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*In case you missed it, this important Health Policy report was presented at the CUA Annual Meeting held in Hawaii. Please read at your convenience.*

### **HEALTH POLICY COMMITTEE UPDATE 2010**

**Submitted By Jeffrey Kaufman MD, FACS, Chair, Health Policy Committee**

Although many changes pertaining to health policy were enacted this year by CMS and other groups who implemented laws and rules drafted in 2009, the big event occurred early in the year with the passage of the Patient Protection and Affordable Care Act (usually referred to as the Affordable Care Act or ACA) which promises to be a game changer in terms of how physicians are evaluated and paid. Already, the 2010 CMS Final Rules and 2011 CMS proposals reflect implementation of this bill.

Although there are a myriad of details buried within the 2000+ pages of legislation, the major issues—addressing the triplet goals of increased access to care, improved quality and reduced costs—change the basis on which health care delivery is reimbursed from paying for volume to paying for value. Toward this end, there are many new and extended programs for reporting quality outcomes and profiling resource utilization. The end result will be a blend of financial rewards for participation, demonstrating quality outcomes, and cutting costs (gainsharing money saved in the system) offset by fines and penalties for refusing to participate or failing to meet externally set targets. Although metrics designed to measure quality are still in evolution, the current PQRI system is being developed and expanded to allow payers such as CMS to determine which physicians and which treatment strategies are most likely to produce desired outcomes. While current efforts are little more than Pay for Reporting rather than the ultimate Pay for Performance, the goal is to mandate reporting at multiple levels in a fashion that proves that quality care was delivered. The AUA QUIPs committee, Quentin Clemens MD and David Penson MD among others have been leaders in urology's efforts to make sure that the measures used to determine outcomes are fair and reflective of AUA values. Much work was done this year developing guidelines that will form the basis of future standards. Those who have so far refused to participate in PQRI reporting are well advised to begin developing their office systems in advance of fines and penalties for non-participation beginning in 2015. Additionally, since reported quality outcomes will soon be the basis for payment, developing familiarity with the system will pay dividends in the next few years. An update on PQRI quality reporting will be presented by QUIPs chair Quentin Clemens MD as part of our Health Policy Forum at this meeting. Additionally, we will address how quality measures will be combined with resource utilization to determine physician "value" which in turn will impact fee schedules as part of the Sunday discussion. This Physician Feedback Program beginning in 2015 is designed to institute a budget neutral payment adjustment based on comparative quality and cost for specific conditions across various physicians and geographic regions. At the present, prostate cancer is one of the first 5 conditions addressed.

In a further effort to integrate outcomes with cost, CMS is developing various methods to bundle payments in an attempt to improve or maintain quality while cutting the health care budget. Not to be left behind, the large private payers are emulating their efforts. The lead concept among these proposals is known as an Accountable Care Organization (ACO). The intent is to form large health delivery systems able to coordinate care, share information and assume complete responsibility for treatment. If you think this sounds familiar and brings to mind memories of prepaid, full risk, HMO plans, many of which failed in years past, you're not far off the mark. Payers clearly hope that by insisting on reporting of quality measures and providing financial bonuses, providers will be motivated to do better than they have previously. Many of the details of this program are still being developed at this time but a pilot project has already been designed to begin 1/1/11 that includes at least one site in the Western Section. Details of these plans and how they might impact our members will be presented by several speakers as part of our Sunday Health Policy Forum.

Another of the threatening provisions of ACA is the establishment of an Independent Payment Advisory Board (IPAB) that begins in 2014. An appointed committee of 15 full time members, the board will have major responsibility for controlling most financial aspects of health care delivery in the nation, both public and private. Their recommendations based on government projections of whether future budgets will exceed spending targets calculated to cut overall costs will carry the weight of law unless overridden by a supermajority vote of Congress. Since a vote of 60 Senators is unlikely on these proposed changes, it is most probable that the IPAB recommendations will become de facto law in future years. Knowing the bias and philosophy of the current MedPAC who advises Congress on health care issues but has no real power to set policy, we can only guess where the IPAB decisions will take us in the second half of this decade if it is allowed to develop. At the present, efforts are underway to prevent or weaken this proposed panel.

We already see evidence that changes in the system are increasing our practice overhead costs due to greater levels of regulation and mandated reporting. At the same time, there appears to be a dedicated effort to cut physician reimbursement although similar efforts to reign in payments to other elements of the health delivery system are considerably weaker suggesting a bias against physicians. (Remember, even paranoids have enemies!) Although many of these changes are designed to be budget neutral, there is no doubt that the resulting shift of funds from specialists to primary care physicians will have a negative effect on urologists. Going further in this direction, everyone is already aware that payment for consults has been abolished. Although the change was designed to be budget neutral and some money was redistributed to increase surgical codes (adjusting for the E&M portion included in global payments), the net effect of this change was to enrich primary care doctors at the expense of specialists. The AUA among other groups continues to lobby to reverse this decision with little effect.

Unfortunately, both independent decisions at CMS as well as changes due to ACA are negatively impacting the bottom line fee schedule. Everyone is aware that the SGR formula was only temporarily altered (several times) earlier this year. The current freeze is due to expire 11/30/10 at which time overall Medicare fees will drop 23%. One month later, we will enjoy another 6.3% drop. In other words, by 1/1/11, overall Medicare rates will be 30% below 1/1/10. Continued lobbying efforts are underway but there is little chance of any legislation before the upcoming midterm elections. More likely, we will face another 11<sup>th</sup> hour standoff with Congress that will result in another temporary patch. The question is "how long can we continue to blunder along from temporary patch to temporary patch"? Some are of the opinion that we will have one short term fix after another until the IPAB comes into effect in 2014 at which point Congress can comfortably step aside as fees are drastically cut back and declare their good intentions were overridden by the mandates governing the IPAB. This is a very scary scenario with real potential to come true.

As if this weren't enough, several other changes either have been made already or are proposed for the near future that will further cut urology fees. A major factor in determining the relative value units for any given code is the Practice Expense value associated with delivering care. In the past, Practice Expense data was generated by the AUA and accepted by CMS. Last year, CMS began to accept data generated by an AMA survey that was significantly below the values we have found historically. Although the AUA has successfully proven that the AMA data set was based on practices that do not reflect the typical urologist office, CMS has yet to agree to adjust their figures. Consequently, urology codes are being cut 8% over the next four years; this transition was already begun in 2010 and will continue unless CMS agrees with our arguments. An even bigger component of the fee structure is based on the work necessary to provide any given CPT code level of care. Based on a finite sized pie, in the past, the AMA Relative Value Update Committee (the RUC) involved horse-trading whereby various specialties adjusted fees against one another to maintain a fair and balanced payment structure. The ACA has now formally instructed CMS to second guess those values (informally referred to as a Shadow RUC) based on their suspicion that physicians are not honest enough to govern themselves. Assuming inherently misvalued codes, CMS may now unilaterally alter relative fees. This is likely further politicize payments (naturally favoring primary care at the expense of specialists). It also destroys the entire concept of relativity in determining payment. This proposal bodes ill for urologists. In addition, CMS has proposed alternative methods to quantitate the amount of work associated with various procedures. They have gone so far as to propose using time-motion studies to determine how much to pay for care.

Taken altogether, these proposals reflect a mindset suspicious of physician practices and a dedicated desire to drastically cut physician reimbursement.

At the same time, further efforts have been taken to limit ancillary sources of physician income. The ACA formally prohibited further physician ownership of hospitals and even put limits on pre-existing relationships. Greater scrutiny is being paid to potential abusive situations involving physician self-referral for imaging, pathology and radiation oncology services. There has been discussion of severely limiting, altering or even abolishing the In Office Ancillary Service Exemption that allows safe harbor self referral that would otherwise have been prohibited by the Stark Laws. A previous attempt to reduce fees by cutting payment for imaging contiguous areas of the body by the same modality has been significantly extended now to reduce payment for multiple imaging procedures performed on the same day (now including ultrasound) irrespective of whether the imaging modalities are different and independent of what body part is viewed. For urologists who own their own ultrasound machines and perhaps a CT scanner, this will be an expensive adjustment.

Together, these cuts are expected to cost urology at least 1% in 2011 compared to this year in addition to whatever changes occur due to the SGR payment schedule. However, once fully implemented, these proposals could prove much more costly.

Finally, many in Washington have been placing their faith and hopes on implementing electronic health records in an effort to cut waste, improve quality and increase safety by coordinating care and sharing information. Even though these assumptions have never been proven true, arguing the merits of this with the powers-that-be is like discussing religion: unlikely to change anyone's mind and a good chance of inciting a riot. To encourage the transition to computerized records, the federal government has provided more than \$20 billion in various incentives with the promise that they intend to give it all away. To qualify, systems must demonstrate "meaningful use". Unfortunately, the meaningful use standards recently published set a very high bar that is unlikely to be met by many who had counted on receiving up to \$44,000 over the next few years from the government. In the first two years of the program, practices must report on 10 core measures and select another 5 from a menu in addition to 3 general quality measures and another 3 from a list to merit payment. More daunting, the mechanism by which these reports are submitted is challenging. And yet, this reporting mechanism seems the beginning of how payers will evaluate the quality portion of your practice used to determine "value" that ultimately will determine reimbursement rates. For those Luddites who refuse to move to EHR, penalties are pending.

On the legislative front, the AUA has now established a permanent Legislative Committee and increased our lobbying efforts in Washington. The Joint Advocacy Conference this year drew a record number of attendees including a substantial representation from the Western Section. In an effort to elevate recognition of urology's interests, the AUA working together with our lobbyists has introduced 2 major pieces of legislation. Designed as "white hat" issues, legislation to increase research funding and attention to Urologic Trauma has an excellent chance of becoming law as a bipartisan effort to support our troops. Additionally, to brand prostate cancer as urology's main responsibility (and to defend turf infringement from several other specialties), the AUA staff has drafted a bill to better coordinate and increase funding for prostate cancer research. To our delight, this effort has attracted significant support and is moving forward toward passage. The AUA staff has also maintained steady pressure on Congress and CMS to adjust our fees appropriately, resolve the practice expense dilemma, allow ongoing participation in ancillary services and recognize the quality care our members provide to their patients. Recognizing that our specialty is under siege, to protect members and strengthen our advocacy efforts, the AUA has added substantial resources and ramped up attention to focus on these many challenges.