Insurers Couldn't Cope With Medicaid Cuts

Proposed reductions are not viable because 'there is no private sector alternative . . . for the poor.'

BY LISE STEVENS
Contributing Writer

NEW YORK — As Congress contemplates cuts to Medicaid, legislators are placing in peril the overarching goals of the program in covering low-income, disabled, and older Americans in favor of expeditious budget cuts, James R. Tallon Jr., president of the United Hospital Fund of New York, said at a meeting sponsored by the New York Academy of Medicine.

"Congress has moved to address Medicaid in terms of budget reconciliation, in terms of $10 billion in federal savings over 5 years," Mr. Tallon said. "Here's the question: Is it right to take this step toward repealing a major building block of the 20th century domestic policy to pass a budget resolution? Is it right to change fundamentally America's largest health care program under expedited reconciliation of procedures? Congress seems headed in that direction."

According to the Department of Health and Human Services, Medicaid covers 41 million Americans; that number has grown steadily in recent years.

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MR. TALLON

The number of uninsured Americans is projected to grow to 56 million by 2013. National health spending continues to soar as well, from $1.7 trillion in 2003 to a projected $3.4 trillion in 2013, Mr. Tallon said.

"There is no doubt we're going to hear a lot of personal responsibility rhetoric. Before this is over, you're going to hear the program ridiculed, you're going to hear beneficiaries demonized, and you will be assured that all of this is for our own good.

"If other congressional debates are a guide, there will also be a lot of misinformation brought in," he said.

Other forces are driving the proposed cuts as well, Mr. Tallon said.

Among them are the rewriting of Medicaid regulations through a waiver process to shift responsibility away from Washington and to shift administration of Medicaid programs to private insurance companies.

Medicaid is the "workhorse" of the American health care system, Mr. Tallon said.

It was designed to provide health benefits for low-income children and adults; to provide comprehensive coverage to disabled beneficiaries who do not have access to other health insurance, including Medicare; and to supplement Medicare for the elderly and disabled who need long-term care, who exceed the benefit limit for acute care services, or who cannot afford Medicare.

"In our current economy, we are off track," Mr. Tallon said.

"We face major risks from Washington—the long-term objectives of some are simply to limit the federal financial burden and to shift to states the cost of the uninsured and of Baby Boomers' long-term care. The consequences of the current debate will be with us for decades," he commented.

The current proposals for cutting Medicaid are not viable because there is no alternative to Medicaid for the populations it serves, he said.

"There is no private sector alternative to health insurance for the poor. The insurance industry does not serve this market," Mr. Tallon said.

"There is no private insurance market for high-cost, chronically ill or disabled individuals. Before Medicaid, this was a state responsibility. The reason we're able to have an insurance industry is because the government picks up the tab for these high-risk, high-cost individuals over the long term," he said. ■

Physicians Are Hoping for a CMS Revision on NPI Numbers

BY NELLIE BRISTOL
Contributing Writer

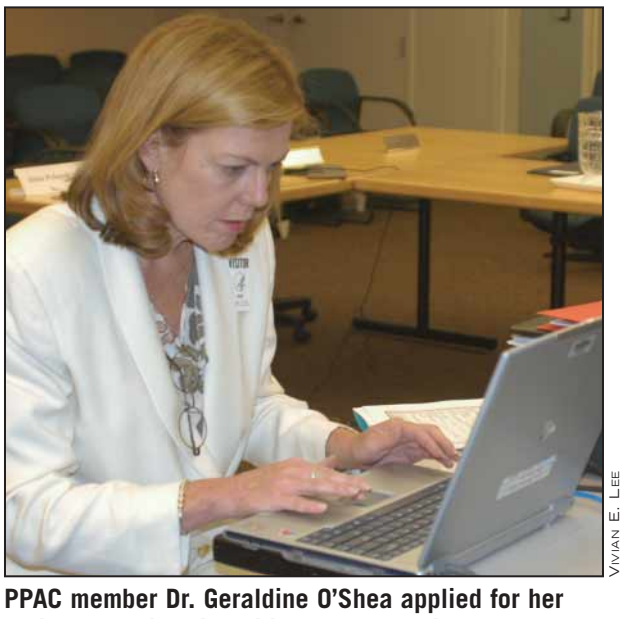
WASHINGTON — The Centers for Medicare and Medicaid Services will review national provider identifier protocols that now require separate numbers for each covered entity. The requirement could mean some physicians who are also part of group practices and other arrangements would have multiple NPI numbers.

At a meeting of the Practicing Physicians Advisory Council, members brought the issue to the attention of CMS' director of program integrity, Kimberly Brandt. She said the goal is to have fewer numbers — not more. "So I appreciate your point, and it's a very good one," she said. "And that's something I will definitely look into."

PPAC member Barbara McAneny, M.D., an oncologist from Albuquerque, suggested the review as part of a draft recommendation approved by the council. The recommendation suggests CMS clarify which current provider numbers would be replaced by the NPI number and which entities would need their own numbers.

Dr. McAneny also suggested CMS "put pressure" on other groups, including state licensure boards, "to eliminate some of the numbers and not to just add them on and add them on and add them on. …"

NPI enrollment began May 2 and continues through May 2007, when all providers will be required to use the system for standard electronic health care transactions. "With national standards and identifiers in place for electronic claims and other transactions, health care providers will be able to submit transactions to any health plan in the United States," CMS Administrator Mark McClellan, M.D., said in a May letter to health care providers.



VIVIAN E. LEE

PPAC member Dr. Geraldine O'Shea applied for her national provider identifier number during a break at a recent council meeting.

As a requirement of the Health Insurance Portability and Accountability Act, many health plans—including Medicare, Medicaid, private health insurance issuers, and health care clearinghouses—must use NPIs in standard transactions by May 2007. Small health plans have an additional year to comply. The number is intended to replace current numbers, including the unique physician identification number (UPIN).

Ms. Brandt told the advisory council that CMS is conducting a "massive outreach effort" to inform providers of the change and encourages them to apply for an NPI. Applications can be made electronically or through the mail. To demonstrate the process of getting an NPI, PPAC Chairman Ronald Castellanos, M.D., got his number at the council's meeting, in a process that took approximately 8 minutes. "I'm not bleeding," Dr. Castellanos said when asked how painful the process was.

CMS is encouraging health plans to devise a transition plan for a system that accepts both the UPIN and NPI until the May 2007 compliance deadline. Ms. Bryant said that although a few health plans already have systems developed, most do not—including Medicare, which she said will not have the "capacity to be fully changed over" until 2007.

"We need the next year and a half to finish getting our claims-processing system completely converted over, and then we'll begin the phase-out I would say about 6-8 months ahead" of the May 2007 deadline, she said. CMS is recommending that members of groups not sign up individually now but wait until fall, when "batch enumeration" systems will be in place to accept group applications.

Once assigned a random NPI, providers will have that number for the remainder of their careers and need only contact CMS to make changes. The system will be meshed with Social Security information to track provider deaths, and the agency hopes to be able to coordinate with state licensing groups as well, Ms. Brandt told the council. ■

Please, Can We Have a Directory?

Security concerns are currently keeping CMS from developing a directory of all NPI numbers for all health providers and covered entities, but one may be developed in the future, Ms. Brandt told PPAC members.

"We may get to a point where we have a directory, but right at the moment, we don't have a [list] like the unique physician identification number directory in the works," she said.

Instead, the agency is planning to publish in the Federal Register in October a notice on how NPIs can be obtained from other health care providers and covered entities.

PPAC members encouraged Ms. Brandt to look into a directory for referring physicians, even if such a directory turned out to be a subscriber service. "I would strongly advocate that you [develop a directory] even if there's a subscription fee because one of the more problematic things when you bill for a consult is to try to track down Dr. Jones' [UPIN], and it's a significant hurdle and a big burden on the practice," said surgeon Anthony Senagore, M.D., of the Cleveland Clinic Foundation.

Ms. Brandt noted that an encrypted or password-accessed system would be necessary, given that "people have been able to get access to [the UPIN director] who shouldn't have been able to get access to it." Council members' recommendation for a subscription fee or encryption is "a good one," she said.