Federal Involvement Criticized

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insurers against people with pre-existing medical conditions;

► A requirement that all Americans purchase health insurance coverage, with penalties for those who do not;

► The creation of health insurance exchanges through which uninsured people could purchase policies, with subsidies to help low-income people pay premiums;

► An expansion of Medicaid to include people with incomes greater than 100% of the federal poverty level (how much greater differs between the two bills); and

► A prohibition on federal funding of abortions, although the specifics of this provision differ between the two versions.

The AAN is working to get neurologists added to the list of providers eligible for primary care bonuses of 10% under the health reform bill.

One thing the two bills vary greatly on is a public option for health insurance—a government-funded insurance program designed to compete with private plans. The House bill includes a public option, but the Senate bill does not, and several senators have said they would not vote for a bill that contains a public option. The Senate briefly considered an expansion of Medicare to persons aged 55-64 years in lieu of a public option, but quickly abandoned that idea after several key senators expressed opposition.

The bills also differ slightly on cost—the Senate measure would cost $871 billion over 10 years, while the House bill would cost $894 billion over the same period, according to estimates from the Congressional Budget Office.

Both bills offset some of the cost by cutting payments to Medicare Advantage plans—private health plans that contract with the government to care for Medicare beneficiaries.

Physician groups have plenty to chew on in the bills, each of which numbers around 2,000 pages. The American Academy of Neurology did not take a position on either bill, but has some concerns about provisions that were left out, according to Michael Amery, AAN legislative counsel.

"We have two key elements, neither of which was fulfilled to date," he explained. One provision was a permanent fix for the sustainable growth rate formula used to determine physician pay under the Medicare program. Instead of a permanent fix, Congress gave physicians a 2-month reprieve from next year's impending pay cut.

The other measure the AAN hoped to see included was to add neurologists to the list of providers eligible for primary care bonuses under the health reform bill. Under the incentive plan, certain providers who claim at least 60% of their billable charges as evaluation and management codes are eligible for a 10% bonus. The list of eligible physicians includes family physicians, internists, geriatricians, pediatricians, and—in the House version of the bill—ob.gyns.

"Neurologists don't necessarily want to be known as primary care doctors, but the reality is that they provide a lot of primary care to patients," said Mr. Amery. "If you ask patients with amyotrophic lateral sclerosis or Parkinson's disease who is their primary care physician, they would almost all say, 'My neurologist.' "

Mr. Amery noted that a lot of subspecialists are included under the "internal medicine" category of the provision, but because neurologists are not board-certified through the American Board of Internal Medicine, they are not included.

The academy is still working to get the two provisions included in the final bill.

The American Association of Neurological Surgeons expressed its displeasure with both the House and Senate bills.

"We're not very happy," said Katie Orrico, director of the association's Washington office. "Since the release of the original [House bill] this [past] July, we've consistently opposed every iteration that's come out since then."

The association's major concern with the bills, Ms. Orrico said, "really is the significant increase in federal involvement in health care determinations across the board—of quality, including developing and identifying outcomes measures, and various potential concerns we have regarding coverage and payment policies." That includes a provision in the Senate bill calling for an independent Medicare advisory board which would make recommendations on cutting Medicare costs.

Regarding the quality measurement provisions, "Neurosurgery—as I suspect is true of other specialties—is really at the beginning of trying to develop outcomes measures," Ms. Orrico said. In addition to launching a portal for neurosurgeons to participate in Medicare's Physician Quality Reporting Initiative program, "we're also doing some pilot programs on quality measurement and we are about to embark on a venture with Blue Cross Blue Shield. But we believe that's something the profession should be doing with the encouragement and support of the federal government—it shouldn't be taken over by the federal government." ■

Proposed 'Meaningful Use' Criteria Released for EHRs

BY JOYCE FRIEDEN

The Health and Human Services Department has released long-awaited, proposed "meaningful use" criteria for providers interested in receiving bonuses of up to $64,000 for installing or upgrading electronic health information systems.

"We've tried to build in flexibility in these standards and certification criteria as well as providing necessary guidance," Dr. David Blumenthal, the agency's national coordinator for health information technology, said in a Dec. 30 conference call. "We hope we've provided a pathway toward more uniform standards over time, while at the same time making it possible in 2011 for well-intended providers and health professionals who want to become meaningful users to become so, and for the industry to create technology that will support that."

Under the Health Information Technology for Economic and Clinical Health Act (HITECH), a part of 2009's federal stimulus law, physicians who treat Medicare patients can get up to $44,000 over 5 years for the meaningful use of a certified health information system. Physicians whose patient populations are made up of at least 30% Medicaid patients can earn up to $64,000 in incentive payments for their use of the technology.

The regulations include a definition of meaningful use and outline other criteria for obtaining the full incentive payments.

HHS issued two rules: one that outlines proposed provisions governing the incentive programs and an interim final regulation that sets initial standards, implementation specifications, and certification criteria for electronic health record (EHR) technology. Both regulations are open for 60 days of public comment.

For stage 1, which begins in 2011, meaningful-use requirements include:

► Use of computerized entry for 80% of all patient orders.

► Use of electronic prescribing for 75% of all permissible prescriptions.

► Maintenance of active medication and medication-allergy lists as part of the EHR for at least 80% of patients.

► Inclusion of demographic data (language, gender, ethnicity, insurance type, and date of birth) in the EHR of at least 80% of patients.

► Inclusion in the EHR of at least 50% of the lab results that can be recorded as either positive or negative or can be recorded with numerical data.

There are also requirements dealing with reporting quality data, filing claims electronically, encouraging patients to be more active in their care, improving care coordination, and ensuring privacy.

In 2012, the rules tighten for submitting quality data. While providers are allowed to report quality data to the Centers for Medicare and Medicaid Services through attestation in stage 1, data must be reported directly through certified EHR technology in stage 2.

The Medical Group Management Association said in a statement that the proposed criteria "are overly complex and … medical groups will confront significant challenges trying to meet the program requirements." It cites "unreasonable thresholds" for some criteria, including CPOE and electronic claims submission; "potentially difficult meaningful use attestation after the first year;" and a requirement that physician offices provide patients and others with electronic copies of medical records among its objections. ■

The proposed regulations, fact sheets, and instructions on how to comment on the proposed regulations can be found at www.cms.hhs.gov/Recovery/11_HealthIT.asp.