Dateline Washington

prepared by the Division of Advocacy and Health Policy

CMS issues guidance on EMTALA care for aliens

The Centers for Medicare & Medicaid Services (CMS) issued final guidance on May 9 regarding the use of funds set aside to help hospitals and other providers recoup some expenses incurred when providing care to undocumented aliens under the Emergency Medical Treatment and Active Labor Act (EMTALA). Provisions in the Medicare Prescription Drug Improvement and Modernization Act set aside $1 billion in funding through 2008 for these services. Under the final rule, the money may be used to cover all medically necessary and appropriate services that physicians furnish to EMTALA patients in both inpatient and outpatient hospital settings, as well as related ambulance services. Although each state will receive federal funding, six states with relatively high numbers of undocumented aliens—California, Texas, Arizona, New York, Illinois, and Florida—will receive larger dollar amounts.

According to the announcement, providers will be able to claim payment for emergency services furnished to eligible patients on or after May 10, once the single contractor responsible for enrolling providers and processing claims nationwide has been designated. All claims must be filed electronically within 180 days of the end of the federal fiscal quarter in which the services were provided. Also of interest, CMS dropped an earlier, controversial proposal to require hospital staff to ask patients directly about their citizenship or immigration status. Information on the program and the new guidance material can be found at *http://www.cms.hhs.gov/providers/section1011/.*

Congress continues to review Medicare payment issue

On May 12, Reps. Clay Shaw (R-FL) and Ben Cardin (D-MD) introduced H.R. 2356, legislation to reform the method used to determine Medicare payments to physicians. H.R. 2356 would repeal the current sustainable growth rate (SGR) methodology, which will cut physician payments by an estimated 4 to 5 percent annually for the next seven years. Instead of the SGR, H.R. 2356 would determine physician payments using the Medicare economic index, which is based on annual changes in physicians' costs to care for patients. While organized medicine views these provisions as the ultimate goal of Medicare physician payment reform, passage of the bill this year is unlikely because of its estimated $150 billion budget impact.

Meanwhile, Sens. Jon Kyl (R-AZ) and Debbie Stabenow (D-MI) introduced S. 1081, which would provide temporary relief to the Medicare payment crisis. Instead of replacing the current system, the Senate bill would legislate across-the-board payment updates based on inflation in 2006 and 2007.

In related activity, the American College of Surgeons sent a letter on April 22 to the chairs and ranking Democratic members of the key congressional committees that are considering options for addressing the problems in the Medicare physician fee schedule. The letter explains that reduced reimbursements, coupled with increasing expenses, are putting the viability of surgical practices in jeopardy. The letter notes that, unlike other physicians, surgeons cannot recover lost revenue by increasing volume and that the quantity of surgical services has remained relatively stable over the years. The College urged Congress to stop the scheduled Medicare payment reductions from taking

effect. The full text of the letter can be viewed at *http://www.facs.org/ahp/views/sgr.html.*

CMS clarifies volunteer faculty payment rules

CMS has posted information on its Web site clarifying Medicare direct medical education (DME) payment rules for residency training outside the teaching hospital environment. Answers posted for nine frequently asked questions about payment and documentation policies pertaining to volunteer faculty might interest surgeons.

On the Web site, CMS notes that to receive DME payments, teaching hospitals must incur all or most of the direct costs of training a surgical resident in a nonhospital setting. If the outside facility or volunteer teaching faculty incurs costs, the hospital must sign a written agreement to cover those costs to receive payment for them. The agency goes on to state that costs include such items as a portion of a teaching physician's salary and fringe benefits and travel and lodging costs of the residents. Historically hospitals have been reluctant to pay for the costs of off-site training. For more information, go to *http://www.hhs.gov/providers/hipps/non-hospQA.pdf.*

Hospital pay-for-performance program applauded

Premier, Inc., a nationwide alliance of about 1,500 not-for-profit organizations, announced May 3 that a demonstration project on hospital pay-for-performance offers promising evidence that financial incentives may improve quality of care. The CMS/Premier Hospital Quality Incentive Demonstration Project tracks hospital performance using a set of 34 nationally standardized and widely accepted quality indicators and pays annual incentives to top performers among the more than 270 participating hospitals. In just one year, the median performance composite score for all hospitals increased by 7.5 percent, according to the release. The five clinical focus areas of the project include acute myocardial infarction, coronary artery bypass graft surgery, heart failure, pneumonia, and hip and knee replacement surgery. CMS Administrator Mark McClellan, MD, PhD, echoed the findings, concluding that limited performance-based payments can improve quality of care while lowering Medicare program costs.

During the first year of the program, hospitals scoring in the top 10 percent of these quality measures receive a 2 percent point bonus on the Medicare payments for each condition. Those in the second 10 percent receive a 1 percent bonus, while hospitals remaining in the top 50 percent are recognized for their quality. At the end of the first year, static baselines will be set for the top 10 and bottom 20 percent. Any hospitals below the 20 percent bottom baseline at the end of the three-year demonstration will face a 2 percent payment penalty, while those remaining in the bottom 90 percent will receive a 1 percent penalty.

In addition, the U.S. Department of Health and Human Services launched a new Web site April 1 that provides patients with access to comparative hospital performance information on specific quality measures pertaining to heart attack, heart failure, and pneumonia. The Web site, *http://www.hospitalcompare.hhs.gov,* contains government-verified data voluntarily provided by the hospitals themselves.