

CMS Final Rule for 2012 Physician Pay Includes 27.4% Pay Cut

According to the Centers for Medicare & Medicaid Services (CMS), unless Congress intervenes to change the underlying law, Medicare physician pay rates will be cut by 27.4% starting January 1, 2012. In its final rule, announced on November 1 and published in the November 28 Federal Register, CMS said, “By law, we are required to make these reductions, and these reductions can only be averted by an Act of Congress.”

The cut is slightly less than the amount announced in the proposed rule issued in July (29.5%), because – CMS said – it is required to use for the final rule “the best data available” as of September 1. To determine physician pay, relative value units (RVUs) for a particular service are multiplied by a fixed-dollar conversion factor and a geographic adjustment factor to arrive at the payment amount for each service. For 2011, the conversion factor was \$33.9764; for 2012, it will be \$24.6712. CMS projects that, under this 2012 physician fee schedule, total payments will be approximately \$80 billion.

In a statement released in conjunction with the final rule, Health and Human Services Secretary Kathleen Sebelius said, “the pattern of threatened SGR [Sustainable Growth Rate] cuts and last-minute Congressional rescues is in itself not a sustainable solution and must be remedied.” That sentiment was echoed by American Medical Association President Peter Carmel who said the congressional Joint Select Committee on Deficit Reduction “must include repeal of the formula in their recommendation to Congress to protect access to care for seniors and stabilize the Medicare program.”** Carmel asserted, “Payments for Medicare physician services have fallen so far below increases in medical practice costs that there is a 20% gap between Medicare payment updates and the cost of caring for seniors.”

Comments on the final rule will be accepted until December 31. Areas under consideration include certain 2012 Healthcare Common Procedure Coding System codes, as well as the physician self-referral designated health services codes. The rule also implements the third year of a four-year transition to new practice expense RVUs, and it updates a number of physician incentive programs including the physician Quality Reporting System, the e-Prescribing Incentive Program, and the Electronic Health Records Incentive Program. Additionally, in the rule CMS finalizes: an expansion of its “potentially misvalued code initiative” intended to ensure Medicare is paying accurately for physician services; revisions to geographic practice cost indices for each Medicare locality; and the quality and cost measures to be used in establishing a new value-based modifier for adjusting physician payments based on the level of quality and efficient care. With regard to the value-based modifier, CMS is required by the *Patient Protection and Affordable Care Act* to begin making payment adjustments to certain physicians and physician groups by 2015, and to apply the modifier to all physicians by 2017. For the purposes of adjusting payments in 2015, performance during 2013 will be used to calculate the modifier to be applied. (Cont'd page 2)

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Investigations into Drug Shortages May Forestall Action on Bills

Despite a boost from the Administration in the form of President Obama's executive order urging drug companies to hasten their efforts to notify the government about expected prescription drug shortages, bipartisan bills to address such shortages may not move forward until lawmakers finish investigating the cause of the shortages. Representative Diana DeGette (D-CO) and Senator Amy Klobuchar (D-MN) assumed the order would help advance their bills (H.R. 2445/S. 296) requiring that manufacturers notify the Food and Drug Administration (FDA) at least six months in advance if any drug is being discontinued or production is being interrupted.

But, according to an aide for Senator Tom Harkin (D-IA), Chair of the Senate Health, Education, Labor, and Pensions Committee, legislative movement might hinge on a bipartisan group of senators investigating the root causes of the drug shortages. In addition to Harkin, the working group – developed as part of the Committee's efforts to reauthorize a program that helps fund the FDA's drug approval process – includes Senators John McCain (R-AZ), Bob Corker (R-TN), and Richard Burr (R-NC). "We can't say definitively what, if anything, might get marked up because the working group has not yet concluded its work," said the aide, who added that the ideas from Klobuchar and co-sponsor of S. 296 Senator Bob Casey (D-PA) are "very much in the mix." Although Klobuchar has admitted her bill could be a short-term approach, she said it would help while the Senate working group develops a longer-term solution.

Some conservative lawmakers consider congressional action premature, since the causes of the drug shortages are so complex and somewhat unclear. In addition, Representative Joe Pitts (R-PA), Chair of the House Energy and Commerce Committee's Health Subcommittee, criticized the Administration for deciding to "politicize" the issue and rush to action. He noted that the Subcommittee is still waiting for a report from the Administration promised at its hearing in October on the causes of drug shortages. A spokesperson for Representative Tom Rooney (R-FL), who introduced H.R. 2445 with DeGette, said that Rooney was hopeful the Administration would issue its report soon and that he would continue to work with Pitts and supporters of H.R. 2445 to secure a mark up of the legislation.

Meanwhile, Representative Elijah Cummings (D-MD), Ranking Member of the House Oversight and Government Reform Committee, launched an investigation into five companies – Allied Medical Supply, Inc., Premium Health Services, Inc., PRN Pharmaceuticals, Reliance Wholesale, Inc., and Superior Medical Supply, Inc. – in an effort to examine the prescription drug "gray market" in which critical medications in short supply are sold at extremely inflated prices. Cummings found that paclitaxel, a drug used to treat breast and ovarian cancer, was being sold by Superior Medical Supply, Inc. for more than \$500 per vial – many times higher than the typical contract price. At first, the company's attorney promised to cooperate with the inquiry, but calls since then have not been returned and Cummings has intensified his investigation.

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**As it happened, on November 21, the Joint Select Committee reached its deadline without presenting any recommendation to Congress. It now appears that a physician payment fix may have to be proposed in a stand-alone bill. In fact, congressional aides predicted that possibility in October. Still, as one aide pointed out, canceling the cut would cost between \$20 billion and \$25 billion for one year. The high cost of a permanent fix for Medicare's physician payment system – estimated to be as much as \$30 billion over 10 years – has prevented Congress from acting on such a plan to date.

As Berwick Leaves, Tavenner Is Nominated for CMS Administrator

Following CMS Administrator Donald Berwick's announced resignation on November 23, President Obama nominated Marilyn B. Tavenner to head the Centers for Medicare & Medicaid Services (CMS) effective December 2. Tavenner spent most of her previous career with Hospital Corporation of America, starting as a staff nurse, and eventually became chief executive officer of Johnston-Willis Hospital in Virginia. She also served as a member of the board of trustees of the American Hospital Association (AHA) and president of the Virginia Hospital Association. Tavenner was Virginia's Secretary of Health and Human Resources under former Governor Timothy M. Kaine (D) and has been CMS's Deputy Administrator since a CMS reorganization in February 2010.

Tavenner will serve as acting administrator after Berwick's departure, until the Senate acts on her nomination. According to Health and Human Services Secretary Kathleen Sebelius, Tavenner "has proved her skill in managing challenges like overseeing the integration of insurance oversight into CMS and implementing the numerous improvements to Medicare, Medicaid, and the Children's Health Insurance Program."

After the announcement was made, Richard J. Umbdenstock, AHA president and chief executive officer, said that Tavenner's "varied and rich background as a former nurse, health care executive, and government official at the state level gives her a very unique perspective in understanding both the implications of public policy and their implementation."

Another Senate confirmation battle could be shaping up. Little controversy has accompanied Tavenner's work at CMS, but it is not clear how the confirmation process might play out in an election year, with the health care law before the Supreme Court, and with Republicans still upset that Berwick was appointed during a congressional recess, circumventing a Senate vote. The one thing that is clear is that GOP lawmakers would react with hostility if Tavenner received a recess appointment. Republicans objected so strongly to Berwick's nomination that President Obama gave him a recess appointment in July 2010, which allowed Berwick to serve through December 31 of this year without full Senate confirmation. Administration officials said at the time that they had to make a move to end GOP attacks on Berwick that portrayed him as a proponent of rationed health care.

CDC Survey on ED Use Sparks Discussion

According to a new study from the Centers on Disease Control and Prevention (CDC), visits to hospital EDs increased to an all-time high of 136 million in 2009. This number represents almost a 10% increase from the 2008 figure of 123.8 million, and marks the largest increase since the government started tracking EDs in the early '90s. The annual visit rate cited is 45.1 ED visits per 100 persons, but the study also breaks out the visits further by age, gender, and race. In addition, other visit data includes expected sources of payment, reasons for visit, diagnoses, and medications provided or prescribed.

The statistics regarding age are: patients under age 15 accounted for 21% of ED visits in 2009; those between ages 15 and 24, 15%; patients between ages 25 and 44, 28%; patients between ages 45 and 64, 21%; and those age 65 and older, 15%. As for gender, the study indicates that females visited the ED at a rate of 48 visits per 100 persons, while males visited at a rate of 42 visits per 100 persons; as for race, Whites had a rate of 41 visits per 100 persons, while Blacks/African Americans, 84 visits per 100 persons.

The expected sources of payment were: private insurance – 39%; Medicaid or State Children's Health Insurance Program – 29%; Medicare – 17%; other and unknown – 5% each; and no insurance – 19%. (The total is higher than 100% because more than one payment source may have been reported per visit.) (Cont'd page 4)

CDC Survey on ED Use Sparks Discussion (Cont'd from page 3)

The leading discharge diagnosis groups were: nonischemic heart disease – 1.1 million; chest pain – 927,000; pneumonia – 832,000; ischemic heart disease – 513,000; and cerebrovascular disease – 477,000. Medications were provided or prescribed in 78% of ED visits for a total of 268 million drugs.

Some physicians attribute the increase in ED visits to both a swelling of demand for services and improvements that allow EDs to treat patients faster. They view the increased demand for ED services, at least in the short term, as a sign of the tough economic times. These physicians also argue that it is counterproductive to dissuade patients from going to the ED to save money in overall health care costs.

Countering the view that EDs are not the places to cut costs, other health care experts contend the federal health law will force health care providers and policymakers to reevaluate how to spend money in the health system. “We’re spending way too much on surgery, hospitals and emergency rooms and

not enough money on primary care,” said health care consultant Walter Kopp. “If primary care had more resources, we could do a better job . . .”

The authors of two new studies published in the *Annals of Emergency Medicine* suggest that increasing concerns about medical malpractice litigation have led

to higher hospital admittance rates. In one study, physicians surveyed during an 18-month period said medical-legal concerns were the main reason for admitting 11% of ED patients with acute coronary syndrome. In 27% of the cases, the doctors said they would not have chosen hospitalization if they were the patients. In the second study, researchers examined ED visits in 27 urban, suburban, and rural EDs in New Jersey and New York and compared admission rates for congestive

heart failure patients in 1996 and 2010. They found the percentage of patients discharged from the ED decreased to 9.1% from 24.4%. The authors said they suspected concern about litigation as the main reason for the decrease.

MOST COMMON REASONS FOR VISITING THE ED

- ✓ Stomach and abdominal pain – 9.6 million
- ✓ Fever – 7.4 million
- ✓ Chest pain – 7.2 million
- ✓ Cough – 4.7 million
- ✓ Headache – 4 million
- ✓ Shortness of breath - 3.7 million
- ✓ Back symptoms – 3.7 million

Short ...

Discussion on Repealing SGR

On October 27, Representatives Allyson Schwartz (D-PA) and Phil Roe (R-TN) co-hosted a bipartisan briefing and panel discussion titled “The Future of the Medicare Physician Payment System.” Both hosts expressed the need for a permanent and financially sustainable solution to how Medicare pays physicians and urged repeal of the SGR formula. Schwartz cited her bipartisan letter to the Joint Select Committee on Deficit Reduction signed by more than 115 members of Congress that said an SGR repeal should be included as part of any deficit reduction package. Roe warned of the potential effects that a cut in physician pay would have on access to care for Medicare beneficiaries. The health care experts participating in the briefing held similar views; however, as previously noted, action on the SGR by the Joint Select Committee is now a moot point.

From the States ...

Iowa and Tennessee Join Washington in Limiting Medicaid Pay for ED Visits

Nearly all states have at least one program to encourage Medicaid enrollees to reduce ED use considered unnecessary. But at least three – **Washington**, and now **Iowa** and **Tennessee** – have begun limiting Medicaid fees for what they classify as inappropriate visits.

On September 1, **Iowa's** Medicaid agency began tiered payment reduction involving Medicaid ED patients without a condition the state says it will cover as an emergency. The agency reduced Medicaid fees to 75%, half, or zero of normal rates for nonemergent ED hospital visits depending on whether the patient has a physician referral and is part of a state primary care case management program. The limits do not apply to enrollees who are younger than 21, pregnant, receiving family planning, or who are admitted to the hospital. Roger Munns, spokesperson for the **Iowa** Department of Human Services, said, "The rationale is to save public dollars and to discourage improper use of emergency rooms."

On July 1, **Tennessee** ended Medicaid pay for 51 nonemergent conditions as part of a budget reduction plan. Kelly Gunderson, spokesperson for TennCare, the state's Medicaid agency, said the agency closely monitors access to care and requires all enrollees to sign up with a managed care plan and choose a primary care physician.

Washington Judge Rules Against Medicaid ER Visit Limit

On November 10, Thurston County Superior Court Judge Paula Casey halted implementation of the state's controversial three ED visit benefit limit for Medicaid enrollees. The ruling, in favor of the **Washington** Chapter of the American College of Emergency Physi-

cians, the **Washington** State Medical Association (WSMA), the **Washington** State Hospital Association (WSHA), and Seattle Children's, found the state failed to follow proper rulemaking procedures. Consequently, the current rule implementing the three visit limit policy is invalid. The policy may not be implemented until formal rulemaking is complete.

Washington's physicians and hospitals filed the lawsuit to preserve access to emergency care for the state's most vulnerable residents. The state's plan would have limited payment for Medicaid patients to three "non-emergency" visits to EDs each year. More than 700 diagnoses are classified as "non-emergent," including many truly emergent conditions such as chest pain, abdominal pain, miscarriage, and breathing problems.

The state now is required to go through a formal rulemaking process including public hearings and comments before implementing the new policy. According to WSMA President Douglas R. Myers, "**Washington** State physicians, hospitals, and Medicaid patients themselves look forward to the chance to air their concerns about the denial of necessary emergency care . . . Our hope is that the state devises a plan through the formal rulemaking process that reduces unnecessary emergency room care without endangering our patients. Under the current plan, patients who may be seriously ill or facing a life threatening situation may forego necessary medical care with disastrous consequences. We simply cannot sacrifice patient safety for the state's erroneously-classified 'non-emergency' list."

After the ruling, Scott Bond, WSHA President stated "**Washington's** physicians and hospitals will continue to work together and with the state with the goal of creating a safe but effective policy on unnecessary emergency room use. We must ensure access to quality care for Medicaid enrollees."