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when minutes count

Physician Pay Cut Slated for 5.1% in 2007

Under a statutorily required fee schedule reimbursement change proposed by the Centers for Medicare & Medicaid Services (CMS), Medicare payment rates to physicians would fall 5.1% on January 1, 2007, rather than the original CMS estimate of 4.6%. CMS Administrator Mark B. McClellan told reporters on August 8 that CMS is very concerned about how a drop of this magnitude would affect the quality of care received by Medicare beneficiaries and has been working to help develop a new system. According to McClellan, Congress would have to appropriate an additional $13 billion over five years for physicians to receive no change in payments between 2006 and 2007. As it currently stands, the proposed fee schedule that appeared in the August 22 ***Federal Register***, will cost taxpayers $61.5 billion in 2007.

The current sustainable growth rate formula (SGR), which required the cut, compares the actual growth rate of physician services in spending to a target rate. If the actual rate exceeds the target, the update is decreased. Expenditures for physicians' services in 2005 increased 10% over 2004. This was due to an increase in the number and complexity of services, including more frequent and intensive office visits, and rapid growth of imaging techniques, laboratory services, and physician-administered drugs.

While Congress did smooth over projected cuts by adding additional funds to pay doctors for Medicare services during the last several years because of similar situations with the SGR, these were only stop-gap measures. Congress did not adjust the target, further increasing the gap between actual spending and the targets – exacerbating an already difficult situation. According to McClellan, CMS is trying to develop a payment system to replace the SGR. He stated that physician groups and quality forums have made "lots of progress" toward developing quality measures, so that a new payment system can be based on quality of care without raising costs.

The comment deadline is October 10, 2006, and a final rule is expected out later in the fall. However, it is extremely unlikely that substantial changes in the projected reimbursement cut will be made.

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CMS Proposes New Rule for Medicare Payments

The Centers for Medicare and Medicaid Services (CMS) has issued a proposed rule that revises policies and payment rates under the Outpatient Prospective Payment System (OPPS). The revisions proposed in the rule are myriad, but some of those having particular relevance to AAEM are described below.

Under the proposed rule, hospitals would receive a total of $32.5 billion in 2007 for outpatient services provided to Medicare beneficiaries. The rule includes a 3.4% inflation update in Medicare payment rates for services paid under the OPPS for 2007. After taking into account other factors affecting the level of payments, CMS estimates that the changes in this proposed rule would give (Cont'd page 3)

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FY 2007 Hospital IPPS Rule Contains EMTALA Changes

On August 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued the hospital Inpatient Prospective Payment System (IPPS) final rule for FY 2007. In this rule, CMS estimates FY 2007 operating and capital payments for hospitals under the Medicare program will increase by $3.4 billion, with payment rates increasing by 3.5% on average to all hospitals. The final rule also contains a number of provisions relating to EMTALA, all of which are effective October 1, 2006.

In this rule, CMS is finalizing two revisions to current regulations recommended by the EMTALA Technical Advisory Group (TAG). The agency is modifying the current requirement under which only a physician is authorized to determine that a pregnant woman having contractions is in false labor. As recommended by the TAG, CMS will allow hospitals the flexibility to use certified nurse-midwives or other qualified non-physicians acting within their scope of practice, as defined in hospital medical staff bylaws and State law.

Over the past year, CMS has considered how provisions of EMTALA should apply to specialty hospitals. The EMTALA TAG was asked to consider: (1) whether there should be a federal requirement that all hospitals must have an ED; (2) whether EMTALA should be interpreted as meaning that all hospitals (including specialty hospitals) with specialized capabilities or facilities must accept appropriate transfers; and (3) whether specialty hospitals are exacerbating problems with "on-call" coverage for emergency departments.

After taking into account the EMTALA TAG's deliberations, CMS does not currently intend to recommend to Congress that all hospitals must have an ED; or require, as a condition of Medicare participation, that all hospitals have an ED. Furthermore, the agency is not proposing any statutory or regulatory changes regarding on-call requirements. However, CMS is requiring that all Medicare-participating hospitals with specialized capabilities, including specialty hospitals, must accept appropriate transfers of unstable individuals, regardless of whether the hospital with specialized capabilities has an ED. CMS has, in the past, taken enforcement actions based on its policy that all participating hospitals with specialized capabilities have an EMTALA obligation to accept an appropriate transfer of an unstable individual protected by EMTALA.

Emergency Care Systems Facing Critical Workforce Shortages

According to a new study by the Center for Health Workforce Studies (CHWS) at the University at Albany's School of Public Health, emergency care systems in the United States are at serious risk of critical shortages in staffing in the near future. The three key reasons are: an inadequate supply of board-certified emergency medicine physicians; the worsening shortages of RNs; and difficulty recruiting and retaining EMTs in rural areas. Meanwhile, the future demand for emergency care services and workers is expected to increase due to issues such as: the potential for bioterrorism or other mass casualty incidents; the aging population; and the growing number of uninsured.

The study, entitled ***The Emergency Care Workforce in the U.S.***, covered prehospital emergency services, EDs in hospitals, freestanding urgent care centers, and teams dispatched by local, state, or federal governments or volunteer organizations in response to a widespread emergency or disaster. Among the study's key findings are:

- The supply of board-certified emergency medicine physicians may not be adequate to meet demand. Nearly 20% of physicians specializing in emergency medicine are working as independent contractors, compared to 4% of all physicians.
- Emergency care services are currently affected by the shortage of RNs. EDs are one of the most common locations for RN openings at hospitals, and this situation will persist as RN shortages worsen.
- The composition of the emergency care workforce varies significantly between rural and urban areas, with fewer emergency medicine physicians in rural areas and fewer ED RNs and physician assistants in urban areas.
- While EMTs are not generally seen as in short supply, the high rate of turnover in rural areas makes the recruitment and retention of EMTs in these areas a continuing concern.

CMS Proposes New Rule for Medicare Payments (Cont'd from page 1)

hospitals an overall average increase of 3% in Medicare payments for outpatient department services in 2007.

These statutory payment increases are projected to continue a trend of rapid growth in hospital outpatient expenditures, due – in turn – to the rapid growth in the use and intensity of hospital outpatient services. Under the OPPS, payments increase with the number and intensity of services provided, regardless of their impact on quality or patient health – an aspect of the system of concern to CMS because of its impact not only on beneficiaries whose monthly premiums must pay for 25% of Part B expenditures. Therefore, in order to promote greater value in Medicare hospital outpatient services, the CMS proposed rule ties payment rate increases to the reporting of quality measures beginning in 2007.

CMS published its proposed rule in the August 23, 2006 ***Federal Register***. Comments on the proposed OPPS revisions contained in the rule will be accepted until October 10, 2006, and a final rule will be published later this fall.

The approach used in the proposed rule is as follows: Hospitals would be required to report quality measures for inpatient services in order to receive the full inpatient prospective payment system update. Hospitals that do so would receive the full update on outpatient payments as well. Those that fail to do so would receive the OPPS update minus two percentage points. The reasoning behind this approach is that many inpatient measures involve the same activities as those in outpatient care, and CMS anticipates the data collected will serve to encourage quality improvement for all hospital services. As additional quality measures specific to hospital outpatient care are developed, CMS also proposes to require their reporting.

With respect to hospital outpatient services, the proposed rule includes steps to improve the accuracy of payment for services in outpatient clinics and EDs, and for critical care services. To match the levels of effort for physician services, the rule would increase from three to five the number of payment levels for visits to a hospital clinic or ED. Payment rates would be established based on historical hospital claims data. As a result, the maximum payment for clinic visits would increase from $92 to $133, and the maximum payment for ED visits would increase from $244 to $345.

CMS is also proposing to create a new set of Healthcare Common Procedure Coding System codes to describe hospital ED visits provided in dedicated EDs (DEDs) that are subject to the requirements of EMTALA but do not meet the more prescriptive requirements consistent with the Current Procedural Terminology ED definition. The new codes would enable CMS to gather data to determine the relative resource costs of the services provided in these entities, as distinct from emergent care furnished in a facility that is accessible 24/7. While gathering such hospital cost data, CMS proposes to pay for the new DED visit codes at the payment levels set for clinic visits.

Another revision in the proposed rule concerns the critical access hospital (CAH) conditions of participation; it allows the use of RNs on site at the CAH as qualified medical personnel available to perform emergency medical screening, if the nature of the patient's request for medical care is within the scope of practice of the RN and consistent with applicable state laws. This revision conforms to the recent changes made to EMTALA regulations and will align the emergency medical screening requirements in CAHs with those applicable to acute care hospitals.

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