

IMS Advocate

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Legislative update

Adjournment: The exact date of adjournment is unclear, but it should be within the next few days. A full wrap-up of this year's session will be in the next *IMS Advocate*.

DIA bill related to dependent adult abuse: Legislators passed **SF 2333**, which requires the Iowa Department of Inspections and Appeals (DIA) to disclose its investigation of potential dependent adult abuse to the facility and the health care worker being investigated. It also permits an appeal process that delays placement on the central abuse registry until final agency action. The bill awaits the Governor's signature.

IowaCare changes: Under **SF 2356**, IowaCare will offer regionalized services. Also, for the first time since the program's enactment in 2005, payment will be provided to UIHC physicians. Amended by the House, the bill has been returned to the Senate for concurrence.

Hospital provider assessment: The legislature continues to discuss **SF 2388**. Championed by the Iowa Hospital Association, this bill would enact an assessment on hospitals for an initial period of three years. The funds collected would be deposited into an account within the Iowa Department of Human Services, which would then use the funds to draw down additional federal Medicaid funds that would be used to compensate providers.

Congress passes health system reform legislation

On Sunday, March 21, the House narrowly passed the health system reform bill previously passed by the Senate. A second reconciliation bill that altered provisions in the original bill then passed both houses of Congress on Thursday, March 25. The AMA supported the legislation; IMS did not take an official stance. It is crucial for physicians to understand some of the legislation's effects on their practices, which include:

No SGR fix. The bill did not remedy the flawed sustainable growth rate (SGR) formula. Furthermore, on March 25, the Senate held debate on a bill that once again would postpone the 21.3 percent Medicare physician payment cut. In a replay of last month's events, Sen. Tom Coburn (R-OK) objected to the bill's consideration. As a result, the cut will take effect on April 1. CMS soon will announce its plans and will likely create a short-term delay in claims processing to allow for a congressional remedy.

Geographic payment differentials. The law re-establishes the national average "floor" on Medicare's geographic payment adjustment for physician work. In 2010 and 2011, Medicare will make a separate adjustment for the practice expense portion of physician payments, which will benefit physicians in rural and low cost areas such as Iowa.

Some Medicare physician payment increases. All primary care physicians whose Medicare charges for office, nursing facility, and home visits comprise at least 60 percent of their Medicare charges will be eligible for a 10 percent bonus payment from 2011-16. Additionally, general surgeons who perform major procedures in health professional shortage areas will be eligible for a 10 percent bonus payment from 2011-16. For 2010, Medicare will increase payment for psychotherapy services by five percent.

Medicaid. Medicaid payments will be raised to at least Medicare rates in 2013 and 2014 for family medicine physicians, general internists, and pediatricians for evaluation and management services and immunizations.

Administrative simplification. Federal rules will be implemented between 2013 and 2016 to standardize and streamline insurance claims processing requirements.

Employer-based insurance. By 2014, employers with more than 50 employees will generally be required to offer health insurance coverage. Small business tax credits for employers contributing at least 50 percent of the costs of coverage will be established.

Preventive and screening benefit expansions. In 2011, cost-sharing for proven preventive services will be eliminated in Medicare and Medicaid. In the private sector, beginning in 2010, health plans will be required to provide a minimum level of coverage without cost-sharing for preventive services such as immunizations, preventive care for minors, and additional preventive care and screenings for women.

Medicare prescription drug coverage. In 2010, Medicare patients whose prescription expenses reach the Medicare Part D coverage "doughnut hole" (\$2,700 to \$6,150) will receive a \$250 rebate. During the next 10 years, the co-insurance rate for this coverage gap will be narrowed in phases from the current 100 percent to 25 percent in 2020.



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IMS challenges PE GPCI as part of CMS 2010 review process

Every three years, federal law requires CMS to review the geographic practice cost indices (GPCIs) and their values as applied in each of Medicare's 89 Part B payment localities. The review is to be conducted in consultation with appropriate representatives of physicians. CMS will conduct its next GPCI review this year and will publish its recommendations for change, if any, in the proposed 2011 Medicare physician payment rule for comment. The proposed rule is released in late June/early July.

This week, IMS submitted its letter of participation in the GPCI review. IMS emphasized that the practice expense (PE) GPCI, its inputs, and its weights are inadequate, inaccurate, and antiquated measures of actual physician practice expenses. AMA analysis of its Physician Practice Information Survey (PPIS) data concluded that physician practice expenses do not differ significantly by location. Nevertheless, the current PE GPCI disparity among the 89 payment localities is substantial, ranging from a low of 0.694 to a high of 1.441. Iowa's PE GPCI is among the lowest at 0.870, which is 39.6 percent below the highest PE GPCI region.

Similarly, survey findings from *Medical Economics* establish that physician practice expenses in the Midwest are actually the highest of the four regions of the United States. Physician practice expenses average \$270,000 in the Midwest, \$250,000 in the South, \$220,800 in the West, and \$208,500 in the East. Despite these figures, Midwestern states as Medicare payment localities have among the lowest PE GPCIs.

For a copy of the IMS letter to CMS, visit www.iowamedical.org. *Please note:* IMS data in this letter does not take into account the two-year (2010 and 2011) PE GPCI relief included in recently adopted health reform legislation. That legislation would take Iowa's PE GPCI from 0.870 to 0.935 for each of 2010 and 2011, retroactive to January 1, 2010. IMS believes the arguments and data points in its letter to CMS also will be helpful in the upcoming Institute of Medicine study of all three GPCIs and the hospital wage index. That study will be convened by HHS Secretary Kathleen Sebelius in April.

Information available for IMS Annual Meeting

Not able to attend the IMS Annual Meeting on April 17-18? You can still have your voice heard. Visit www.iowamedical.org/hod to find the Delegate Handbook and resolutions that have been submitted. For each resolution, you can submit your comments, which will be shared with the Reference Committee – just as if you were at the meeting. The Handbook also contains summaries of activities by the IMS Board of Directors and committees.

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