Health Industry Online

January 3, 2006 ● STRASBURGER & PRICE, LLP

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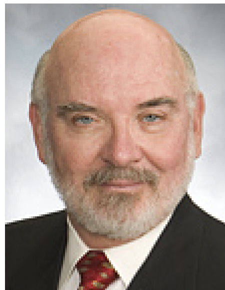

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CONGRESS EXPANDS PHYSICIAN REPORTING OF QUALITY MEASURES

Medicare Part B provides payments for physicians' services, outpatient hospital services, durable medical equipment, physical therapy and certain other outpatient services. Generally, Part B payments are made on the basis of fee schedules that are adjusted for inflation each year. Physician services, however, are adjusted through a methodology known as the Sustainable Growth Rate ("SGR").

A survey of the publications of various medical societies and associations make it clear that organized medicine is no fan of the SGR. The SGR is a complex formula that was designed to suppress the growth in spending by Medicare for physicians' services. Payment rates for "incident-to" goods and services, which include laboratory tests and physician-administered drugs (such as chemotherapeutic formulations), are not determined by the physician fee schedule.

The SGR consists of three components, each of which is based on a statutory formula. The components are:

1. Expenditure targets established by applying a growth rate (calculated by formula) to spending during the base period of April 1, 1996, to March 31, 1997;
2. The growth rate, which factors in inflation, the changes in Medicare enrollment, a 10-year average annual growth rate of GDP per capita, and the impact of changes in law or regulation that would affect spending for services that are subject to the SGR; and
3. Annual adjustments to payment rates for physicians' services, which are designed to bring spending in line with the Medicare expenditure targets over time.

The Congressional Budget Office ("CBO") reported on September 6, 2006, that the future of the SGR was questionable given that Congress had overridden the formula's result in each of the past four years.[1] In December 2006, Congress once again overrode the SGR through passage of the "Tax Relief and Health Care Act of 2006" ("Act"). President Bush signed the Act, which contains provisions that avert what would have otherwise been SGR-mandated cuts of approximately five percent (5%) in Medicare payments to physicians in 2007. The CBO has suggested that the results of SGR calculation will result in greater reductions in future physician payment rates.

While a major focus of the Act, the overriding of the negative effect that the SGR would have on 2007 physician reimbursement rates is only part of the story. The Act also contained provisions that provide physicians with a one and one-half percent (1.5%) bonus payment for reporting on

[1] See http://www.cbo.gov/ftpdocs/75xx/doc7542/09-07-SGR-brief.pdf for an in-depth discussion of the formula.

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quality measures between July and December 2007. The payment would be based on previously developed reporting requirements. The Act does not mandate that any of the data reported by individual physicians be made public or that a certain level of compliance with the quality indicators must be achieved to receive the bonus payment.

The quality measures to be used for reporting under the Act will be taken from the measures developed for the Physicians Voluntary Reporting Program ("PVRP"). CMS established the PVRP as of January 1, 2006, and the PVRP is part of CMS' comprehensive efforts to "identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care."[2] CMS reports that PVRP measures consist of evidence-based, clinically valid quality measures. The measures are also part of quality guidelines that have been endorsed by medical specialty societies.

The list of 2007 quality measures for reporting under the Act is as follows:

2007 Physician Voluntary Reporting Program
Physician Quality Measures[3]

1.* Hemoglobin A1c control in Type 1 or 2 diabetes mellitus
2.* Low density lipoprotein control in Type 1 or 2 diabetes mellitus
3.* High blood pressure control in Type 1 or 2 diabetes mellitus
4.** Falls: Screening for fall risk
5.* Heart Failure: Angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy for left ventricular systolic dysfunction (LVSD)
6. Antiplatelet therapy prescribed for patient with coronary artery disease
7.* Beta-blocker therapy for patient with prior myocardial infarction
8. Beta-blocker therapy for left ventricular systolic dysfunction
9.* Antidepressant medication during acute phase for patient with new episode of major depression
10. Stroke and Stroke Rehabilitation: Computed tomography (CT) or Magnetic resonance imaging (MRI) reports
11. Stroke and Stroke Rehabilitation: Carotid imaging reports
12. Primary Open Angle Glaucoma: Optic nerve evaluation
13. Age-Related Macular Degeneration: Antioxidant supplement prescribed/recommended
14. Age-Related Macular Degeneration: Dilated Macular examination
15. Cataracts: Assessment of visual functional status
16. Cataracts: Documentation of pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation
17. Cataracts: Pre-Surgical dilated fundus evaluation
18. Diabetic Retinopathy: Documentation of presence or absence

[2] *See* Background and General Information on the PVRP as published by CMS at: http://www.cms.hhs.gov/PVRP/Downloads/PVRPBackground.pdf.
[3] Quality Measures #1-#45 are effective as of January 1, 2007; Quality Measures #46-#66 are expected to become effective sometime after January 2007. Quality measures denoted with an "*" are measures from the 2006 PVRP Core Starter Set. Quality measures denoted with an "**" are AMA-PCPI Measures substituted for measures of the same topic as the 2006 PVRP Core Starter Set.

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of macular edema and level of severity of retinopathy
19. Diabetic Retinopathy: Communication with the physician managing ongoing diabetes care
20.** Perioperative Care: Timing of antibiotic prophylaxis - ordering physician
21. Perioperative Care: Selection of prophylactic antibiotic - first OR second generation cephalosporin
22. Perioperative Care: Discontinuation of prophylactic antibiotics (non-cardiac procedures)
23.** Perioperative Care: Venous thromboembolism (VTE) prophylaxis (when indicated in ALL patients)
24. Osteoporosis: Communication with the physician managing ongoing care post fracture
25. Melanoma: Patient medical history
26. Melanoma: Complete physical skin examination
27. Melanoma: Counseling on self-examination
28.** Emergency Medicine: Aspirin at arrival for acute myocardial infarction (AMI)
29.* Beta blocker at time of arrival for acute myocardial infarction
30. Perioperative Care: Timing of prophylactic antibiotic - Administering physician
31. Stroke and Stroke Rehabilitation: Deep vein thrombosis prophylaxis (DVT) for ischemic stroke or intracranial hemorrhage
32. Stroke and Stroke Rehabilitation: Discharged on antiplatelet therapy
33. Stroke and Stroke Rehabilitation: Anticoagulant therapy prescribed for atrial fibrillation at discharge
34. Stroke and Stroke Rehabilitation: Tissue plasminogen activator (t-PA) considered
35. Stroke and Stroke Rehabilitation: Screening for dysphagia
36. Stroke and Stroke Rehabilitation: Consideration of rehabilitation services
37.* Dialysis dose in end stage renal disease (ESRD) patient
38.* Hematocrit level in end stage renal disease (ESRD) patient
39. Screening or therapy for Osteoporosis for women aged 65 years and older
40. Osteoporosis Management following fracture
41. Osteoporosis pharmacologic therapy
42. Osteoporosis: Counseling for vitamin D, calcium intake, and exercise
43.* Use of IMA in coronary artery bypass graft (CABG)
44.* Pre-operative beta blocker in patient with isolated coronary artery bypass graft (CABG)
45. Discontinuation of prophylactic antibiotics (cardiac procedures)
46. Medication Reconciliation
47. Advance Care Plan
48. Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
49. Characterization of Urinary Incontinence in Women Aged 65 Years and Older
50. Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
51. Spirometry evaluation

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52. Bronchodilator therapy
53. Percent of patients with mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
54. Electrocardiogram performed for non-traumatic chest pain
55. Electrocardiogram performed for syncope
56. Vital signs for community acquired pneumonia
57. Assessment of oxygen saturation for community acquired pneumonia
58. Assessment of mental status for community acquired pneumonia
59. Empiric antibiotic for community acquired pneumonia
60. Assessment for alarm symptoms
61. Upper endoscopy for patients with alarm symptoms
62. Biopsy for Barrett's Esophagus
63. Barium Swallow- inappropriate use
64. Percent of patients who were evaluated during at least one office visit during the reporting year for the frequency of daytime and nocturnal asthma symptoms
65. Percent of patients who were given a diagnosis of upper respiratory infection and were not dispensed an antibiotic prescription on or 3 days after the episode date
66. Percent of patients who were diagnosed with pharyngitis, prescribed an antibiotic and who received a group A streptococcus test for the episode

The Act authorizes the Secretary of Health & Human Services to modify the quality measures until July 1, 2007. Thus, the exact composition of the quality measures may not be known until that date. The Act further directs the Secretary to develop a set of quality measures for use in 2008 no later than November 15, 2007.

Physician groups have expressed unhappiness about the reporting provisions of the Act primarily because of the cost of participating in the PVRP. The cost of tracking the selected quality measures may exceed the bonus payment for compliance. The cost of non-participation by physician may also go beyond the loss of the 1.5% bonus payment.

The use of quality measures is a key component of pay for performance ("P4P") models. CMS has continually expressed its desire to move Medicare to a P4P payment methodology. Physician groups that anticipate the advent of a formalized Medicare P4P performance model and that develop the necessary IT infrastructure to accomplish the reporting of quality measures, like those developed under the PVRP and used under the Act, will be better able to transition to the new payment models. Those that eschew participation will likely find themselves behind the curve in investing the capital and training necessary to compete in future programs and payment models that rely on quality measures.

To quality for the 1.5% incentive payment, a physician must report at least eighty percent (80%) of patient cases if there are no more than three quality measures that are applicable to services provided by a

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health care professional during the reporting period prescribed in the Act. If four or more quality measures are applicable to the services provided by the health care professional during the applicable reporting period, at least 80% of three of such quality measures must be reported. The Act provides that CMS should audit physicians' reports to ensure compliance with this requirement.

To conclude, the SGR was developed to limit the growth in Medicare payments to physicians. Prior to the use of the SGR, Congress determined the increases in Part B payments to physicians through annual updates to the Medicare physician fee schedule. Physicians deemed the end of year legislative activity, including passage of the Act, as necessary because the SGR mandated an across the board reduction in 2007 physician payment rates. It is likely that without a change in the SGR that a repeat of such legislative activity at the end of 2007 will occur. If no further overrides are made by Congress, the CBO projects that the SGR will produce continued decreases in physician reimbursement rates, but will result in a growth of Medicare spending on physician services in 2012 (due to growth in volume and intensity of services provided) that will be only thirteen percent (13%) higher than spending on physician services in 2005.

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