CMS May Tie Outpatient Pay to Quality in 2009

BY ALICIA AULT
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The Centers for Medicare and Medicaid Services has proposed an overall 3% increase in payments for outpatient hospital care in 2009, almost a full percent below the update for 2008. As expected, reporting on quality of care is being tied to the amount of increase hospitals and other outpatient providers will receive.

For the first time, hospitals and other recipients of payments under the outpatient system that do not report data on seven quality measures on emergency department and perioperative care will see only a 1% increase.

The proposed rule, issued in July, also outlines changes for ambulatory surgery centers (ASCs) that are part of a 4-year transition to a new payment system that began this year. In 2009, as was the case this year, ASCs would be paid 65% of the rate paid for the same service in an outpatient hospital department.

The agency estimates it will spend $29 billion in 2009 on payments to acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term acute-care hospitals, community mental health centers, children's hospitals, and cancer hospitals. That's a $2 billion increase from the estimated $27 billion CMS will spend on outpatient services this year, said the agency. Payments to ambulatory surgery centers will increase from an estimated $3.5 billion in 2008 to $3.9 billion in 2009, according to CMS.

For imaging—a huge and growing portion of Medicare expenditures—CMS would make a single payment for multiple imaging procedures performed in a single hospital session, including ultrasound, computed tomography, and magnetic resonance imaging.

CMS also proposes reducing pay for some of the higher-cost device-oriented procedures: a 48% reduction in pay for the placing of left ventricular pacing add-on leads; a 3% decrease for replacing pacemakers, electrodes, or pulse generators; 4% for stent placement; and just 1% for drug-eluting stents.

CMS is proposing to more aggressively penalize hospitals and other outpatient providers that do not report quality data. Providers must report on 7 measures in 2008 and on 11 in 2009, including 4 imaging efficiency measures. In addition, the agency is seeking to reduce copayments for beneficiaries who are treated at hospitals that do not report quality data.

By law, Medicare is gradually changing the payment system so that beneficiaries will be liable for only 20% of a covered service. The coinsurance rate has varied widely over the last 8-10 years. In 2009, about 25% of services will be subject to the 20% coinsurance, up from 23% in 2008, said CMS.

For ASCs, reimbursement would decrease for 92 procedures, but increase for 2,475 procedures, according to the Ambulatory Surgery Center Association. Gastrointestinal procedures as a whole are slated for a 6% reduction, and nervous system procedures and pain management would be reduced by 3%, according to Washington Analysis, a firm that advises investors on health policy developments.

Finally, the agency said that it is proposing to create four new ambulatory payment classifications for type B emergency departments (those that offer emergency-level services but are not open 24 hours a day, 7 days a week). According to data collected by CMS, most type B emergency visits are more expensive than a clinic visit, but less expensive than a visit to a traditional emergency department. The goal is to make payment for the type B centers more reflective of actual costs. The four payment groups will be based on claims data from the type B providers.

CMS is accepting public comments on the outpatient and ASC proposals until Sept. 2 and expects to issue the final rule Nov. 1. ■

AMA Urged to Use Apology as a 'Springboard' for Action

BY MARY ELLEN SCHNEIDER
New York Bureau

African American physicians are looking for action to back up the words of apology recently tendered by the American Medical Association for more than a century of racial inequity and bias.

In accepting the AMA's apology, the National Medical Association (NMA), which represents minority physicians, urged the AMA leadership to work with them on three initiatives: recruiting more African American physicians, reducing health disparities among minorities, and requiring medical schools and licensing boards to make cultural competency mandatory for medical students, residents, and practicing physicians.

The AMA should go beyond the apology for racial discrimination by backing it with meaningful action.

DR. BELL

"We really want to use this apology as a springboard," said Dr. Nedra H. Joyner, chair of the NMA board of trustees and an otolaryngologist in Chicago. These changes will be critical to reversing racial health disparities that have led to poorer health outcomes in African Americans, she said.

"Talk is cheap," said Dr. Carl Bell, professor of public health and psychiatry at the University of Illinois at Chicago.

Dr. Bell said that while he is hopeful that the AMA will take some meaningful action to reduce health disparities, he is unimpressed by the apology alone. Instead, he would like the AMA take a stand on issues that would advance minority health in the United States. For example, he said that he wants to see the AMA push for single-payer national health insurance, be stronger in challenging the pharmaceutical industry, do a better job of promoting public health, and support research into minority health and mental health issues.

Dr. Warren A. Jones, who was the first African American president of the American Academy of Family Physicians, agreed that further action will be needed but called the AMA's apology "appropriate" and "timely." This is not an apology of convenience, he said, but a signal of a change in the mind-set of the AMA leadership.

The AMA now has an opportunity to ensure that cultural competency becomes a tool in the medical armamentarium in the same way as the stethoscope or the scalpel, he said. "Now is the time for the AMA to put its resources where its mouth is," said Dr. Jones, executive director of the Mississippi Institute for Improvement of Geographic Minority Health.

The AMA offered the apology in July to coincide with the release of a historic paper in its flagship journal that examined race relations in organized medicine (JAMA 2008;300:306-313).

The paper, which chronicles the origins of the racial divide in AMA history, was prepared by an independent panel of experts convened by the AMA in 2005. The panel reviewed archives of the AMA, the NMA, and newspapers from the time to provide a history from the founding of the AMA through the civil rights movement.

The paper notes a number of instances where the AMA leadership fostered racial segregation and bias. For example, in 1874 the AMA began restricting delegations to the organization's national convention to state and local medical societies. This move effectively excluded most African American physicians because many medical societies, especially those in the South, openly refused membership to them. Later, in the 1960s, the AMA rejected the idea of excluding medical societies with discriminatory practices.

During the civil rights era, the AMA was seen as obstructing the civil rights agenda, the paper noted. In 1961, the AMA refused to defend eight African American physicians who were arrested after asking to be served at a medical society luncheon in Atlanta.

In its review, the independent panel applauded AMA for its willingness to explore its history. But the researchers also noted that the legacy of inequality continues to negatively affect African American physicians and patients. For example, in 2006 African Americans made up 2.2% of physicians and medical students, less than in 1910 when 2.5% were African American.

The AMA's apology is a signal of change in the mind-set of the organization's leadership.

DR. JONES

In a commentary to accompany the history, Dr. Ronald M. Davis, immediate past president of the AMA, acknowledged the "stain left by a legacy of discrimination" and outlined what AMA is doing to eliminate prejudice within the organization and improve the health of minority patients (JAMA 2008;300:323-5).

Dr. Davis said that the AMA leadership felt it was important to offer the apology because it demonstrates the "current moral orientation of the organization" and lays down a marker to compare current and future actions.

Within the organization, AMA has in place a number of policies that explicitly prohibit discrimination in membership and support funding for "pipeline" programs to engage minority individuals to enter medical school. In addition, in 2004, the AMA joined the NMA and the National Hispanic Medical Association to form the Commission to End Health Care Disparities. That group has been working to expand the "Doctors Back to School" program, which brings minority physicians into schools to encourage students to consider careers in medicine.

The ultimate goal is to have as much diversity among physicians as in the general population, where African Americans make up about 12% of the U.S. population, Dr. Davis said. "Obviously, we have a long way to go," he said. ■

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