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when minutes count

MedPAC Likely to Present Several Options for Physician Payment System

At the latest meeting of the Medicare Payment Advisory Commission (MedPAC) on November 9, Chair Glenn M. Hackbarth said that the commission is unlikely to recommend to Congress a particular course of action for reforming Medicare's physician payment system. Instead, he said, it is "very much an open possibility" that MedPAC will present several different options, along with the advantages or disadvantages of each. He added that such options "would unfold over a period of years . . . sort of a long term solution."

Having been charged by Congress with recommending ways to fix Medicare's physician payment system, MedPAC is scheduled to report its findings on the issue in the spring of 2007. Physicians have said the report is likely to be used to help craft a physician payment bill, particularly if lawmakers decide to do more than just increase Medicare reimbursements to doctors, but rather begin to develop an entirely new payment system. As it stands, the Medicare payment rate to physicians is scheduled to be reduced 5.1 percent on January 1, 2007; and this time, since it is unlikely that the cut will be averted by Congress (as it has in the past) in the lame-duck session that began on November 13, the issue will have to be addressed in some form in 2007.

At its November 9 meeting, MedPAC rejected one possible way to reform the payment system: introduce sustainable growth rate (SGR) targets for physician specialties. MedPAC staff said that, while SGR targets would encourage work by specialty physicians to improve their efficiency, they could also hamper collaboration between physicians. The commission is looking more favorably on a physician payment system that bases payment in part on the geographic location of doctors. Other ideas being considered are providing incentives for physicians to choose a hospital with which they want to be affiliated; providing incentives for beneficiaries to choose a "responsible" physician; providing financial incentives for using electronic medical records; and having physicians report performance measures via groups (termed "extended hospital medical staffs") and establishing spending targets at this group level.

Slow Start to Funding Program for Undocumented Immigrant Care

Nine months into the first year of a controversial federal program intended to provide $1 billion in funding for hospitals that provide emergency care to undocumented immigrants, only 15% of the money has been handed out nationally. Federal officials cannot explain why. Herb Kuhn, director of the government unit responsible for administering the program (CMS' Center for Medicare Management), simply stated, "We are really not certain why providers are not claiming the money." In contrast to Kuhn's statement, hospital officials, public health experts, and immigrant advocacy groups offered several explanations. They cited paperwork problems and red tape as deterrents to applying for the money, and ethics concerns with respect to patient confidentiality. (Cont'd page 2)

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The first issue – time-consuming paperwork that can offset any money gained – was named as most providers' biggest deterrent to applying for the federal money. In elaborating, Carla Luggiero, senior associate director for federal relations at the American Hospital Association, said, "There are hospitals that say, 'I am only going to get 33 cents on the dollar and then I have to hire people to complete these forms and house them.' They say it's not worth the effort." Sonal Ambegaokar, a health policy expert for the National Immigration Law Center in Los Angeles, added that the paperwork problems have led some hospitals to submit bills only for their most costly cases. And, while Lynn Fagnani of the National Association of Public Hospitals and Health Systems said that, as a result of her group's working with the government to iron out the paperwork and other issues, some progress has been made. Yet, "the program continues to be problematic," she continued, noting that such problems add to the frustrations of public hospitals barely getting by. "When you are on the margin, every dollar counts," Fagnani stated.

Another deterrent is how the government calculates costs and often dramatically trims hospital bills. Cynthia Pike-Fuentes, spokesperson for Chicago's Advocate Illinois Masonic Medical Center, said, "We fully embrace the program and we set up systems to flag potential participants." She added, however, that the program has its shortcomings. "If it is emergency care, we only get paid for two days until the patient is stabilized for inpatient [care]," she said. But, she added, if the patients stay any longer, the hospital has to swallow the rest of the bill. Indeed, government figures show that Illinois Masonic submitted $1.3 million in payment requests to the federal government and received about $250,000 in reimbursements. Federal officials say the cuts take place because hospitals often bill for their services and not their costs, and – in some cases – seek funds for longer periods of stay than allowed.

The third problem cited is a concern by hospital officials that questioning patients about their immigration status will scare them off and cause them to forego health care. Hospital officials are uneasy about the program's requirement to document whether patients are eligible for the federal money; they find it an awkward process. Instead of asking if someone is undocumented, they are told to seek proof of birth outside the U.S. such as a driver's license, passport, or birth certificate. And, although the federal form says patients' information will not be provided to immigration officials – except in cases of suspected terrorism or crimes – some immigrant advocacy groups and healthcare providers are skeptical of such promises.

> "Many of the state's healthcare facilities decided not to seek the federal money because we want to make our facilities as friendly as possible to immigrants."
>
> – Dr. Francesca Gany
> Immigrant Health Center
> New York University School of Medicine

As a result of such concerns, the nation's largest public health system, New York City's health network, announced in November 2005 that it would forgo the federal money in order to protect patients' confidentiality about their immigrant status. Dr. Francesca Gany from the Immigrant Health Center at New York University School of Medicine said, "It is not like there's a special New York state pot of money that is overflowing. It is the decision to consider the health of the people as the primary mandate and not to scare people away." When initially asked why less than $100,000 has been spent so far out of the $15.1 million available in New York State, federal officials said they were not aware of New York City's position. They later acknowledged the confidentiality concerns and the "strong immigrant advocacy" in New York that views the documentation as "onerous."

In Arizona, only $5.1 million out of a potential $47 million for the state's providers has been approved. Senator Jon Kyle (R-AZ), a key supporter of the program, indicated that he is frustrated in his efforts to find out why so little money has been used. He said, ". . . there is no consistent response from the hospitals in Arizona to tell us what's happening." Still, he has no doubts about the need for the funding. "Emergency rooms are stressed out for a lot of reasons," he said, adding that it is important they "be kept open for everyone."

On the other hand, some legislators believe the money should go elsewhere. For example, Representative Dana Rohrabacher (R-CA), a proponent of more restrictive immigration policies, issued a statement saying, "Providing (Cont'd page 4)

CMS Releases Final OPPS Rule

The Centers for Medicare and Medicaid Services (CMS) has released its final rule for policies and payment rates under the outpatient prospective payment system (OPPS). The rule shows a willingness on the part of CMS to listen to providers and make changes to the proposed OPPS rule released in August. As in the proposed rule, the final rule includes provisions expanding quality-reporting requirements for hospital inpatient services as well as hospital outpatient services.

Under the final rule, the overall estimated amount that hospitals will receive in 2007 under the OPPS is unchanged from the proposed rule: $32.5 billion. That translates to an overall average increase of 3% in Medicare payments for outpatient department services in 2007.

In addition, the final rule's revised policies and payment rates relevant to AAEM generally remain unchanged from the proposed rule. The final rule still requires hospitals to report quality measures for inpatient services in order to receive the full inpatient prospective payment system update, as well as the full update on outpatient payments; but it delays implementation of tying payment to the submission of quality measures until 2009.

The final rule does not create a new set of Healthcare Common Procedure Coding System (HCPCS) codes for visits to hospital clinics, full-time EDs, and critical care services. It does, however, establish five ambulatory payment classification (APC) levels for service in the ED or in clinics. It also creates five new HCPCS codes to describe hospital emergency visits provided in part time dedicated EDs (DEDs); these are EDs subject to the requirements of EMTALA but not open 24/7. For two years, CMS will gather data on the costs of services provided in these entities and pay for the new DED visit codes at the payment levels set for clinic visits.

Another relevant change from the proposed rule concerns critical care services. The final rule modifies critical care to include activation of a trauma response team. In addition to reporting existing current procedural terminology (CPT) codes for critical care, providers must report the code for trauma response team activation associated with hospital critical care when appropriate to receive payment under a new APC code. This payment ($491.66) will be generated in addition to payment for the CPT code.

The final rule is effective for services furnished to Medicare beneficiaries on or after January 1, 2007. It will be posted on the CMS web site at **www.cms.hhs.gov/HospitalOutpatientPPS/01overview.asp**.

Quality Measures Developed for Physician Reporting Program

CMS has published a list of 86 quality measures that the agency expects to have available at the beginning of 2007 for its Physician Voluntary Reporting Program (PVRP). The agency plans to select a subset of the measures for use in the reporting program for 2007 "in order to achieve an appropriate balance in measures to be reported by different specialties." The list covers 32 of 39 physician specialties. At present, the measures include such actions as providing a beta blocker for a prior myocardial infarction, assessment of elderly individuals for falls, prescribing antidepressant medication for patients during the acute phase of a new episode of major depression, and use of anticoagulant for patients with atrial fibrillation.

CMS first announced the PVRP in October 2005 as a way to measure quality of services provided in primary care, surgery, nephrology, and emergency medicine, and furnish doctors with confidential feedback. Then, earlier this year, CMS began the PVRP with an initial set of 16 measures to determine quality of service provided in the aforementioned areas. (Cont'd page 4)

IOM Recommends CMS Phase in Pay-for-Performance Measures

At the request of Congress, the Institute of Medicine (IOM) recently examined the current Medicare reimbursement system and the effect of implementing pay-for-performance measures, and issued its report on the subject. The report states that, although more than 100 pay-for-performance measures have been implemented in the past ten years, "a robust evidence-base on the effectiveness of these programs is not yet available," and, as a result, evaluation of the programs is difficult. The report does suggest that, while it is likely that the implementation of pay-for-performance measures will improve health care quality, it might not reduce cost.

According to the report, the current fee-for-service Medicare reimbursement system "tends to reward excessive use of services, high-cost complex procedures and lower-quality care." Health care providers are reimbursed for the treatment of illnesses and injuries and for promoting the use of technology, but they are not reimbursed for patient education or other measures that might reduce costs over time. IOM also noted that the current system does not reimburse for coordination of care for Medicare beneficiaries who receive treatment from several different providers and does not provide financial incentives to encourage providers to invest in improvements in the overall health of beneficiaries.

In concluding its report, IOM recommends that large providers and companies with the ability to report health care quality information to the federal government begin to report such data. In addition, the report calls for CMS to phase in pay-for-performance measures in the Medicare reimbursement system over time, with voluntary participation for smaller physician practices during the first three years. After three years, the Department of Health and Human Services secretary should decide whether to require mandatory participation for all providers. Finally, IOM recommends that CMS establish pools of funds to be used to reward providers whose care is demonstrated to improve the overall health of Medicare beneficiaries, and that the pools be financed with as much as a 2% reduction in Medicare reimbursements for some services.

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illegal aliens with free health care is an incentive for more illegals to come here." He continued, "Draining limited healthcare funds to take care of illegal aliens and reimburse hospitals for their emergency care is ill-conceived and harmful to our own citizens. I will continue to oppose this kind of nonsense."

Meanwhile, the program is scheduled to run through 2008 and federal officials are continuing their search for answers to why it has had such a slow start. They say, however, they are optimistic that it will work out.

Quality Measures Developed for Physician Reporting Program (Cont'd from page 3)

In expanding the PVRP measure set for 2007, CMS used five parameters. The measures will be expanded further to cover as many medical specialties as feasible, using evidence-based, valid measures, with preference given to measures adopted by the Ambulatory Quality Care Alliance. Preference also will be given to measures that are endorsed by the National Quality Forum. In the case of measures for which an endorsement by these two quality groups is not available, CMS will consider input from relevant professional associations and stakeholders.

Go to **www.cms.hhs.gov/PVRP/Downloads/qualmeasures.pdf** to view the quality measures and the accompanying fact sheet.