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Massachusetts Plan Hailed As Model For Covering The Uninsured

With the likelihood that national healthcare reform could get caught in a congressional stalemate during this midterm election year, the Massachusetts plan is the latest example that states are becoming the "labs" for testing solutions to help the uninsured.

In what is being lauded as a landmark reform to extend healthcare coverage to the uninsured, the state of Massachusetts this month adopted a bipartisan plan that requires all residents to obtain a minimum level of coverage and establishes sliding-scale premium subsidies for individuals and families with low incomes.

Two big challenges face the plan, say various analysts. First, is it sufficiently financed to underwrite premium supports? Second, can the private health insurance market deliver affordable coverage policies?

The Massachusetts plan aims to expand health insurance coverage to some one-half million uninsured residents. Nationally, the number of the uninsured has been rising in recent years and is now estimated at 46 million Americans. To address the issue, the President has proposed market-based reforms, such as expansion of health savings accounts and creation of small business purchasing pools. For their part, congressional Democrats generally favor expansion of Medicaid and SCHIP programs. But action has been stalled as other priorities dominate this year's run-up to the November elections. See the *Focus*, pp. 4-5.

INSIDE *NIR*

Medicare Physician Fees Slated For Cut

Pathologists and other physicians will have to get Congress to step in to prevent a reduction in their Medicare fees in 2007. As of January 1, a 4.6% cut is projected to take effect, the Centers for Medicare & Medicaid Services announced this month. The negative fee update, based on current estimates, translates to a conversion factor of $36.1542 vs. the current CF of $37.8975.

This year, lawmakers intervened to reverse a 4.4% cut required under the statutory update formula and froze Part B physician fees at their 2005 levels (*NIR, 27, 7/Jan 23 '06, p. 1*).

CMS reported the looming fee cut in an April 7 letter to the Medicare Payment Advisory Commission (MedPAC). Herb Kuhn, director of the CMS Center for Medicare Management, told MedPAC chairman Glenn Hackbarth that the continuing downward pressure on fees results from high rates of growth in the volume and intensity of physician services.

During 2005, total physician spending increased 8.5% and growth in service volume and intensity accounted for 7.5 percentage points, Kuhn noted. Over recent years this growth has ranged from 6% ➥ *p. 2*

Legislation to overhaul the physician SGR formula was introduced last year, but has not moved since. Prospects for action this year are uncertain. But Capitol Hill watchers speculate that lawmakers facing the November elections are unlikely to let the physician fee cut go forward.

Medicare Physician Fees Slated For Cut, *from p. 1*

to 8% per year, exceeding the average annual 2% increase in the volume and intensity factor in the sustainable growth rate (SGR) update formula and triggering negative updates.

The vast majority of the growth in physician spending in 2005, Kuhn said, is attributable to payment increases for follow-up office visits; physical therapy, podiatry, and dermatology codes; imaging services; and lab and other tests.

The CMS report reflects preliminary estimates, he cautioned, and may be revised as more complete data become available prior to publication later this year of the 2007 Medicare physician fee schedule. So far, the data indicate, he noted, that the increased spending appears to be for certain diagnostic and therapeutic services, including those particularly important in treating the growing number of Medicare beneficiaries with chronic illnesses.

"Understanding the relatively rapid growth in these services, and determining whether they are ways to promote better health while slowing the rapid increase in use of these services, is an increasingly important issue," Kuhn said. And in response to these rising healthcare costs, CMS supports MedPAC's "general recommendation for the development of measures related to quality and efficiency of care by individual physicians and physician groups," he concluded.

Meantime, the American Medical Association and other medical groups are pressing Congress and the Bush Administration to act now to stop the Medicare payment cuts and replace "the flawed physician payment formula." Healthcare spending should be seen as a good investment, the AMA said, and doctors should not be penalized for advances that enable people to live longer and avoid or limit hospital stays.

Lab Groups Urge Congress To Boost Allied Health Funding

The aim is to hike funding from the current low of $4 million to at least $11+ million in fiscal 2007, which starts October 1 of this year.

Clinical pathology and laboratory organizations are lobbying Congress to increase fiscal 2007 funding for Title VII health professions programs, including allied health programs that support the training of medical technologists and medical laboratory technicians.

Lawmakers cut the allied health account to $4 million in 2006 from $11.8 million in 2005, while the overall cut to Title VII was 51% [Note: in our April 10 issue, p. 2, we incorrectly reported the 2006 level for allied health as $11 million.] The President's FY 2007 budget request asked Congress to eliminate even this small amount, but the Senate instead adopted a budget plan with the Specter-Harkin amendment which provides $7 billion for health and education programs whose funding levels have steadily eroded over the years, including Title VII.

The expectation, said Matthew Schulze with the American Society for Clinical Pathology, is that this will provide enough funding to get an FY 2007 Title VII appropriation that is at least the FY 2005 level and restore the allied health account to the $11+ million mark.

In testimony supporting an allied health increase, ASCP told the House Appropriations Committee that vacancy rates for medical lab personnel are at an all-time high and will keep rising sharply, while the number of accredited training pro-

grams has steadily declined from 637 in 1994 to 435 in 2004. Fewer than 5,000 individuals graduate each year from accredited programs. Yet, each year until 2014, the Labor Department estimates, 15,000 jobs for lab personnel will open up due to industry growth or replacements for the aging workforce.

House members from both parties have joined the Title VII lobbying. In a letter to House GOP and Democratic leaders, Reps. Charlie Norwood (R-GA), Diana DeGette (D-CO), and 188 other House members urge that the Title VII appropriation be increased to $300 million next year, the level approved for FY 2005. Senate Appropriations Committee leaders have been sent a similar letter, backed by a broad coalition of health professions groups.

On the authorizing front, there has been no movement on legislation targeting new funding support for lab workforce issues—H.R. 1175, the Medical Laboratory Personnel Shortage Act of 2005—though Elissa Passiment, executive vice president of the American Society for Clinical Laboratory Science, told *NIR* that more members of Congress have signed on as co-sponsors following the lab lobbying blitz late last month (*NIR, 27, 12/Apr 10 '06, p. 1*).

H.R. 1175 would authorize $11.2 million in new funding for scholarship and loan repayment programs for medical technologists, medical lab technicians, and other lab personnel (*NIR, 26, 12/Apr 11 '05, p. 2*). The programs include a period of obligated service in a designated health professional shortage area or other area with a shortage of medical lab personnel. Funds also would be provided for faculty development and public ad campaigns to promote careers in the medical lab professions. Further, to increase the number of cytotechnologists trained to screen for cervical cancer, the Act authorizes $10 million, subject to certain limits.

The bipartisan bill was introduced in March 2005 by Reps. John Shimkus (R-IL), Jesse Jackson Jr. (D-IL), and Michael Bilirakis (R-FL). Backers include ASCLS, ASCP, the American Association of Bioanalysts, the American Clinical Laboratory Association, the American Medical Technologists, and various other health professional and trade groups.

CMS Takes More Flak Over 'Medically Unbelievable' Edits

A host of medical, laboratory, and other health provider groups have fired salvos at the Centers for Medicare & Medicaid Services this month, calling upon the agency to make more major modifications to its highly controversial "medically unbelievable" edits. Late last year, CMS proposed MUEs for more than 10,000 CPT/HCPCS codes, including more than 1,100 pathology and lab codes.

CMS has not budged from its position that the MUE initiative will continue, though last month, in response to concerns raised by medical groups, the agency agreed to extend the comment period to June 19 and change the implementation date from July 1, 2006 to no earlier than January 1, 2007 (*NIR, 27, 10/Mar 13 '06, p. 1*).

Here's a quick rundown of the latest volley of letters from the medical, lab, and other health provider groups to CMS administrator Mark McClellan, MD, PhD:

• ***April 10:*** The American Medical Association and 91 physician specialty co-signers said they are "prepared to undertake the MUE revisions," but CMS must do more if it values their participation. Specifically they want the agency to:

—Institute a single review process for the proposed MUEs, ending ➥ *p. 6*

focus on: Healthcare Reform

'Breakthrough' In Massachusetts, Stalemate In Congress

Health reform legislation signed into law this month by Massachusetts GOP Gov. Mitt Romney is being touted as a 'breakthrough' in providing healthcare coverage for the uninsured, one that other states and even the Federal Government could emulate. In Congress meanwhile, action on major bills to tackle the issue of an estimated 46 million uninsured Americans is either unlikely or problematic, say veteran legislative analysts.

The Massachusetts measure has national significance, observed *Los Angeles Times* columnist Ronald Brownstein, because it shows that a Republican administration and a largely Democratic legislature can work together for a compromise solution. It also represents an adroit "political balancing act" by basing the reform on the principle of joint responsibility on the part of individuals, employers, and government.

State Reform 'Breakthrough'

The Massachusetts reform legislation (H. 4850) aims to expand health insurance coverage to nearly one-half million state residents over three years through a combination of an individual mandate, an employer mandate, and premium subsidy programs.

Individual Mandate: Beginning July 1, 2007, all state residents must obtain and maintain a minimum level of health insurance coverage (called "creditable coverage"). This requirement is likened to state requirements that motorists obtain automobile insurance. Premium subsidies will be available on a sliding scale for individuals whose income does not exceed 300% of the federal poverty level.

Residents must confirm on their state income tax forms that they have creditable coverage. The state will monitor compliance through an individual coverage database. Individuals who don't obtain creditable coverage by January 1, 2008 will not qualify for the personal exemption on their state income tax and will be assessed half the cost of an affordable coverage premium. Exemptions to the individual mandate are granted for religious or hardship reasons or when there is no affordable coverage. Individuals can appeal a denied exemption.

Employer Mandate: Employers with more than 10 employees must offer them group coverage or pay an annual $295 assessment per full-time worker. (Gov. Romney, who is weighing a bid for the 2008 GOP presidential nomination, vetoed this provision as an unnecessary tax hike, but at press time, the Democrat-controlled legislature was expected to override it.)

To discourage dipping into state coffers for uncompensated care, employers that don't provide em-

Enrolling The Uninsured & Financing The Costs

The Massachusetts reform plan for reaching uninsured residents estimates that:

— 100,000 individuals will be added to the state Medicaid rolls.
— 200,000 with low income will get premium support for coverage.
— 200,000 will buy privately offered policies with pretax dollars.

Financing for the plan relies on projected contributions from several major sources:

— $385 million in federal matching funds that were contingent on the state implementing an expansion plan in accord with its Medicaid waiver.
— $125 million from general revenues.
— $45-$48 million from the employer assessment.

Still to be seen is whether private insurers can offer coverage products that are affordable to all residents and won't break the bank. Policy premiums in Massachusetts are among the highest in the country. But insurers will work with state regulators to develop quality affordable products, said Karen Ignani, president of the industry trade group America's Health Insurance Plans.

ployee coverage and whose employees seek such care above certain stringent limits are also subject to a "free rider surcharge" that can range from 10% to 100% of the cost of the care.

Health Insurance Connector: The law establishes a body known as the Commonwealth Health Insurance Connector whose job is to link individuals and small businesses with the coverage policy market. This entity is to certify that the policies meet the criteria for creditable coverage. Individuals can also buy coverage through the Connector.

National Reforms Stalled In Congress

The House and the Senate returned from spring break this week, and GOP leaders in both chambers plan to sponsor a "Health Week" to revive languishing GOP healthcare reform bills and bring them to a floor vote. Given Democratic opposition thus far, nothing is likely to pass, but even so, Republicans say this will sharpen the policy differences ahead of the November elections. House GOP leaders expect to hold a "Health Week" this summer. Senate GOP leaders have set aside the first week of May for theirs. The following are major bills to be considered.

Medical Malpractice Reform: A revised S. 354, authored by Sen. John Ensign (R-NV), would raise the cap on jury awards for non-economic damages to $750,000 vs. $250,000 in previous bills. But even this change may not be enough to resolve partisan discord. The GOP majority in the House has passed malpractice reform legislation many times, but similar moves have stalled in the Senate due to Democratic opposition.

Health Savings Accounts: Legislation is being drafted to expand the availability of HSAs, Ensign said. HSAs enable individuals to buy high-deductible coverage for routine care with pretax dollars. In his fiscal 2007 budget request, the President called for expansion of HSAs, but the Senate struck the proposal from the budget alternative it approved. Finance Committee chairman Charles Grassley (R-IA) has said he thinks HSA expansion is unlikely. He also is not keen on the President's proposal for tax subsidies to help individuals buy private insurance coverage, preferring to examine current subsidies to see if they are working before adding new ones.

Small Business Access To Coverage: This market-based reform would enable small businesses to form association health plans, or purchasing pools, to gain leverage in the private insurance market, similar to that enjoyed by large companies. A major Democratic concern, however, is that this could gut consumer protections and state oversight and let insurers "cherry-pick" the healthiest and the youngest.

The leading Senate legislation on this issue is S. 1955. It would allow small businesses to purchase health insurance coverage that deviates from state insurance requirements as long as the plans offer an alternative containing the covered benefits offered in a state employee health plan in one of the five most populous states. Currently, these states are California, Texas, Illinois, Florida, and New York.

The bill's author, Sen. Mike Enzi (R-WY), who chairs the Health, Education, Labor & Pensions Committee, has said it might be difficult to get the measure passed on the floor, in light of possible Democratic maneuvers to derail it. S. 1955 passed the HELP Committee, 11-9, on a strict party-line vote.

The current mood in Washington is, "Don't expect anything substantive until after the November elections." Though a break in the healthcare reform logjam can't be ruled out, it doesn't appear likely as yet.

The coding edits, or MUEs, are limits on the units of service that can be billed per Medicare beneficiary per day; for example, a limit of two biopsies even if more than two polyps were found during a colonoscopy. Payment for claims that exceed the established limits would be automatically denied.

CMS Takes More Flak, *from p. 3*

September 15, 2006. The groups said that CMS's staggered approach allowing for dual review—first by June 19, then again in the fall—"will discourage a thorough and systematic review of all the codes."

—Disclose the rationale and frequency data behind each proposed MUE.

—Establish modifiers to bypass the MUEs where appropriate and create an appeals process for MUE determinations.

• ***April 11:*** The American Society for Clinical Pathology asked that all pathology and lab codes be removed from any revised MUE list. As a Society spokesperson summed it up: "We are doing what the physicians order, and we should get paid for this work." ASCP has confirmed with CMS, this source added, that the agency is working on a proposed appeals process for MUE determinations.

While ASCP supports curbs on inappropriate billing for Medicare Part B services, it told McClellan that it regards the MUE policy and process as "seriously flawed," warning that the initiative could harm patients by "setting clinically inappropriate limits." In addition, ASCP noted, a number of the proposed MUEs "conflict with established clinical guidelines for patient diagnosis and treatment."

• ***April 17:*** Fifteen medical specialty groups and clinical lab organizations, organized by the American Clinical Laboratory Association, asked McClellan to reconsider the scope of, and the process taken in, the MUE initiative and "completely rethink the MUE program."

David Mongillo, ACLA's vice president for policy and medical affairs, told *NIR*: "We have always been of the mind that CMS should conduct the MUE process consistent with its stated intent—to spot obvious erroneous claims and billing mistakes. If so, there should be a more targeted list of MUEs in identified problem areas, not the sweeping list of CPT codes." ACLA also contends that CMS should not shift the burden of proof for each proposed edit from its contractor for the project, Correct Coding Solutions LLC (Carmel, IN), to the affected medical and lab groups. We need to see more transparency, Mongillo said, in terms of the policy basis for the MUEs and the methodology and data used to drive the MUE initiative. ACLA favors a formal notice and review process and a wider distribution channel to allow all affected groups to have direct input and get regular updates.

Inpatient PPS Increase, DRG Changes Proposed For FY 2007

The current estimated inflation update in fiscal 2007 to Medicare inpatient prospective payment rates to acute-care hospitals will be 3.4%, starting October 1 of this year, the Centers for Medicare & Medicaid Services has announced. In rural areas, more than 1,000 hospitals will see an average increase of 6.7%, CMS estimates. In FY 2006, the inflation update was 3.7% (*NIR, 26, 20/Aug 17 '05, p. 4*).

Overall, the CMS proposal for FY 2007, unveiled April 12 and due to be published in the April 25 *Federal Register*, would hike payments to acute-care hospitals by $3.3 billion.

Significantly, the proposal marks what CMS calls a two-step policy transition to improve the accuracy of payment rates for inpatient stays. In the first step, effective October 1, 2006, the agency plans to use costs, not charges, in assigning weights to inpatient DRGs (diagnosis-related groups). "This would eliminate biases in the

Also in FY 2007, hospitals that voluntarily report quality measures in treating heart attack, heart failure, and pneumonia will get the full market basket update, while non-reporting hospitals will get 2% less (currently, they get 0.04% less). Nearly all eligible hospitals voluntarily report, says CMS.

current system arising from the differential markup hospitals assign for ancillary services among the DRGs," according to a CMS statement.

In the second step, beginning in FY 2008 (or possibly even earlier, CMS noted), DRGs would be adjusted for case severity. The agency proposes to replace the current 526 DRGs with either (1) 861 proposed severity-adjusted DRGs or (2) an alternative severity-adjusted DRG system based on public comments.

The proposed policy changes reflect recommendations from the Medicare Payment Advisory Commission, CMS said, and address some congressional concerns that the current DRG system may give hospitals an incentive to "cherry-pick" more profitable cases. The reforms would especially impact specialty hospitals, which typically are owned in whole or in part by physicians who serve as referral sources, the agency pointed out.

The proposed threshold for outliers (or the more expensive cases) would rise from the current $23,600 to $25,530 in FY 2007. This is expected to keep aggregate outlier payments within the target of 5.1% of total inpatient PPS spending. Comments on the proposal are due June 12. Mail to CMS, DHHS, Attn: CMS-1488-P, PO Box 8011, Baltimore, MD 21244-1850, or send electronically to *www.cms.hhs.gov/eRulemaking*. A final rule will be published later this year.

Medicare Managed Care Rates Up 4% On Average

Beginning January 1, 2007, CMS also can pay entry and retention bonuses to managed care regional plans from the $10 billion stabilization fund created by the 2003 Medicare reform law.

Average payment rates for managed care plans in the Medicare Advantage program will rise 4% in calendar 2007, according to the Centers for Medicare & Medicare Services, but what a plan actually gets will be less because of big changes being introduced next year, including a 100% risk adjustment for the health status of enrollees. Other major changes affecting how payments are calculated are the end of budget neutrality and fee-for-service rate rebasing.

Medicare Advantage (MA) rates vary by plan, CMS noted in an April 3 announcement, but "assuming that a given plan's risk score next year is approximately the same as in 2006, we expect [its] payments will increase, on average, by about 1.1% after the [fee-for-service adjustment]."

If the risk score for enrollees' health status increases, the increase in payment will be greater, the agency said. Implementation of the 100% risk adjustment factor will allow plans with sicker enrollees to get higher payments.

The 2007 rates are used to set benchmarks for local and regional plans. The benchmarks, combined with bids that MA plans make in June, determine the payments to the plans, CMS noted.

Earlier this year, the preliminary estimate for the managed care rate increase was approximately 6.9%, slightly more than 2% above the 4.8% increase for 2006 and close to the 6.6% hike granted in 2005 (*NIR, 27, 10/Mar 13 '06, p. 8*). The final lower rate of 4% for 2007 results mainly from the phase-out of the budget-neutrality factor, as required by the Deficit Reduction Act of 2005. This factor had been used to soften the impact of risk adjustment on plan payments. Analysts advise managed care plans to work closely with their provider networks to improve coding for risk adjustment to ensure they get paid properly.

Top HHS Advisory Panel Releases Genetic Testing Report

Patient access is threatened when genetic testing costs outstrip reimbursement rates, the panel noted, citing such examples as testing for Fragile X syndrome, the most common inherited form of mental retardation, and Factor V Leiden, the most common hereditary blood coagulation disorder in the U.S.

After more than a year of fact-finding, deliberation, and public comment, the HHS Secretary's Advisory Committee on Genetics, Health & Society (SACGHS) on March 27 released its final report on current policy and needed changes in coverage and payment for genetic testing and related counseling. It identifies nine steps that the Secretary could take to overcome barriers to patient access and improve the availability of such testing.

The steps include more consistent coverage decisions by Medicare and other third-party payers, addition of more screening services to Medicare's preventive services benefit, and higher fees to align genetic test prices with actual costs.

On the latter point, SACGHS recommends that when the congressional freeze on lab fees ends in 2009, the Secretary should be ready to revise fees to reflect the "true cost of a genetic test." In the meantime, the panel says the Secretary should direct CMS to use its inherent reasonableness authority to increase fees for genetic test CPT codes. Under this authority, CMS can adjust fees up or down by 15% if they are "grossly excessive" or "grossly deficient" (*NIR, 27, 6/Jan 9 '06, p. 4*). The SACGHS recommendations were hammered out during the panel's meeting last summer and later circulated for further review (*NIR, 26, 19/Jul 25 '05, pp. 3-6*). The report is online at *www4.od.nih.gov/sacghs/sacghsml.htm* under "Reports and Correspondence."

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