Aetna and AMA Lock Horns Over Medicare

BY JANE ANDERSON
Contributing Writer

Aetna Inc. reported that it is working with the American Medical Association and state medical societies to resolve issues involving nonparticipating physicians after the AMA complained that the insurer was paying those physicians just 125% of Medicare rates and then telling patients they didn't need to pay the rest.

In a letter to Aetna, Dr. Michael Maves, AMA's chief executive officer and senior vice president, noted that Aetna's policy—implemented last June—fails to take into account different practice costs that are reflected by physicians' billed charges.

"It is simply arbitrary and capricious for Aetna to deem 125% of Medicare to be a fair payment across the board," Dr. Maves wrote in his letter to Dr. Troyen Brennan, Aetna's chief medical officer.

Dr. Maves also said in the letter that physicians nationwide are reporting receiving Aetna Explanation of Benefits (EOB) forms stating that the patient has no obligation to pay the nonparticipating physician the difference between the physician's charge and the amount Aetna has paid.

This practice, Dr. Maves said, potentially violates the 2003 settlement agreement with Aetna in Multidistrict Litigation 1334, the large class action lawsuit in which physicians sued large managed care companies, including Aetna, over business practices.

However, Dr. Brennan said in an interview that the settlement in that case "clearly differentiates between HMO-based plans and traditional plans." It requires Aetna to tell members in traditional plans that they can be balance-billed by nonparticipating physicians, but it treats HMO plans differently, he said.

HMO members receive an EOB stating that Aetna does not contract with a nonparticipating provider, and that the provider might not accept Aetna's payment as payment in full for services, Dr. Brennan said. "In the notice, we inform the member that we 'seek to ensure that they do not pay this provider any amount above any applicable copayment, coinsurance, or deductible at the in-network (referred) benefit level,' and if they receive a bill for the difference, they should send the bill to us," Dr. Brennan said.

Aetna believes it has complied with the 2003 settlement agreement "in all respects," but is in discussions with the AMA and state medical societies about the issues involved, Dr. Brennan said. However, "no substantive discussions have occurred as of yet with the AMA," said AMA spokesman Robert Mills.

Meanwhile, nonparticipating physicians are being placed in an awkward situation, said Dr. Alan Schorr, a Langhorne, Pa.–based endocrinologist who does not participate with Aetna. Some of his patients have received the Aetna EOBs.

"This puts the patient and physician into adversarial roles," said Dr. Schorr, who added that, although Aetna might believe that 125% of Medicare represents fair reimbursement, "the patient has to have some sense of responsibility."

But the EOBs from Aetna state that the patient has no responsibility to pay the difference between 125% of Medicare rates and the actual charges, Dr. Schorr said, and patients therefore don't want to pay the difference.

Aetna "is trying to force physicians back into the [network] fold," Dr. Schorr said, adding that he had complained to the AMA and to the Pennsylvania Medical Society about Aetna's practice. "What we're looking at, in my opinion, is restraint of trade. They're trying to ratchet down physicians' fees," he said. ■

Aetna Announces Refusal to Pay for Preventable Inpatient Hospital Errors

BY MARY ELLEN SCHNEIDER
New York Bureau

In a move that could have significant implications for physicians and hospitals, the insurer Aetna has said it will not pay its network hospitals for care necessitated by certain preventable errors.

The announcement follows a policy shift by the Centers for Medicare and Medicaid Services, which has finalized plans to stop paying for eight preventable events as of October 2008.

Aetna Inc. has incorporated language into its hospital contracts that calls for waiving all costs related to a number of serious reportable events. The language comes from the Leapfrog Group's "never events" policy, which includes a list of 28 events considered so harmful that they should never occur. The list, compiled by the National Quality Forum (NQF), comprises events ranging from surgery performed on the wrong body part or on the wrong patient, to stage III or IV pressure ulcers acquired after admission to a health care facility.

The question is whether hospitals will continue to report these types of serious preventable errors.

DR. OPELKA

The policy instructs hospitals to report errors within 10 days to the Joint Commission, state reporting programs, or patient safety organizations. Hospitals also are asked to take action to prevent future events and to apologize to the patient or family affected by the error. Aetna is the first health plan to endorse the Leapfrog policy.

"The major goal here is to get hospitals to focus on having the systems in place to prevent these events from happening," said Dr. Charles Cutler, Aetna's national medical director.

Adopting the Leapfrog Group's never events policy is not about saving money, Dr. Cutler said. In fact, many of the never events carry no additional cost. Instead, Aetna is seeking to send a consistent message to hospitals about quality, he said.

But the Aetna announcement has encountered some skepticism from the physician community. The NQF list of never events is much broader than the eight preventable events selected under the Medicare policy, said Cynthia Brown, director of the division of advocacy and health policy at the American College of Surgeons (ACS). One reason that many of those events were not included on Medicare's list is that they are difficult to measure with the current coding system, she said.

Another problem with the Aetna approach is that it's hard to affix blame to a hospital or a particular physician. "If there's a problem with blood incompatibility, is it the surgeon's fault?" Ms. Brown asked. "It's hard to know how it's going to be operationalized."

When used properly, the NQF never events list protects patients and directs a patient environment enriched with safety and quality, said Dr. Frank Opelka, chair of the ACS Committee on Patient Safety and Quality Improvement. But he cautioned that if payers drift from the intentions of the NQF never events, the specifications could be lost and overreporting could create unintended consequences.

For example, because of hospital overcrowding and limited resources in a rural environment, a frail patient may be admitted despite the lack of health care resources. If the patient has a pressure ulcer that progresses from a stage II on admission to a stage III, this should not be considered an NQF never event, he said.

Dr. Opelka also questioned whether hospitals would continue to report these types of serious preventable errors if they aren't being paid for the care. "If the reports are generated from a hospital claims system and the payer no longer recognizes the events as payable, isn't the message to stop reporting rather than to prevent the never events?" asked Dr. Opelka, also vice chancellor for clinical affairs at Louisiana State University Health Sciences Center, New Orleans.

Since Medicare announced its policy shift last summer, other insurers have considered changes to their policies. Officials at Cigna, for example, are evaluating how to implement a similar policy within their hospital network. The insurer plans to have a national policy in place by October 2008, said Cigna spokesman Mark Slitt. ■

CMS Unveils Electronic Health Record Demonstration Project

BY JANE ANDERSON
Contributing Writer

Primary care doctors welcomed news of a federal project aimed at extending the use of electronic health records in small- to medium-size practices, but noted that its success rests on how it is implemented.

"The devil is in the details," Dr. Steven E. Waldren, director of the Center for Health Information Technology at the American Academy of Family Physicians, said. "What are going to be the real requirements for physician practices to participate and submit data?"

The demonstration project, sponsored by the Centers for Medicare and Medicaid Services, would be open to participation by up to 1,200 physician practices beginning this spring.

Over a 5-year period, the project will provide financial incentives to physician groups using certified electronic health records (EHRs) to meet certain clinical quality measures.

Bonuses will be provided each year, based on a physician group's score on a standardized survey that assesses the specific EHR functions a group employs to support the delivery of care.

All participating practices would be required to use a certified EHR system to perform specific functions that can positively affect patient care processes, such as clinical documentation and writing prescriptions. The system, which must be in place by the end of the second year of the 5-year demonstration, must also be approved by a certification body officially recognized by the Department of Health and Human Services, according to CMS. The core incentive payment to practices will be based on performance on the quality measures, with an enhanced bonus based on how well integrated the EHR is in helping to manage patient care.

"This project will appropriately align incentives to reward doctors in small physician practices who use certified EHRs as tools to deliver higher-quality care," CMS's acting administrator Kerry Weems said in a statement.

Over the course of the demonstration project, CMS estimated that 3.6 million consumers will be affected directly as their primary care physicians adopt certified EHRs.

In order to amplify the effect of the project, CMS also is encouraging private insurers to offer similar incentives for adopting EHRs.

Dr. David Dale, president of the American College of Physicians, praised the demonstration project as "an encouraging step in the right direction," and said it was acknowledging that market forces alone will not be enough for physicians to afford new market systems. ■