Washington News

Legislative Update

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The first session of the 106th Congress came to a close with a whirlwind of negotiation, bipartisan compromise, and legislative drafting and redrafting through the night. Ultimately, the daunting final efforts culminated in several significant pieces of legislation and laid the groundwork for new initiatives to be tackled during the second session. In addition to advocating for pain management physicians on Capitol Hill, AOPMA also has been continuously monitoring several administrative and professional issues critical to physicians.

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999

Among the most crucial healthcare legislation for which consensus was reached in the final days of the session was the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (the "Act"). The legislative package, agreed upon by the White House and the Congress, provides an estimated \$16 billion over five years and \$27 billion over ten years in financial relief from the spending cuts imposed by the Balanced Budget Act of 1997. The givebacks are not without concern however. Both the General Accounting Office and the Medicare Payment Advisory Commission ("MedPAC") have warned that it is premature to assess whether the BBA policies are responsible for any of the existing or predicted fiscal problems.

Physicians, hospitals, skilled nursing facilities, rural health care and home health providers received significant financial relief. The core of these provision are highlighted below.

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1. Hospital Outpatient Prospective Payment System

The Act provides BBA relief to hospitals through changes in the hospital outpatient department (HOPD) prospective payment system and reimbursement for graduate medical education. The Act aims to address several of the major unanticipated affects of the HOPD PPS by: requiring outlier adjustments; permitting pass-through for additional costs associated with the use of innovative medical devices, drugs, or biologics; authorizing HOPD payment to be based on mean hospital cost versus the median; limiting the variation of resource consumption among services within an ambulatory payment classification ("APC"); increasing payments, over a four year transition period, for services slated to be paid less under the PPS than prior to the BBA; providing increased payments for small rural hospitals; and eliminating the budget neutrality requirement for changes mandated by the Act.

Of the changes listed above, the outlier adjustments, the mean cost, APC variation, and four year transition period provisions may have the most direct impact on physician services. The outlier adjustment language requires the Secretary to provide additional payment for HOPD services or groups of services for which the hospital's charges, adjusted to cost, exceed a fixed formula provided in the Act. Aggregate outlier adjustment payments are limited annually to a fixed percentage of the total program payments for all HOPD services. For years before 2004, this fixed percentage is 2.5%. Use of mean rather than median costs may, for some services, increase payment rates simply because the mean cost may be greater than the median resulting in a greater relative weight assignment.

The Act also constrains the Secretary's freedom to develop APCs by requiring that items and services within a group not be treated as "comparable," and therefore, may not be

grouped together and assigned the same payment rate, if the highest median or mean cost for an item or service within the group is more than two times greater than the lowest median or mean cost for another item or service in the same group. As a result, the APCs which include pain management services may be remodeled if the variation in costs among the current APCs exceeds the statutory limit. Furthermore, the Secretary is mandated to seek advice from providers on the clinical integrity of the APC groupings.

2. Graduate Medical Education

Teaching hospitals are slated to receive some financial relief from BBA provisions implementing a gradual reduction of indirect medical education payments and a cap on the number of residents for which a graduate medical education program will receive Medicare funding. In relation to Direct Graduate Medical Education, the relief package establishes a payment methodology for resident services based upon a national average per resident payment amount adjusted for geographic wage differences in order to adjust for differences in costs related to physician training across the country. Beginning in fiscal year 2001, each hospital's per resident amount would be benchmarked against standardized upper and lower national average per resident amount thresholds (also adjusted for locality). Institutions with per resident amounts below 70% of the adjusted national average would have their per resident payments increased to 70%, and payments to hospitals with per resident amounts greater than 140% of the average would be frozen for two years and updates of consumer price index minus two percentage points the following three years. Hospitals with per resident amounts within the 70% and 140% thresholds will continue to receive their current per resident amounts, which will be updated annually for inflation.

Graduate medical education in rural areas received unique support as part of a larger package of BBA relief for rural health providers. The BBA included resident ceilings to limit the growth of new or expanded residency programs. However, the potentially adverse impact the caps may have on the number of available rural health providers, however, Congress directed the Secretary to give special consideration to rural and frontier residency programs in implementing GME regulations. Following release of the GME rule, rural programs argued that despite this directive they did not receive any specific protections. As such, the Act attempts to promote residency opportunities in rural areas

by allowing a 30% expansion in residents in rural areas, permitting urban hospitals with accredited rural medicine training programs to receive direct and indirect medical education payment for cost reporting periods beginning on or after April 1, 2000, and authorizing certain previously uncounted residency slots in the Veteran's Hospital system to be included in the residency limits established under the BBA.

3. Physician Fee Schedule

The Act makes several technical changes to the methodology for calculating the annual physician fee schedule conversion factor in order to limit oscillations in physician payment related to the annual update. Besides requiring that future update adjustments be based upon data measured on a calendar year basis and adding a new component to the conversion factor formula to account for past year variances from allowed spending, the Act also requires that sustainable growth rate to be calculated on a calendar basis and requires that an estimate of the conversion factor be publicly available by March 1st of each year. The Agency for Health Care Policy and Research is charged with conducting a study on the utilization of physician services under the fee-for service program.

Another important amendment to the BBA - particularly for AOPMA members - is the requirement that the Secretary establish a process under which HCFA would accept and use, to the maximum extent possible within sound statistical methods, practice expense data collected by organizations and entities in determining practice expense relative value units.

4. Ambulatory Surgery Center

Importantly, the Act also includes a phase-in process for the recently proposed ASC payment system. Historically, Medicare payments for services in ASCs have been based on a fee schedule. According to legislative mandate, HCFA published proposed regulations in June of 1998 updating the ASC rate-setting methodology by using 1994 survey data and regrouping ASC-approved procedures into APCs similar to those to be implemented as part of the hospital outpatient prospective payment system. In response to strong opposition, including significant input from AOPMA, to HCFA's reliance on the now outdated survey data for ASC final rule, the Act authorizes the Secretary to implement the new system over three years and encour-

ages HCFA to incorporate the 1999 survey data, which is currently being collected. For ASC rates based on pre-1999 data, the new ASC rates cannot exceed one-third of the total payment made to an ASC in the first year and two-thirds in the second year.

5. Rural Provider Provisions

Several of the BBA reforms aid Medicare beneficiaries in rural and frontier America by improving the Critical Access Hospital (CAH) Program. Under the BBA, for a small, rural, limited service hospital to be classified as a CAH, it must be geographically remote, a rural nonprofit or public hospital certified by the state as a necessary provider, and generally provide lengths of stays of no more than 96 hours. To strengthen and broaden the CAH program, the Act applies the 96 hour limit on hospital stays as an annual average rather than a strict 96 hour per patient limit, expands the program to for-profit entities, permits hospitals that closed within ten years of the enactment of the Act or downsized to a clinic to obtain CAH status, authorizes the outpatient departments of CAHs to be reimbursed facility fees on a cost basis and beyond the physician fee schedule for professional services, eliminates beneficiary co-payments for clinical diagnostic laboratory tests furnished in CAH outpatient departments, and grants CAH participation in the skilled nursing facility swing bed program.

6. Home Health Care Services

Among those hardest hit by the BBA were providers of home health care services. To ensure that Medicare beneficiaries will continue to have access to these services, the Act includes relief from several key BBA mandates. The Act delays the 15% cut in Medicare payments to home health agencies ("HHAs") scheduled for October 1, 2000, until one year after the implementation of the home health prospective payment system, requires Health and Human Services (HHS) to report to Congress if the 15% or any other reduction in reimbursement rates is necessary within six months after the implementation of the PPS; provides for an interim administrative payment to HHAs of ten dollars per beneficiary to offset the costs of collecting OASIS data during 2000; increases the per beneficiary limit 2% under the interim payment system for HHAs below the national median payment level for cost reporting periods beginning in or after fiscal year 2000; eliminates the BBA requirement that HHA's bill durable medical equip-

ment, including oxygen and oxygen supplies, under consolidated billing; and relaxes the HHA's surety bond requirements of HHAs

7. Therapy Services

The BBA implemented annual caps on Medicare payments for outpatient therapy services rendered by nonhospital providers. The first cap limits annual per beneficiary Medicare payments for speech language pathology services and physical therapy to \$1,500. A second limits the occupational therapy benefit to \$1500 per beneficiary annually. The Act provides a two year moratorium on the caps for services provided during 2000 and 2001. In addition, the legislation directs HHS to conduct focused medical reviews of therapy claims during these two years with particular emphasis on services provided to residents of skilled nursing facilities and to recommend an alternative payment system for outpatient therapy services based on beneficiaries' diagnosis and their functional status.

Pain Relief Promotion Act

On October 27, 1999, the House of Representatives passed the Pain Relief Promotion Act (H.R. 2260) which would invalidate Oregon's assisted suicide law by banning the use of federally regulated drugs for assisted suicides and preventing the U.S. Attorney General from recognizing any state law that permits assisted suicide or euthanasia.

This legislation also amends the Controlled Substances Act to provide that alleviating pain or discomfort in the usual course of professional practice is a legitimate medical purpose for the dispensing of a controlled substance that is consistent with public health and safety, even if the use of such a substance may increase the risk of death. Moreover, the bill mandates and pays for training programs in pain management at the local, state and federal level.

A companion bill (S.1272) introduced by Senate Majority Whip Don Nickles (R-Okla.)(S.1272) is pending before the Senate. The legislation was inadvertently referred to the Senate Judiciary Committee, instead of the Health, Education, Labor, and Pensions (HELP) Committee. To have the bill redirected to the HELP Committee, unanimous consent must be reached by members of the Senate. Moreover, Senate leaders indicate they have the votes to pass the measure despite a threatened filibuster from Senator

Ron Wyden (D-OR), who has introduced a measure, the Conquering Pain Act of 1999 (S.941), to compete with S. 1272.

HHS Appropriations

On November 29, 1999, the President signed the Omnibus Consolidated Appropriations Act 2000 (H.R.3194), which contains long-awaited funding for HHS. Overall, the Labor-HHS portion of the measure provides \$96.8 billion in discretionary spending for fiscal year 2000, which is \$1.39 billion more than the version of the bill that was vetoed by the president on November 3. The measure also includes a financial package for medicare providers totaling \$16 billion over five years and \$27 billion over ten years, and sets forth changes to Medicaid and the State Children's Health Insurance Program.

The bill provides the Agency for Health Care Policy and Research \$111.4 million to carry out Titles III and IX of the Public Health Service Act and Part A of Title XI of the Social Security Act. In addition, the Substance Abuse and Mental Health Services Administration will receive \$2.6 billion to for carrying out Titles V and XIX of the Public Health Service Act.

This measure also provides \$17.9 billion for the National Institutes of Health (NIH) for fiscal year 2000, a 15 percent increase above 1999 levels. Moreover, the bill authorizes \$40 million in funding for pediatric medical education. In addition, the measure includes \$1.59 billion for the Ryan White AIDS program, an increase of \$184 million over last year. There is also a \$264 million increase in disease prevention programs under the Centers for Disease Control (CDC), bringing fiscal year 2000 funding to \$3 billion.

Healthcare Integrity and Protection Data Bank Launched

The new Healthcare Integrity and Protection Data Bank required by the Health Insurance Portability and Accountability Act of 1996 was launched November 22. Different than the National Practitioner Data Bank, which was developed to protect patients by organizing malpractice payment information and adverse licensure and clinical privilege actions, the purpose of the new data bank is to aid in the government's fight against fraud. Under the final rule, state and federal law enforcement, licensing and certifying boards, and health plans are expected to report exclu-

sions of providers from the Federal healthcare programs, criminal convictions, civil judgments, as well as license actions. Reports regarding provider "overpayments," however, need not be reported.

No entity is required to query the data bank, as is the case with the National Practitioner Data bank, but health plans and state and federal agencies may choose to inquire about providers voluntarily. In addition, providers may make self-query of the data bank.

National Labor Relations Board Rules House Staff are Hospital Employees

Physicians gained additional support in the ongoing efforts to organize. On November 26th, the National Labor Relations Board reversed a 20-year history of considering hospital house staff as students by ruling that interns, residents and fellows at Boston Medical Center are employees. The decision now makes some 90,000 house staff members in private institutions across the country eligible to unionize under the National Labor Relations Act. The two dissenting members argued that the decision would irreparably damage graduate medical education by permitting collective bargaining to impose upon academic freedom.

Institute of Medicine Reports Up To 98,000 Americans Die Annually Due to Medical Errors

On November 29th, the Institute of Medicine's Committee on Quality of Health Care in America released *To Err is Human: Building a Safer Health System*. (The report may be accessed on IOM's website at <http://www.iom.edu>). According to the report, between 40,000 and 98,000 lives are lost each year due to medical errors. IOM estimates that of these deaths some 7,000 are related to prescribing errors. In addition, the estimated cost to the healthcare system for all the errors is estimated to be \$29 million.

Both the White House and Congress took immediate action on the findings. By Executive Order, President Clinton ordered the Federal Quality Interagency Coordination Task Force, which organizes quality control of the federal health programs, to study IOM's findings and make recommendations to the Administration within 60 days. Senator Edward Kennedy (D-MA) announced that he will introduce patient safety legislation early in the second session in response to IOM's findings.