the commission's researchers looked at the impact of imaging on total spending within an episode, they said. Past studies examined the question more narrowly, such as investigating whether certain diagnostic tests within a limited timeframe reduced hospital costs or length of stay during an admission, staff said.

Previous studies were also based on older data, with only two studies controlled for differences in patients' clinical conditions, only one study looking into physicians who refer patients to other members of their practices and none examining imaging spending during an episode of care — all areas MedPAC dug into, researchers said.

Upon being told that imaging is associated with more total costs, a few commissioners wanted exact numbers from staff. But MedPAC Executive Director Mark Miller nixed such detailed talk, saying he wasn't sure the analysis allowed for a definitive answer. Before Miller spoke, however, one of the presenting researchers, Ariel Winter, said that for every dollar in additional imaging spending, staff found an additional 60 cents in total episode costs, or total episode spending, at the high end. This would mean that if an extra dollar was spent on imaging, the total episode cost could go up 60 cents.

Other commissioners centered on the health aspects, asking if future research could spell out how many benefi-

ciaries per year reach an unsafe radiation dose. The patient safety concerns from overuse worried Commissioner Jay Crosson, from the Permanente Medical Group in Oakland, CA, who said pointedly that “there is more than just dollars at stake.” Though commissioners seemed eager for a study on the relationship between imaging and outcomes, staff said it was too difficult to relate a specific outcome to a diagnostic test.

When the commission starts focusing on policy options, Crosson’s preference would be to “look first at policy options that deal with removing the incentive for over-utilization as opposed to policy options that serve to remove the capability of physicians to perform these tests,” he said.

**“So I would like to see us take a hard look at modeling things like bundled payments, for example, and other counter-incentives that might remove or significantly mitigate the inherent incentive to over-utilization. And then failing that, if we determine that that simply can’t work because of complexity or other issues as we model it, as a secondary issue, look to removing the capability, because I think there would be a loss there in terms of the quality of care.”**

However, Hackbarth told the group that though he agreed that “if you have the incentives right, these issues are not very important,” getting to that point is not easy.

Hackbarth’s comments followed those from Commissioner Ronald Castellanos, of Southwest Florida Urologic Associates, who told the panel that the downstream effect may be much better with outcomes than the research could portray. Physicians today are finding many more aneurysms, renal cell carcinomas and making many more clinical discoveries because of CT scans, he said.

**But Castellanos took it one step further, blaming the payment system for forcing doctors to request more imaging purely for financial reasons.**

“Why are physicians [ordering scans]?” Castellanos asked. “Well, they’re doing it for one reason only, to increase income. And I think it’s a reflection on, unfortunately, the physician payment system and the incentives in the fee-for-service [program]. Because of the unfunded mandates, because of the lack of significant updates, because of business and practice expenses, I am forced to do things that perhaps I don’t really want to do. And the reason I do it is because I want to stay in business.”

According to the MedPAC researchers, the primary definition of self-referring physicians was those who referred more than half of their patients to their practice for imaging. And a self-referral episode was defined as at least one physician who met definition of self-referral provided an office visit during an episode. The research factored in patient severity level, geographic market and physician specialties.

In response to MedPAC’s findings, Michael Pentecost, associate chief medical officer for National Imaging Associates, acknowledged that self-referral has to be addressed in the health care reform effort. But Pentecost added that the location of imaging exams isn’t as important as “the need for every patient to receive the appropriate test, given the diagnosis and identified clinical need.”

Health care reform should include “a global approach that can ensure every procedure is clinically appropriate at the moment it is recommended,” Pentecost said. “Ensuring appropriate use of imaging is good public policy and good medicine that ultimately protects patients as well as the Medicare program.” — *Seth Freedland*

## **GROUP TOUTS NO TAX SOLUTION TO MEDICARE, MEDICAID PAYMENT REFORM**

The Haley Group is pushing a CMS payment reform plan that it says would generate up to \$797 billion over 20 years without additional taxes by simply extending from 14 days to 30 days the processing deadline for provider claims and offering doctors the option of receiving direct deposit payment within two days if they accept a 2 percent deduction. The group developed an electronic transaction network that would enable the quick payment.

Dave Haley, the group’s founder, CEO and president, sent letters to governors in 14 states and the 152-member general assembly of Indiana (Haley Group’s home base), and will be in Washington to lobby federal lawmakers.

“It cost very little to do what I’m talking about, relieves tax burden on our country and extends the length of time until Medicare Part A becomes insolvent,” Haley told *Inside CMS*.

According to the Haley Group, the plan would generate \$466 billion over 20 years by enabling Medicare and Medicaid dollars to collect interest on invested dollars for an extra 16 days each month if provider claims processing changed from 14 days to 30 days. The proposal would leave the programs’ dollars invested an additional 192 days per year, or 10.6 years over 20 years, Haley said. Using a 2 percent return on investment, he estimates interest alone would generate the \$466 billion in 20 years.

Haley Group’s plan would also give providers the option of receiving Medicare and Medicaid payments through direct deposit two days after claims clear, but providers would have to agree to a 2 percent deduction. Even with the deduction, Haley said doctors’ financial situation would improve, as the quick turnaround on payments would put them on a “near cash transaction basis.”

If all providers participated in the direct deposit plan, Haley estimates Medicare and Medicaid would generate

up to \$797 billion over 20 years.

**Sen. Richard Lugar (R-IN) said the two-week to 30-day switch “has merit” and he would keep the “suggestion in mind** as health care reform proposals continue to be debated in Congress.” An aide to Lugar told *Inside CMS* the Indiana senator has not specifically endorsed any plan, but he “appreciated hearing from a Hoosier organization.”

Asked how Haley Group would respond to providers pushing back against an extended deadline to receive payment, Haley said the government pays other vendors on a 30-day cycle. Being careful to point out he’s not anti-provider, Haley said there’s no reason during poor economic times that health care providers should receive preferential treatment.

“The interest of the whole outweighs the interests of a few,” Haley said, adding it’s more important to have good financial stewardship of tax dollars than to ensure providers are paid in 14 days as opposed to 30 days. “All senior citizens are on a 30-day payment cycle on a fixed income [and are the] most vulnerable in our society to these economic times.”

Provider groups did not respond to requests for comment on the proposal.

A contractor told *Inside CMS* the Haley Group proposal wouldn’t require additional work for them to make Medicare payments, but said it’s difficult to envision providers embracing the change.

Haley hopes to get states and the federal government to pick up the proposal so that the electronic network he designed can be used to extend the direct deposit offer to providers, accept the clients and implement the payments.

**States picking up on the proposal could also save money in their Medicaid programs.** According to Haley’s calculations, New York would generate \$14.9 billion over 10 years and California would see \$14.4 billion in 10 years.

“We’re trying to get this thing out there,” Haley said. “I think it’s probably one of the best shots at reform [but] not a silver bullet. ... If anyone can come up with a plan that’s going to cost taxpayers nothing, we ought to be banging down their doors.” — *Ashley Richards*

## **BAUCUS: HEALTH DELIVERY SYSTEM REFORMS WILL BE DRIVEN BY MEDICARE**

A marathon roundtable discussion on delivery system health reforms, hosted April 21 by the Senate Finance Committee and attended by various health care experts, revealed a number of Medicare-based reforms — like the Physician Group Practice (PGP) Demonstration — and private sector innovations — like “concierge” nursing care for very sick patients — that could be included in health reform legislation.

“Medicare is the big driver here,” said Finance Chair Max Baucus (D-MT), and will be where the committee focuses reimbursement and delivery reforms. “How to scale it up” will be one of the key questions, he said, but “Medicare will be a big part of that solution.”

A variety of delivery system policies were discussed at the roundtable and stakeholders suggested various reforms, many of which are not new.

Among the suggestions:

- Authority should be given to CMS that allows more flexibility, with proper oversight, to pilot test and then implement policies that improve care and cut costs.
- The Accountable Care Organization policy, being tested through the PGP demo, should be expanded. But stakeholders suggested the policy will only work in certain areas of the country at first and that it should be phased in slowly (see *Inside CMS*, August 29).
- Bundled payments for Part A and Part B services also should move forward.
- The Patient Centered Medical Home is one way to more fairly reimburse primary care physicians (see *Inside CMS*, April 2).
- Advanced care nursing and nursing that focuses on chronically ill patients can improve outcomes and free up physicians for other work.

Increased mandates for CMS should come with more funding.

- Private sector innovations that are “scaleable” should be incorporated into Medicare policies.

There was a unanimity about the idea that at the center of health reform should be the patient’s best interest.

Many on the panel suggested that Medicare will be the fulcrum that enables health reform to move forward. They said this will have to come, however, with expanded authority and more money for CMS.

One theme throughout the testimony was that policymakers need to find out what works through comparative effectiveness research, then either require or reward doctors and patients who follow the evidence-based medicine to improve quality, lower costs and improve outcomes.

There was a clear tension felt by many Republicans on the panel about the level of spending involved in real, sea change-like, innovations.

There was a clear consensus among the panel members on a few health reform policies. Team-based care that

relies heavily on nursing and targets the 20 percent of Medicare patients who consume 85 percent of the program's resources is a policy that the committee should incorporate into the reform bill, suggested Mary Naylor, a nurse and professor of gerontology at the University of Pennsylvania School of Nursing in Philadelphia.

"I think the leverage is in Medicare," said Glenn Steele, president of the Geisinger Health System in Danville, PA.

He explained that reforms should be slowly be phased in and take the form of numerous "patient-focused goals" in the "highest utilization areas" — which include Chronic Obstructive Pulmonary Disease, diabetes and heart disease. A deadline for achieving the goals should be set in law and resources should go to crafting metrics that can track quality and value improvements in high-cost illnesses.

"And if you don't get there in three to five years, maybe there should be a Plan B, that is something that is a lot more onerous," he said. "That Plan B should be pretty motivating." Pressed by Baucus about details about Plan B, Steele said "I'm not willing to say," adding that "we can talk about Plan B later."

"Sometimes," Baucus said, "a very sobering Plan B will encourage Plan A." Much nervous laughter followed from provider, hospital and other stakeholders who realize how difficult improving patient health is.

Geisinger's Steele has some experience improving outcomes and said that patient behavior often results in hospital readmissions. He said the main reasons for readmissions stems from patients who fail to take prescribed medications, or to take the meds at an appropriate time.

"Now solving that problem is immense and complex," he said. "We've put nurses in our community practice sites. The nurses take care of 125 of the sickest patients on a 24/7 basis, so it's like concierge care for the sickest," Steele added. This frees up primary care patients to provide other care. Steele said the policy should be designed so CMS can focus on this over three or five years and would likely garner "huge savings" from the Congressional Budget Office.

The impact of the "concierge" nursing care and Geisinger's experience is the focus of a clinical article the health system is getting ready to submit to a peer-reviewed journal, Steele said. He added that the clinical and financial rewards of the program have been enormous and sustainable.

"The return on that for the patients was incredible. In a number of our sites it was a 50 percent decrease in re-hospitalization in a year and that's been durable," he said. "Quality goes up and costs go down, they're not inversely related," he said.

Sen. Charles Grassley (R-IA), the ranking Republican on the committee, said that he hadn't heard anyone on the panel suggest that "we need to spend more money" to achieve health reforms. "Is that your conclusion? That we don't need to spend more money? Can I conclude that?"

Sen. Jeff Bingaman (D-NM) interjected that former CMS Administrator Mark McClellan had suggested increasing spending on Medicare and Medicaid and urged him to reiterate his comments.

"Let me clarify this in two ways," said McClellan, who now directs the Engelberg Center for Health Care Reform at the Brookings Institute. "One is, if you are going to ask CMS to do more and more quickly to drive the kinds of reforms in health care that Dr. Steele is talking about, well, let's face it, they're going to need more support."

"To be frank, Sen. Grassley, some of the reforms you heard about today do mean more spending in the short term, like we did with health IT in the stimulus bill; like some of the additional payments for primary care — medical home. I don't see a way of doing that, meaningfully, without spending more, at least, in the short term," said McClellan, who was President George W. Bush's nominee to head both CMS and FDA.

This will have to be accompanied by real "results" that close the "huge gaps in quality and care" and eliminate excessive or unnecessary Medicare spending over the long term, McClellan said. Ideally, he said, the reform proposal should link spending to improvements in care, this would be showing the American public some real "accountability."

He also said that HHS has an opportunity to do this right now by defining "meaningful use" of health IT "that I would argue ought to be an actual impact — a demonstrated impact — on improving outcomes, patient-level outcomes ... and reducing overall costs." This would "demonstrate to the American public that they are getting better health care as a result of these reforms," he said. After the roundtable, McClellan would not put a dollar figure on the CMS investments that are needed, but suggested that CMS' annual spending is about \$10 billion, which is far smaller than the amount of money being wasted in health care right now. A number that was thrown around at the hearing is \$700 billion in Medicare and Medicaid waste.

Medicare Payment Advisory Commission Chair Glenn Hackbarth said that Congress should both increase the level of reimbursement for primary care physicians and the method by which they are paid for their services. The commission has recommended bonus payments for primary care-focused physicians, but also lump sum payments per-patient for the medical home model. He also supported CMS' efforts to increase payments for Evaluation and Management services and to better value all services. However, his focus was primary care incentives.

"We have abundant research that shows strong primary care is essential for a well-functioning, high-performing health care system. As you know all too well, primary care in the United States is weak and, unfortunately, getting

weaker. That is a key priority,” he said.

Another major opportunity for reform, he said, is a focus on hospital readmissions which occur in 18 percent of Medicare patients are readmitted to a hospital within 30 days of discharge (see *Inside CMS*, Oct. 16, 2008 ). This is costly to Medicare, but also affects the patient through significant “pain and suffering,” he said.

“What is striking about these numbers is that there is a very large variation in readmission rates across hospitals.” The opportunity is to take lessons learned from those hospitals with lower rates and try to apply them across Medicare. A reporting mechanism that compares a hospital’s readmission rate to others, followed by “a penalty for an excessive readmission rate” was another recommendation by Hackbarth.

American Hospital Association President Rich Umbdenstock, however, said in written testimony that the readmission policy should distinguish between readmissions that are in the power of the hospital to prevent “and those that are not.” He said the policy should focus on “unplanned, yet related, readmissions.” He said one fear is that if the policy does not clearly define planned and unplanned readmissions, patients who need to be readmitted could suffer.

Hackbarth also suggested the idea of global capitation, used by groups like Harvard Vanguard to give physicians the flexibility to allocate resources to the patients who really need them. This often included “cross subsidies” from private payers to traditional Medicare fee-for-service patients. He also suggested that Finance members might reconsider the way the government generates revenues for Part A and Part B Medicare, but didn’t offer specifics.

Sen. Ron Wyden (D-OR) didn’t mince words. He wanted to know what suggestions the panel had to “ring-out some savings” from the current health care system.

Peter Lee, executive director of national health policy for the San Francisco-based Pacific Business Group on Health, said Medicare should implement consumer-based programs that incentivize patients toward health behaviors.

Bingaman also cut to the chase, asking McClellan: “Why can’t CMS be given a broader mandate to implement many of these practices, that I think everybody around here says make a lot of sense and will save a lot of money an improve care?”

McClellan said that the way CMS is managed now “doesn’t leave a whole lot of room for discretion implementing the kinds of reforms we have been talking about today: moving away from payment on a fee-for-service basis, promoting wellness, new steps to help patients with chronic disease.” McClellan pointed out that the Finance Committee, and Congress in general, sets payment for every Medicare service in every county of the country.

McClellan said that part of the answer would be to give CMS the ability to “enable and support more pilot programs” like the Physician Group Practice Demonstration, which is testing a modified Accountable Care Organization pilot that began under McClellan’s watch.

“It’s going to take more resources and more authority for CMS to pilot these new approaches,” McClellan said. He referred to the failed Medicare Health Support demonstration that ended up “not delivering the savings hoped” but it was able to be ramped up quickly and when it didn’t show promise, shut down just as quickly, he said (see *Inside CMS*, March 20, 2008).

“But at least successful programs could be expanded quickly. That might be a model to look at more closely,” he said.

The American College of Physicians’ president, John Tooker, said that Medicare should “value primary care as highly as we value every other critical service” provided to patients.

Frank Opelka, a general surgeon and professor at the Louisiana State University, suggested that the ranks of general surgeons are also falling, but that stakeholders and CMS should be able to sit down and “collegially” work out policy differences. About CMS, he said, the Finance Committee should take steps to make CMS a more attractive place to work. “It should be the place where people want to work if they want to work in government,” Opelka said. — *Brett Coughlin*

**SUBSCRIPTIONS:**

**703-416-8500 or  
800-424-9068  
custsvc@iwppnews.com**

**NEWS OFFICE:**

**703-416-8577  
Fax: 703-416-8543  
insidecms@iwppnews.com**

Health Group Publisher: Donna Haseley (donna.haseley@iwppnews.com)

Chief Editor: Brett Coughlin (bcoughlin@iwppnews.com)

Associate Editors: Amy Lotven (alotven@iwppnews.com)

Seth Freedland (sfreedland@iwppnews.com)

Ashley Richards (arichards@iwppnews.com)

Julian Pecquet (jpecquet@iwppnews.com)

Production Manager: Lori Nicholson

Production Specialists: Daniel Arrieta, Sharonel Pedronan, Andrew Leonard

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### PHYSICIAN GROUPS OFFER GUIDANCE TO CMS ON MEDICAL HOME DEMOS

Four physician groups have drafted guidelines for CMS patient-centered medical home demonstration projects that they say could ensure meaningful data are extracted from the projects and, ultimately, national implementation of medical homes can be achieved. The guidelines call for local primary care professional organizations to be briefed on the projects and given a chance for input, the results to be broadly disseminated, and CMS to compensate participating practices for the extra staff time.

Patient-centered medical homes are uniquely efficient in bringing together preventative and primary services while offering extended hours and communication options, the groups say. Leaders of the four groups — the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA) — view their guidelines as important to ensure apples-to-apples comparison across projects.

“If projects are consistently and appropriately evaluated, it will indeed facilitate more meaningful interpretation and understanding of the lessons learned as we move forward to full implementation of medical home nationally,” said AAP President David Tayloe.

The guidelines — also endorsed by the Patient-Centered Primary Care Collaborative, a coalition of more than 400 health plans, consumer groups and others — include 16 recommendations for any project testing the patient-centered medical home model. Those recommendations range from how participating practices should be chosen to how those practices should be reimbursed.

“It is essential that we conduct uniform studies of the PCMH in an effort to determine best practices and identify potential shortcomings,” AOA President Carlo DiMarco said. “The information we gather will provide valuable insight into efforts aimed at refocusing our nation’s health care system on the value of primary care.” — *Seth Freedland*

### AHIMA: INCREMENTAL EHR ADOPTION BEST WAY TO DEFINE ‘MEANINGFUL USE’

A steady and uniform utilization of electronic health records (EHR) is the best way to define “meaningful use,” the stimulus package’s criteria for receiving reimbursement, the American Health Information Management Association (AHIMA) told the National Committee on Vital and Health Statistics this week. Stakeholders have complained that the stimulus law’s definition of the term is vague and have been clamoring for government guidance on the issue.

AHIMA, a group of health information management professionals, said in its statement that the “most critical element” in the definition of meaningful use is widespread adoption without variation by payer, patient or provider group. The association points to gains made in development standards that could form the base of EHR utilization. These standards aren’t just tools toward interoperability and data

consistency, AHIMA adds, the standards themselves have to be used in a consistent way.

“Providers cannot be faced with providing and documenting care one way for [stimulus] incentives and other ways for other industry parties and partners,” AHIMA said. “Certification cannot be accomplished appropriately if all that is judged is consistency with [stimulus] requirements and not all the other demands on the EHR system ... If the government and health care industry cannot agree on the priorities for meaningful use, then quality and efficiency will not be attained.”

CMS should evaluate a proper EHR user by employing measurements that are incremental with the meaningful use as “a roadmap to be stepped up” over the years, according to AHIMA (see *Inside CMS*, March 16). Criteria in the initial stage should stem from what can be achieved today with current technology, the group adds.

Elements of that roadmap should include medication administration and e-prescribing, functional laboratory orders and sending discharge data from one provider to another to improve continuity of care.

Other recommendations include making sure meaningful use focuses on the use of the gathered information with EHR, not the technology itself, as well as the method of measuring meaningful use should be able to be audited by minimizing manipulation and mitigating the odds of fraudulent reporting.

### FAMILIES USA, PHRMA JOIN FORCES TO PUSH MEDICAID ELIGIBILITY EXPANSION

Families USA and PhRMA announced April 21 that the two frequently adversarial groups will be teaming up for a massive congressional push for a host of reforms, including expanding the Medicaid rolls to a floor of 133 percent.

The two organizations will also push for major private-market subsidies for people who aren’t eligible for Medicaid but can’t afford health care. This proposal would also reform the insurance market to prevent insurers from refusing care to those with preexisting conditions, according to *Politico* and NPR, who broke news of the collaboration.

The third proposal includes a catastrophic cap of out-of-pocket costs to give patients financial protection.

Though Families USA and PhRMA have teamed up before — namely on a two-year campaign for CHIP expansion — the rare combining of forces for a multimillion-dollar lobbying campaign could make a real difference on reform talks on the Hill, as Families brings in Democrats and PhRMA works to persuade Republicans to back the expansion. The campaign will include joint congressional visits as well as the potential for some combination of print, mail, radio and cable and network television ads.

PhRMA President Billy Tauzin told *Politico* that Republicans may be distressed with PhRMA’s support for growing Medicaid.

“We hope they understand that our politics is very different this year and that’s a product of the election,” he

told *Politico*. “We got a new team in town who could, I guess, pass what they wanted to. Our job is to make sure that what they pass has as many elements of our principles in them as possible, and that means being at the table.”

### **AMA, MGMA CREATE TOOLKIT TO HELP WITH MEDICARE ENROLLMENT PROCESS**

A pair of physician organizations have teamed up to aid practices handle the new requirements of the Medicare enrollment in the form of an online toolkit. The guide is available at the Web sites of the two groups, the American Medical Association (AMA) and the Medical Group Management Association (MGMA). Only members of the two groups

can access the toolkit.

The biggest changes to enrollment went into effect on April 1, namely that physicians now have only 30 days to make changes to their enrollment information — with their status potentially revoked if they miss the deadline. Also assuming physicians meet all enrollment requirements, they can only bill Medicare retroactively for 30 days once successfully enrolled, rather than up to 27 months as previously allowed.

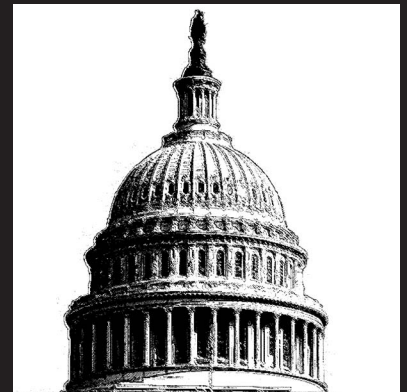
“Many of the changes to Medicare’s enrollment process are cause for concern, and we are working to improve the process so physicians can enroll without disruption to their practice,” said AMA Board Chair Joseph Heyman.

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## CMS PROCEEDS WITH DME COMPETITIVE BIDDING, INDUSTRY PRESSES FOR DELAY

CMS is moving forward with its competitive bidding rule for durable medical equipment despite a last-minute industry push to further delay the program. A CMS official said by law the program must open up the competition for the round-one rebid in fiscal 2010. Industry is already vowing a legislative push to quash the bidding effort.

While the interim final rule issued Jan. 16 will go into effect April 18, CMS said in an announcement that there is no immediate change for Medicare beneficiaries or suppliers. Guidance on the rebid process and timeline for implementation is forthcoming, CMS said.

The American Association of Homecare, a trade association representing DME suppliers, told *Inside CMS* the group is going to work on a legislative fix to eliminate the program. “We will also work through regulatory channels to ensure that patient concerns, stakeholder concerns, and congressional concerns are all addressed if the bidding program does go forward,” the AAHomecare source said.

CMS said it expects to begin round-one rebidding by the end of 2009, as is required in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), and the agency estimated when the interim final rule was issued it would begin round two bidding, which will extend competitive bidding to additional regions, in 2011.

Sen. Jay Rockefeller immediately praised CMS for finalizing the rule, touting the \$1 billion annually the program is estimated to save Medicare. “Competitive bidding is good for Medicare, and it’s good for seniors,” Rockefeller said. “Competitive bidding gives seniors access to high quality medical equipment and supplies, reduces out-of-pocket costs, and helps combat fraud and abuse. We have known for too long about rampant fraud and abuse in this area and I commend the President and his Administration for their decisive action. It is time we stand up to special interests and fight for our seniors and individuals with disabilities.”

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**“We will also work through regulatory channels to ensure that patient concerns, stakeholder concerns, and congressional concerns are all addressed if the bidding program does go forward.”**  
— AAHomecare

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**The DME supplier industry has some congressional support to block the program.** On April 15 a group of 85 House members, led by Rep. Betty Sutton (D-OH), signed a letter to acting HHS Secretary Charles Johnson, acting CMS Administrator Charlene Frizzera and head of the White House Office of Health Reform Nancy Ann-DeParle opposing CMS’ planned implementation of competitive bidding. Sen. Pat Roberts (R-KS), a member of the Senate Finance Committee, also sent a letter in opposition to the rule on April 9. Both letters question CMS’ rationale for issuing an interim final rule instead of using the lengthier comment and rulemaking procedure. There has been widespread industry uproar about the rule. DME suppliers were successful in convincing Congress to delay the competitive bidding program in MIPPA by agreeing to a 9.5 percent fee schedule cut. Tyler Wilson, president of the DME trade association American Association of Homecare, argued that by some estimate the 9.5 percent cut saved Medicare

more than originally expected, but was unable to quantify that savings (see *Inside CMS*, Jan. 22).

**In July 2008 the initial round-one bidding process was criticized due to financial documents submitted that were outside of the competitive range.** A patient advocate said the quality of low-bidding suppliers was also worrisome because those companies had not provided DME equipment for as long as the established suppliers. But CMS said its calculations accounted for that.

In February, CMS solicited comments about potentially extending the effective date of the rule, as was allowed by a January regulatory review memorandum from the Obama White House. The April 17 announcement from CMS confirming the April effective date of the rule and DMEPOS competitive bidding program singled out comments calling for the bid process to be fair and transparent and the agency said it would continue to gather input from stakeholders as it implements the program.

DME suppliers have firmly opposed the program, dubbing it “anti-competitive” because the number of companies providing DME in each metropolitan statistical area would be reduced. In the first weeks of April suppliers held a DME “survival summit” in western Pennsylvania, during which the industry stakeholders said the DME competitive bidding rule would erode patients’ choices and hurt local business.

Rep. Heath Shuler (D-NC) held a subcommittee hearing in the Small Business Committee and said he was working to garner support for a legislative fix to the competitive bidding program, as he worries about the effect it would have on community business (see *Inside CMS*, Feb. 19). — Ashley Richards