Congressional Leaders Eye Pay Fix in 2006, Despite Looming Difficulties

BY JENNIFER LUBELL

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WASHINGTON — A permanent fix to the Medicare physician fee schedule "will be a difficult bill to pass through Congress," Mark Hayes, a majority spokesman for the Senate Finance Committee, said at a conference sponsored by AcademyHealth.

"It's an expensive proposition in the current budget climate we're in," Mr. Hayes said, voicing the concerns of other Republican staff members who participated in a discussion on the 2006 health care agenda. This year's midterm congressional election also will play a role in shaping progress on this issue, he said.

Driving the cuts in pay is the sustainable growth rate (SGR), a component of the Medicare payment formula that ties medical spending to the ups and downs of the national economy and determines the conversion factor update each year. Errors made to the formula in 1998 and 1999 led to a 5.4% decrease in physician payments in 2002 and will continue to cause decreases until the process is changed.

In recent years, Congress has staved off additional reductions by providing small increases in pay. This year's Deficit Reduction Act provided another 1-year fix to the physician payment issue, a "0%" update, instead of a fee increase.

"Unfortunately, under the existing formula, physicians are expected to take another 4.4% reduction in 2007," said Chuck Clapton, chief counsel for the House Energy and Commerce Committee's subcommittee on health.

"We have to make sure that beneficiaries continue to get access to physician services," Mr. Clapton said. At some point, this will require yet another short-term fix for 2007, but for the long term, "it's my chairman's [Rep. Joe Barton (R-Tex.)] vote that we take more [systematic] steps to address some of the underlying problems that led to these recurring issues."

Pay for performance should factor into this reform, Mr. Clapton said. "We should eventually move toward systems built on rewarding for high-quality services."

Sen. Max Baucus (D-Mont.), ranking member of the Senate Finance Committee, agreed that the issue was complex and expensive. "We anticipate action on the issue this year," said Carol Guthrie, an aide to the senator, in an interview. "Sen. Baucus feels that it's vital, given our country's limited pool of health care dollars, to recognize and encourage excellent provider care with pay-for-performance measures."

Health savings accounts and high-deductible plans 'will make health care more expensive for those who stay behind in traditional coverage.'

Sen. Baucus will continue to work with Sen. Chuck Grassley (R-Iowa), chair of the Finance Committee, to approve the pay-for-performance legislation they wrote together, Ms. Guthrie said. "Sen. Baucus was very disappointed to see that most pay-for-performance provisions were stripped from the [Deficit Reduction Act]."

The panel also touched upon health savings accounts, with the Republican staffers supporting the approach as an affordable health care option that's already shown signs of success.

Congressional Democrats have historically criticized these plans for attracting only the young, healthy, and wealthy. This is what health care analysts call "adverse selection," Sen. Baucus said in a recent statement. "Encouraging healthier Americans to choose these accounts and high-deductible plans will make health care more expensive for those who stay behind in traditional coverage," he said. "These accounts will lead to a weaker health care system, not a stronger one."

Other issues on the congressional health care agenda in 2006 include:

► **Medicaid's waiver process.** With the flexibility that the Deficit Reduction Act provided to the states, "we believe we will have a fresh look at [Medicaid's] 1115 waiver process," Mr. Hayes said. The waivers give states the authority to make broad changes in eligibility, benefits, or cost-sharing in Medicaid, providing additional elbow room to test innovative coverage options.

Although it's been a necessary element for states to manage their Medicaid programs, it's still largely operating the way it did in 1965, he said. "We're looking for more transparency, more accountability between the states and the budget neutrality requirements, and also more examination about the lessons learned about those demonstrations, to really turn that program into the demonstration program it was intended to be."

► **State Children's Health Insurance Program.** SCHIP is back on agenda this year, because a number of states are facing shortfalls in 2007 for the program, Mr. Hayes said. "We want to make sure that health coverage for children is protected."

► **Health information technology networks.** The health care industry appears to be moving toward paperless systems, so it would be beneficial to come to some agreement on standards for an interoperable system, said Stephen J. Northrup, health policy staff director for the Senate Health, Education, Labor, and Pensions Committee.

► **Affordable coverage for small businesses.** The Senate Health, Education, Labor, and Pensions Committee is working on legislation to give small businesses newer and more affordable options to pool their resources, offering them more market value and relief from mandates, Mr. Northrup said. ■

Patient Assistance Programs Can Go On, CMS Says

Pharmaceutical companies should not end their patient assistance programs because of the implementation of the Medicare Part D prescription drug program, according to a statement from the Centers for Medicare and Medicaid Services.

Companies can continue to provide free and reduced-cost drugs to Medicare beneficiaries as long as it is done outside of the Part D benefit.

For example, a pharmaceutical company can provide coverage for certain drugs that are part of the Medicare Part D benefit, but no claims for payment can be filed with the Medicare Part D drug plan for that medication and the cost of the medication will not be counted toward the beneficiary's true out-of-pocket costs, according to CMS.

The Department of Health and Human Services' Office of Inspector General (OIG) issued a special advisory bulletin last November warning that pharmaceutical companies would be at risk under the federal antikickback statute if they paid all or a portion of a Medicare beneficiary's Part D cost sharing for their company's products. But the OIG bulletin outlined alternative program designs that would allow Medicare beneficiaries to continue to receive assistance.

"The bulletin also makes clear that pharmaceutical companies may choose to provide free or reduced-price drugs to financially needy Part D beneficiaries, [as] long as the assistance program is properly structured and the free or reduced-price drugs are provided entirely outside the Part D benefit," the CMS statement said.

In addition, the recent OIG guidance does not apply to uninsured patients and Medicare beneficiaries who have not enrolled in the Part D benefit.

But pharmaceutical companies are looking for additional information from both CMS and OIG to explain how companies can continue their current patient assistance programs to help Medicare beneficiaries.

—Mary Ellen Schneider

Compliance Can Be Shown by Accurate Company Records

BY MARY ELLEN SCHNEIDER

Senior Writer

LAS VEGAS — Proper documentation is key to an effective corporate compliance program and can serve as evidence of a good-faith program to investigators, one compliance expert said at a meeting on reimbursement sponsored by the American College of Emergency Physicians.

Documentation should include the group's compliance policies and procedures, training, and any compliance issues and the resolution, said Edward R. Gaines III, senior vice president for compliance and general counsel for Healthcare Business Resources Inc. of Durham, N.C.

But documentation can be a double-edged sword if it's inaccurate when it's created or if it has been manipulated to pass an audit, Mr. Gaines said.

The Health and Human Services Department's Office of Inspector General names seven elements of an effective corporate compliance program:

► Compliance standards and policies.
► Oversight.
► Education and training.
► Effective lines of communication.
► Monitoring and auditing.
► Enforcement and discipline.
► Response and prevention.

Another important element of a compliance program is the ability to prevent and detect fraud and abuse, Mr. Gaines said. Implementing a corporate compliance program will mitigate the risk of potential liability.

Penalties under the Federal False Claims Act are possible as well. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) expanded the federal False Claims Act to all payers, including commercial claims. And the government does not need proof of intent to take action. Physicians are liable for knowingly allowing or encouraging false claim submission, being deliberately ignorant, or having a reckless disregard for the truth, according to the HIPAA law.

In addition, even if the physician is not responsible for performing the billing and coding, they are liable if the claim is submitted in their name.

Mr. Gaines advised physicians to start by getting a commitment to the compliance program from senior-level executives in the organization.

"One of the [places] where compliance programs frequently fail is that they don't have clear leadership from the top," Mr. Gaines said.

Create an environment where physicians and staff members are free to question without fear of retribution or retaliation, he added. And groups should be willing to bring issues to resolution even if it takes years, he said.

Medicare contractors and other auditors will use data analysis to detect aberrant billing practices. The auditors tend to rely on billing reports that compare providers of the same specialty in an area. The auditor might also look at increases in critical care utilization versus historical trends for the group, for example.

But physicians groups can be prepared, Mr. Gaines said, but considering why their E/M coding and billing data might be different from CMS national or Medicare carrier data. For example, higher coding could result from features such as the presence of urgent care facilities or clinics in close proximity to the ED, admission criteria, EMS preference, or the presence of a nursing home nearby or on the hospital campus, he said. ■