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American Medical Directors Association

HEALTH POLICY ADVISOR

NEWS FOR THE LONG TERM CARE PROFESSIONAL

CMS Begins Developing Staffing Quality Measures, not Quotas

On March 2, 2004, CMS and the Colorado Foundation for Medical Care met with stakeholders to discuss Phase 1 of the Development of Staffing Quality Measures Project. The meeting was held to inform a Technical Expert Panel (TEP) that would be meeting the next day to discuss staffing measures and data sources for public reporting. The top concerns of stakeholders focused on five areas: (1) considering the role of facility leadership, (2) defining what is meant by "staff", (3) adjusting for case mix, (4) including the effects of staff competency, retention, and training, and (5) collecting timely, accurate, consistent, and auditable data. Additional comments were made concerning technology as a substitute for staff, the availability of labor supply, and making published data consumer friendly and meaningful.

In their statement to the panel of CMS staff, academics, and researchers, AMDA's primary concern was developing a staffing quality measure that compares equally staffed facilities with the same hours-per-resident stay, yet have different care needs. AMDA further cautioned CMS that staffing numbers alone do not reflect the quality of care in the facility. Many other stakeholders agreed that the development of a quality measure should incorporate retention, staff competency, and level of training. AMDA also encouraged the TEP to focus more attention to the adequacy of the care processes in relation to the numbers of staff. Finally, there was a consistent belief that current data is weak and the development of a staffing measure should consider data, such as payroll records and invoices. As reported in the July 2003 issue of *Caring for the Ages*, the assumptions of the work conducted by Abt Associates are that the reporting of the most important staffing

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elements by providers must be derived from three source documents: payroll records for regular employees; invoices for nursing services provided by contract agencies; and records of the average daily census for the reporting period (in order to compute hours per resident/day). It is likely that these will be the major components of data collection on the number of staff.

The Colorado Foundation for Medical Care is halfway through this 18-month contract. To date, they have formed the TEP, completed a review of the literature, and met with stakeholders. On March 3, 2004, the TEP met to discuss—among other items—stakeholder statements. Next, the TEP will decide how best to configure a staffing quality measure. They will then look at data sources and the relationship between these data sources. The TEP will develop a set of recommendations for CMS before this contract cycle ends on March 29, 2005. However, the real question of whether CMS can or should provide a measure that looks beyond direct care staff and can be comfortably supported by current or proposed data collection systems remains.

CMS Issues Draft SOM Revisions on Role of Medical Director and Quality Assurance

Revisions to the F-501 and F-520 F-tags in the *State Operations Manual* drew a lot of discussion from AMDA members and leadership. Most, of course, were focused on the medical director tag F-501. AMDA sent the revisions to all AMDA state chapter presidents, committee chairs, and the Board of Directors and the comments came surging back, creating an online discussion over a period of several weeks as AMDA leadership honed comments to CMS. At the same time, the two trade associations representing the industry—the American Health Care Association and the American Association of Homes and Services for the Aging—shared their evolving comments as well. These associations and some AMDA members felt the new clarification added responsibilities to the role of the medical director. Perhaps the shock of seeing pages of regulation after more than a decade of being defined by a paragraph led to that reaction. However, once members began discussing and digesting, most agreed that all that was required relates to AMDA's *Role and Responsibilities of the Medical Director in the Nursing Home* that has been policy for more than a decade.

AMDA members Juergen Bludau, MD, CMD; Colleen Cooper, MD, CMD, MPH; Jonathan Musher, MD, CMD; and David Polakoff, MD, MSC, CMD participated in the expert panel for the medical director F-tag revisions. David Gifford, MD, MPH, and Dan Osterweil, MD, CMD, participated in the quality assessment and assurance expert panel.

Steve Levenson, MD, CMD, has written an article in the September 2003 issue of *Caring for the Ages* that takes a look at the historic evolution of these regulations and literally lines up the AMDA position and the new CMS language and demonstrates how the expanded guidance doesn't really add as much as clarifies.

In AMDA's comments to CMS, the association urged a clear message that the medical director is responsible for overall care through clinical systems and policies and procedures rather than by seeing each individual patient as some draft language seemed to indicate. AMDA members reviewed the document word-for-word to ensure that it does not confer any undue liability and urged CMS to be sensitive to this unfortunate reality.

Over the rest of this year, AMDA will be developing an integrated initiative involving every part of the organization to promote the appropriate role of the physician and to education administrators and others about the role and its value. Moreover, AMDA will be developing a wide range of communications, practical tools, and educational programs. Immediate Past President James Lett, II, MD, CMD, sees this as a "tipping point" for AMDA. "We can raise the bar and improve care using this as the fulcrum to make the industry aware of the appropriate role and how it can benefit their facilities and patients." A copy of Dr. Levenson's article can be viewed at: www.amda.com/caring/september2003/survey_revisions.htm.

McClellan Confirmed as CMS Administrator

Scully Praised for Agency Reform Efforts

On March 12, 2004, the Senate approved the nomination of former Food and Drug Administration (FDA) Commissioner Mark McClellan, MD, PhD, as the new Administrator for the Centers for Medicare and Medicaid Services (CMS). Dr. McClellan, a physician with a doctorate in economics, replaces Thomas Scully, JD, who resigned as CMS administrator in December 2003 after guiding the agency through its biggest reforms since 1965.

In a statement on Dr. McClellan's Senate confirmation, Secretary of Health and Human Services Tommy Thompson praised the new administrator and confirmed the agency's commitment to implementing the prescription drug benefit included in the new $534 billion Medicare Prescription Drug, Improvement, and Modernization Act of 2003, "Dr. McClellan will bring a breadth of experience, intelligence and energy that will serve all of us well. . . And we are determined to bring about rapid and effective implementation of the benefits of the Medicare improvement act passed last year, including a new prescription drug benefit and more choices for Medicare beneficiaries." At the FDA, Commissioner McClellan pushed for quicker drug reviews and sought to expand industry user-fee programs that fund FDA activities. He previously served as a member of the White House Council of Economic Advisers, a Stanford University Associate Professor and Director of the Program on Health Outcomes Research, and an attending physician for internal medicine at Stanford Health Services. He earned his bachelor's degree from the University of Texas, his master's degree from Harvard University, his medical degree from Harvard-MIT Division of Health Sciences and Technology and his PhD from Massachusetts Institute of Technology.

Former CMS Administrator Scully, who served three years, accepted a position in the Washington D.C. law offices of Alston & Bird. In a statement to the public, Mr. Scully said, "It has been a great run, and has been great fun working with, and learning from, Secretary Thompson, who has been a great friend and mentor. Watching the President and the Secretary drive the Medicare bill across the finish line in the last few weeks was a very rewarding culmination to a very exciting and fulfilling three years. I have loved every minute of this job and am grateful to the President for the opportunity to serve." Mr. Scully led an intensive effort to improve the responsiveness of the agency, with a new name, adopted from suggestions made by agency employees. He also significantly expanded efforts to inject quality measurement into the agency's programs.

Other highlights of Mr. Scully's tenure include the following efforts:

- Expanding beneficiary education efforts by making 1-800-MEDICARE a 24/7 service with detailed information for beneficiaries, and raising awareness through large scale advertising.
- Serving as a key member of the President's Medicare reform team, who was involved in crafting the President's Medicare Framework over a year ago, and in working with Members of Congress on a bipartisan basis to bring about the biggest improvement in the program since 1965.
- Rationalizing the federal relationship with states and reigning in program loopholes that had eroded the federal/state partnership.
- Strengthening CMS' fiscal responsibility by closing a multi-billion dollar loophole in Medicare for hospital outlier payments; rationalizing payments for rehabilitation services; and most recently, cracking down on fraudulent billing for power wheelchairs.
- Opening up the agency by establishing open door forums and making it clear that Medicare and Medicaid would be reliable business partners for providers and contractors that follow the rules.
- Creating sweeping quality reform initiatives in both the nursing home and home health sectors in partnership with unions, patient advocacy groups, the AARP and providers to develop broad based quality measures that help consumers and providers monitor and improve performance. These outcomes were published in ads in every major newspaper in the U.S. A similar hospital quality system is under development and has been incorporated in the new Medicare legislation.

Stakeholders to CMS: Revamp MDS, Don't Just Tinker with 2.0

In a May 21, 2004, letter to Sean Tunis, MD, CMS Chief Clinical Officer and Director, Office of Clinical Standards and Quality, stakeholders asked CMS to establish a structure and process to revamp the Minimum Data Set (MDS), not simply modify MDS 2.0 to create version 3.0. While initially developed to provide a standardized set of information about each resident to assist nursing facility staff in developing comprehensive, individualized care plans, MDS data is used to generate the quality indicators and quality measures that facilities use in internal quality improvement, used by surveyors to focus the survey and certification process, used on CMS' website Nursing Home Compare as a tool for selecting a high quality nursing facility, and used to place patients in payer groups.

According to AMDA Director of Clinical Affairs Jacqueline Vance, RNC, "Under the current format, the use of the MDS instrument as a tool for various data collection measures far exceeds its original intent and its capacity to accurately measure what is being sought. This warrants a total revamping of the MDS to meet constituents' needs."

Representatives from the American Association of Homes and Services for the Aging, American Association of Nurse Assessment Coordinators, American Health Care Association, American Hospital Association, National Association of

Directors of Nursing Administration in Long-Term Care, American Medical Directors Association, Catholic Health Association, National Hospice and Palliative Care Organization, and the National Citizens Coalition for Nursing Home Reform, met last August to address major concerns with the CMS' development of MDS 3.0. The organizations have followed that meeting with a letter stating that it is critical that the goals and objectives for the MDS 3.0 be clearly defined and prioritized. "The vision, goals and objectives for the MDS must be clearly defined. Objectives must be prioritized, in order to ensure that decisions about items that are/are not to be included are based on a clear and rational set of criteria specifying how competing priorities are to be reconciled," the nine organizations advised. Additionally, the organizations requested that the methodology that will be used for achieving and maintaining the clinical relevance of the MDS in accordance with evolving standards of care must also be defined.

The organizations expressed further concern that current efforts to update MDS 2.0 fail to take into account all of the purposes that the MDS data are expected to serve: "The first step in the process of re-design should be to pose open-ended questions about what information, if collected, could improve the instrument's utility for one or more of its primary or secondary purposes—assessment, care planning, quality measurement, payment, support of regulatory activities, and research."

In addition, the stakeholders urged CMS to improve the instrument's ability to assess the needs of specific types of residents (e.g., long-term, post-acute, end-of-life/palliative care, non-elderly adults, pediatric) by targeting specific questions through the use of skip patterns or a modular approach to the form. The diverse residents in nursing homes are not well served by a one-size-fits-all approach to assessment. Stakeholders further requested that CMS coordinate its efforts on MDS development with other efforts, such as the refinement of the SNF PPS, movement toward standardization of health information systems under the National Health Information Infrastructure initiative, and the DAVE initiative on improving the accuracy of assessment data. Up-front coordination on these various efforts will save everyone significant time and investment and result in greater support and buy-in from all stakeholders.

Stakeholders are hoping to meet with CMS officials this summer to address the concerns outlined in their letter.

Medicare Adjusts NH Payment Rates for Patients with AIDS

Effective October 1, 2004, nursing homes treating patients with Acquired Immune Deficiency Syndrome (AIDS) will see an increase in their Medicare payment rates, according to CMS Administrator Mark McClellan, MD, PhD. Nursing homes will get an increase of 128 percent over the rates they currently receive for the care of these patients. Provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 already provide for additional payments to skilled nursing facilities for certain Resource Utilization Group categories. However, in recognition that costs associated with AIDS residents can be extraordinarily high, section 511 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides a special payment adjustment that specifically reflects the increased costs associated with the care of these residents.

"The care of patients with AIDS can be extraordinarily high," Dr. McClellan says. "This action to implement the new payment rate reflects the increased costs associated with caring for this special group of beneficiaries. We want to take whatever steps are necessary to assure continued access to care for people living with AIDS."

A copy of the transmittal can be viewed at www.cms.hhs.gov/manuals/pm_trans/R160CP.pdf.

QIOs and CMS Prepare 8th Scope of Work

CMS and quality improvement organizations (QIOs) are engaged in a comprehensive strategic planning process for the 8th Scope of Work (SOW), which would begin next summer. As part of the SOW, the agency is looking at ways to accelerate the pace of improvement in nursing facilities by promoting organizational culture change and the use of redesigned care processes. One of the biggest difficulties QIOs have experienced when trying to help nursing facilities is a high rate of staff turnover. So, the 8th SOW will look into ways that quality improvement and culture change can help address staffing issues.

Second, QIOs may target specific indicators that are known to have a real impact on residents' quality of life, such as pressure ulcers, restraints, depression, and pain. Additional work under consideration for the 8th SOW includes additional clinical topics as requested by each nursing facility; studies of workforce turnover and ways to improve retention; monitoring pressure ulcers across provider settings (particularly hospitals and nursing facilities); and components of the plan, which could come in the form of nationwide projects or more localized special studies.

In a meeting with representatives of the Campaign for Quality Care, American Health Quality Association Executive Vice President, David Schulke, stated that the focus for nursing facilities is likely to evolve to a more holistic approach to quality improvement, particularly the concept of culture change, along the lines of models such as Wellspring, Pioneer, and Eden. He added that a lot of this is conceptual and the QIOs are just now beginning to develop the operational planning phase. However, the goal would be for QIOs to introduce organizational change concepts and interventions into nursing facilities, and measure their impact through proxies such as staff retention, leadership, communication, and teamwork. Barbara Frank, former NCCNHR associate director and independent consultant on culture change who is working with the Rhode Island QIO, adds that this concept of culture change brings all levels of staff into the decision-making process and stresses that all staff are links in the quality improvement process. Moreover, it encourages the staff to improve the culture within their organizations by using a mix of learning approaches that provide take-home skills to improve communications, strengthen teams, and build community.

In Rhode Island and Massachusetts, the QIOs already are working collaboratively with nursing facilities on this project. Nursing facility staff are being trained in leadership development and encouraged to change the way staff work together and communicate. Ms. Franks describes the model as one where facility staff (through interdisciplinary conversations by unit) are asked to identify the system for a particular issue (e.g., What would it take to let people

wake up on their own?) and identify what issues the system has created (e.g., Residents are woken up and then must wait a long time for their appointed breakfast time.). CMS is working to identify facilities that have implemented culture change that can serve as a model to others.

A copy of the framework for developing the 8th SOW can be viewed at www.cms.hhs.gov/qio/2s.pdf.

CMS Links Quality Services to Medicare Beneficiaries and Payment

A CMS proposed rule would provide a full market basket update for hospitals if and only if they report on the quality of their care as part of the agency's Hospital Quality Initiative. The rule is derived from a provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which states that hospitals reporting specified quality data will receive an inflation update equal to the hospital market basket percentage increase, currently estimated at 3.3 percent. Hospitals that do not report this information will receive the market basket percentage increase less 0.4 percentage points, or an estimated 2.9 percent increase. The market basket percentage increase refers to the projected rate of inflation for goods and services used by hospitals in caring for Medicare beneficiaries. This is the first time that hospital payment rate increases have been related to performance, in this case by providing incentives for giving information to patients and health professionals related to quality of care. The proposed rule also increases payments to acute care hospitals for inpatient services in fiscal year 2005 and offers additional financial relief to rural hospitals.

Under the Hospital Quality Initiative, launched in 2003, hospitals identified 3 conditions and, for these, selected 10 JCAHO/CMS-developed and National Quality Forum-endorsed measures that are feasible to be publicly reported immediately:

Acute Myocardial Infarction Measures—Aspirin at arrival, Aspirin at discharge, Beta blocker at arrival, Beta blocker at discharge, ACE inhibitor for left ventricular systolic dysfunction;

Heart Failure Measures—Left ventricular function assessment, ACE inhibitor for left ventricular systolic dysfunction;

Pneumonia Measures—Initial antibiotic timing, Pneumococcal vaccination, Oxygenation assessment.

The collaboration plans to add additional measures in these three conditions, as well as measures for surgical infection prevention later in 2004 or in 2005.

According to a May 20, 2004, CMS press release, hospital participation in the initiative is booming. There are now 3,449 hospitals registered to publicly report quality data, compared to 2,727 when the web postings were last updated in February. Among the hospitals currently reporting quality information, 1,952 hospitals will publicly report data on at least 1 of the 10 quality measures included in the initiative, up from 1,407 in February. Additionally, 647 hospitals will report at least 1 measure on all 3 clinical conditions covered by the initiative, compared to 492 in February, and 227 will report on all 10 measures. "There is a lot of work yet to be done, but we are making great progress toward having all hospitals report voluntarily on the quality of their care," Administrator Mark McClellan, MD, PhD, said. "Patients will be able to use

this information to pick the right hospital for their needs, ultimately improving health care for everyone."

The proposed rule, which can be viewed at www.cms.hhs.gov/providers/hospital.asp, was published in the May 18 *Federal Register*. Comments will be accepted until July 12, 2004, and a final rule will be published later in the year. The latest hospital quality initiative information is available at www.cms.hhs.gov/quality/hospital.

CMS Open Door Forum for Skilled Nursing Facilities

On May 25, 2004, CMS held its monthly Open Door Forum for Skilled Nursing Facilities to discuss the recent developments important to providers, including the new prescription drug card benefit and Consolidated Billing changes.

Prescription Drug Cards
Staff from the CMS' Center for Beneficiary Choices reported that three different card sponsors will be endorsed and operationalized on June 1, to provide transitional assistance, as required by the Medicare Modernization Act. Information on the program can be found on the CMS website www.cms.hhs.gov/media/press/release.asp?Counter=990. There are three sponsors of the cards:

1. LTC Card offered by the LTC Pharmacy Alliance and PBM, ACS Healthcare, LLC
2. Community Care Rx offered by the Computer Sciences Corporation
3. PBM Plus Senior Care, offered by PBM, PBM Plus

These three cards were chosen from seven long-term care proposals CMS reviewed. All three cards are making available an opportunity for any pharmacy to be in their network. The PBM Plus card is particularly associated with Omnicare. The LTC Card is associated with several long-term care pharmacy chains. The Community Care RX card is associated with independent long-term care pharmacies. The three cards are only designed for residents in long-term care facilities and two are general cards that also provide this long-term care feature.

All people with Medicare who do not receive prescription drug coverage through Medicaid are eligible for a Medicare-Approved Drug Discount Card. Medicare beneficiaries whose incomes are below 135 percent of the federal poverty limit may be eligible for the $600 credit, but must apply for it. People have to provide information to CMS on their income, retirement and health benefits information, and sign the form. People must not receive outpatient drug coverage from Medicaid, TRICARE, group health insurance, or Federal Employee Health Benefit Plans (FEHBP). There are a few exclusions if the drug coverage is through a Part C Medicare + Choice plan or a Medigap plan. Medicare is giving a special endorsement to selected card sponsors to provide transitional assistance to residents of nursing facilities and skilled nursing facilities, through long term care pharmacies. The long-term care cards can have whatever pharmacies they want in those cards.

Once someone qualifies for the $600 credit, it is their money to be spent on out of pocket prescription drug expenses. If you become Medicaid qualified, Medicaid would have expected to have represented the balance of $600 covered against the drug. Medicare coverage does not allow any of $600 to be paid toward drugs that are a part of Medicare Part A or Part B payment, including deductibles or co-pays.

CMS is working with the card sponsors and the nursing home trade associations to assure information needed by beneficiaries is available. While nursing homes are under no legal obligation to provide this information, the trade associations are encouraging their members to reach out and inform their residents, and nursing homes have been contacting their long-term care pharmacies and the sponsors to find out when they can begin to provide such information.

Consolidated Billing Changes
Transmittal 183 was published Friday, May 21, entitled "SNF CB: Services Furnished Under an 'Arrangement' With an Outside Entity". The instruction clarifies the requirements that must be met in order for a Medicare skilled nursing facility to have a valid "arrangement" in effect with an outside supplier. The Change Request clarifies that a valid arrangement must include a written agreement between SNF and supplier. CMS does not prescribe the specific terms of the agreement (e.g., how much the SNF pays the supplier, or how quickly), but does require that there be a written agreement in place. The existence of a written agreement as described in the Change Request serves to protect the SNF and supplier and avoid disputes. The language of the Change Request states: "Accordingly, whenever an SNF elects to utilize an outside supplier to furnish a service that is subject to consolidated billing, the SNF must have a written agreement in place with that supplier. Conversely, whenever an outside supplier furnishes such a service to an SNF resident, it must do so under a written agreement with the SNF." To view Transmittal 183 of the Medicare Claims Processing Manual, entitled "Skilled Nursing Facility (SNF) Consolidated Billing (CB): Services Furnished Under an 'Arrangement' With an Outside Entity," go to www.cms.hhs.gov/manuals/pm_trans/R183CP.pdf.

Also related to CB, CMS has been working on an analysis of contractor activities to collect certain overpayments, specifically involving claims for portable x-rays that should have billed to the SNF rather than to Part B. CMS had placed a temporary hold on the recoupment of these overpayments, but now is instructing contractors to resume their overpayment recovery actions.
CMS has had an inquiry regarding providers who have told suppliers that they need to get a Medicare denial before the nursing home will pay for a service under CB. CMS clarified that this is not a Medicare requirement. CMS issues and periodically updates a list of services that are excluded from consolidated billing (and, therefore, are separately billable to Part B). Nursing homes should not demand a denial notice from contractors for services that have been clearly identified as being included in the global SNF PPS per diem payment.

CMS is in the process of developing additional educational materials further clarifying the appropriate billing procedures to be followed under the consolidated billing requirement.

Medlearn Matters Article
In a couple of weeks CMS hopes to post an article based on questions received from nonphysician practitioners. It will be posted on CMS' Medlearn Matters: Information for Providers website.

Rules when a Hospice Care Benefit is Provided in a SNF
CMS has been asked to clarify the term "hospice care" in the *State Operations Manual's Section P, Special Treatment in Procedures*. In order to be coded that

hospice care is provided, the provider must be state licensed as a hospice provider or certified under the Medicare program as a hospice provider. A special update to the manual will come out hopefully next month.

The next Open Door Forum is scheduled for June 29, 2004. To sign up to be notified of the details for listening to and participating in the Open Door Forums, go to www.cms.hhs.gov/opendoor, and click on Registration.

Nursing Home Reimbursement Rates Analyzed at PEAC Meeting in Chicago

The Practice Expense Advisory Committee, or PEAC, met last month for the last time to review practice expenses associated with CPT codes and services. Among the many codes discussed were AMDA's very own nursing home evaluation and management (E&M) codes. AMDA Past President Dennis Stone, MD, CMD, presented AMDA's arguments that the practice expense components of the nursing home E&M codes should be reconsidered and revalued to appropriately reflect the services represented by these codes.
While the Centers for Medicare and Medicaid Services (CMS) proposed last August to significantly reduce these inputs through its proposed fee schedule, AMDA was successful in convincing CMS to delay implementation of the reductions. The proposed reductions, which were made by a workgroup of the PEAC in March 2003, would have reduced reimbursements of the nursing home codes by 15% to 22%.

Dr. Stone presented AMDA's arguments for appropriately valuing the PE component of the codes in response the initial CMS proposed cuts back in August 2003. Arguing that nursing home physicians incur considerable practice expense when seeing nursing home patients for E&M services, Dr. Stone cited CMS regulatory requirements as a significant cause of physicians' in-office clinical staff practice expense. In addition, he asserted that the numerous phones calls between family, patients, and the pharmacy resulting from one E&M visit account for additional practice expense.

The PEAC, a subcommittee of the RVS Update Committee (RUC), finally voted to set the practice expense component of the code value to a more acceptable level albeit at a lower amount than the current values, which were carried over from the 2003 fee schedule. In other words, the values were approved at a higher number than CMS had originally proposed but lower than the fee schedules for the previous several years have provided.

Following are the PEAC-approved practice expense inputs:

CPT Code	March 2004 PEAC-Approved Practice Expense Inputs Facility and Non-Facility	August 2003 Proposed Practice Expense Inputs For 2004 FS Facility and Non-Facility	2002, 2003 and 2004 Practice Expense Inputs Non-Facility Only**
99301	14	3	20
99302	14	3	35
99303	14	6	45
99311	11	12	20
99312	17	18	25
99313	21	18	30
99315	12	12	25
99316	12	15	30

** Practice expense inputs for facility place of service are zero.

Payment for a particular code is determined by multiplying the conversion factor by the RVU (these figures do not include any geographic adjustments).

The passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides a 1.5% update to the conversion factor raising it to $37.3374. Another 1.5% increase will be applied in 2005. These changes override the reductions in the regulation. Payment for a particular code is determined by multiplying the conversion factor by the RVU (these figures do not include any geographic adjustments).

90-Day Grace Periods for Discontinued Codes Ends

Physicians, practitioners, and suppliers should be aware that CMS is instructing carriers and DMERCs to eliminate the 90-day grace period for billing discontinued ICD-9-CM diagnosis codes effective October 1, 2004 and for discontinued HCPCS Level II codes on January 1, 2005. Medicare systems will begin enforcing Health Insurance Portability and Accountability Act (HIPAA) standards on October 1, 2004, requiring that ICD-9-CM codes submitted on claims must be valid at the time the service is provided. CMS states that the new codes should be adopted in billing processes effective October 1 of each year and for services rendered on or after that time to assure prompt and accurate payment of your claim.

Medicare had previously permitted a 90-day grace period after the annual October 1st implementation of an updated version of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes. This grace period gave physicians, practitioners and suppliers time to become familiar with the new codes and learn about the discontinued codes. During this 90-day grace period (October 1 through December 31 of each year), physicians, practitioners, and suppliers could use either the previous or the new ICD-9-CM diagnosis codes. For claims received on or after January 1, the updated ICD-9-CM codes were required to be used, and claims received with discontinued diagnosis codes were rejected as Returned Unprocessable Claims (RUCs).

A copy of CMS' instructions to providers on the ICD-9-CM Change Request can be viewed at www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3094.pdf.

In a similar move, effective January 1, 2005, carriers, DMERCs, and fiscal intermediaries will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1. To ensure prompt and timely payment of claims, one must use the new HCPCS for 2005 beginning with services rendered on or after January 1, 2005, and stop using discontinued codes at that time. Each year thereafter, providers must adopt the new codes.

Medicare has permitted a 90-day grace period after implementation of an updated Healthcare Common Procedure Coding System (HCPCS) code set to familiarize providers with the new codes and to learn about the discontinued codes. For example, the 2004 HCPCS codes became effective for dates of service on or after January 1, 2004, and Medicare contractors are able to apply a three-month grace period for all applicable discontinued HCPCS codes. This means that the 2003 discontinued HCPCS codes and the new 2004 HCPCS codes will be accepted by

carriers from physicians, suppliers, and providers during the January 2004 to March 2004 grace period. This 90-day grace period applies to claims received by the carrier prior to April 1, 2004, which contain the 2003 discontinued codes for dates of service January 1, 2004 through March 31, 2004.

However, the HIPAA Transaction and Code Set Rule requires providers to use the medical code set that is valid at the time that the service is provided. Therefore CMS will no longer be able to allow a 90-day grace period for providers to learn about the discontinued HCPCS codes. Providers should be aware that effective January 1, 2005, Carriers, DMERCs, and Fiscal Intermediaries will no longer accept discontinued HCPCS codes for dates of service January 1 through March 31 of the current year (beginning in 2005) that are submitted prior to April 1. In addition, effective January 1, 2005, CMS will no longer allow a 90-day grace period for discontinued codes resulting from any mid-year HCPCS updates.

Visit the CMS Web site to view the annual HCPCS update at www.cms.hhs.gov/medicare/hcpcs/2004qtrupdate.pdf. For more information on HCPCS, visit the CMS Website at www.cms.hhs.gov/medicare/hcpcs/

Physician Groups, MedPAC, and Congress: Physician Payment Formula is Flawed

Predictions that physicians face payment cuts of 5% a year over the next seven years have prompted federal officials to take a hard look at whether the physician payment formula can continue to set payment rates while controlling costs. On May 5, 2004, the House Energy and Commerce Committee, Subcommittee on Health convened a hearing to discuss hurdles that must be overcome to fix physician payment formulas. Less than two weeks later, members of the American Medical Association and physician specialty society staff met with MedPAC to discuss the commission's study on the volume of physician services and physician payment while expressing a theme heard in the Congressional hearings: the formula is flawed.

In his opening remarks at the hearing, Representative and physician Charles Norwood (R-GA) told panel members from the Congressional Budget Office (CBO), the General Accounting Office (GAO), and MedPAC that it is time to change the baseline because Congress put into law a formula for paying physicians that is fundamentally flawed. Addressing CBO, Rep. Norwood warned that Congress will continue to prevent payment cuts because the political reality is that Congress does not like it when senior citizens come to them saying that they cannot find a doctor who accepts Medicare. In a separate statement, Representative Sherrod Brown (D-OH) addressed the two-year fix in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that gives physicians positive payments instead of the payment cuts. He warned that these are only stopgap measures and Congress must act to find permanent statutory and administrative solutions, including de-linking the formula from gross domestic product (GDP). He also urged officials to review the cost underestimation of the drug benefit within the MMA.

House Energy and Commerce Committee Chairman Joe Barton (R-TX) expressed concern with wide swings in physician payments prompting Congress to override the declining reimbursements in the formula the past two years and call for a stable and

predictable payment formula. On the other side of the aisle, Democratic Representative Frank Pallone (D-NJ) stated that the Republican-endorsed tax cuts skew Congressional priorities the wrong way, essentially leaving no money for the patient and the physician. He called on officials charged with advising Congress to re-think the inclusion of skyrocketing drug spending in the formula, noting that physician-administered drugs should not be considered a physician service. Representative Gene Green (D-TX) further cited that the weakening economy, data errors, and an increase in volume of services rendered have contributed to budgetary problems. GAO Director of Health Care-Medicare Payments Issues, Bruce Steinwald, pointed out that both the volume and intensity of physician services has increased and is expected to continue in this manner through 2005. He cautioned that the spending per beneficiary continues to increase more than the payment update. Testimony by MedPAC Chairman Glenn Hackbarth outlined their concern with the sustainable growth rate (SGR) and rise in the volume of physician services. According to the commission's written testimony, "from 2000 to 2001 volume increased 5.4 percent and from 2001 to 2002, it increased by 5.6 percent." MedPAC estimates that this growth will continue in 2003. This volume growth continued regardless of whether the payment update increased or decreased. Partly as a result of the volume growth, monthly Part B premiums have increased over the past few years. The increase was 8.7 percent in 2003, 13.5 percent in 2004, and is projected to be 17.3 percent in 2005.

MedPAC cautions against using a formula such as the SGR to control spending on physician services delivered to Medicare beneficiaries. Instead, MedPAC recommends that the growth in volume of physician services should be addressed by looking at its root causes and proposing specific policy solutions. Some of the root causes they think are worth considering include the growth arising from technology that produces meaningful gains to patients.

MedPAC also points to private sector methods to address rapid growth in volume, particularly in the area of imaging services (i.e., nuclear medicine, MRI, and CT). Some techniques used include profiling, pre-authorization, beneficiary education, privileging, coding edits, and safety standards and site inspections.

MedPAC's testimony *Payment for Physician Services in the Medicare Program* can be viewed at www.medpac.gov/publications/congressional_testimony/050504-SGRTestimony_EC.pdf. To hear the testimony via webcast, go to http://energycommerce.house.gov/108/Hearings/05052004hearing1263/hearing.htm.

AMA Meeting with MedPAC

On May 17, 2004, the AMA and physician specialty society staff met with MedPAC to discuss the commission's study on sustainable growth rate (SGR) and physician payment. The MMA required MedPAC to study "the extent to which increases in the volume of physicians' services…result from care that improves the health and well-being of Medicare beneficiaries." The study directs the commission to examine recent and historic growth in SGR components; Medicare growth trends compared to those of the private sector; the effect of new technology and CMS coverage determinations; the impact of demographic changes; the extent to which reimbursement changes for other providers has led to site of service shifts and the influence these shifts have had on the number and intensity of

services in physicians' offices; and the extent to which CMS takes law and regulations into account in the SGR.

As MedPAC staff undergo work on one of the mandated studies on physician volume that is due out in December, the groups discussed several points and questions they would to see addressed in the study. The AMA stated that there must be consideration of the role of quality improvement and chronic care initiatives in increasing the volume of physician services. The AMA's argument has been that quality improvement initiatives and chronic care programs tend to increase care on the front end (i.e., physician visits) in order to prevent complications and hospitalizations on the back end. So, one would expect to see an increase in expenditures under the SGR even though there might be overall savings to the health care system. MedPAC staff also were urged to consider the role of the liability crisis, the ripple effect of screening benefits, new drug benefits, changing standards of care, the effect of new technology and CMS coverage decisions, and changing demographics, such as the impact of a growing percentage of frail elderly combined with improved ability to provide these beneficiaries with life-extending and enhancing technologies.

Federal Money Available to Support State Legislature Education

The Department of Health and Human Services has issued a call for applications to support an initiative to educate state legislatures about priority public health issues, especially health issues facing older Americans. The original due date for applications is July 12, 2004. For more information, go to www.fedgrants.gov/Applicants/HHS/CDC/PGO/CDC-PA04157/Grant.html.

CMS Issues Transmittal on Incident-To Services on Form CMS-1500

On April 23, 2004, CMS issued Transmittal 148 to clarify where physicians' Provider Information Numbers and names should be reported on the Health Insurance Claim Form (CMS-1500) when both an ordering provider and a supervising provider are involved in a service.

According to CMS, the agency issued the transmittal because of the multiple requests in Open Door Forums and correspondence. The instruction, which updates the *Medicare Claims Processing Manual (Pub 100-4)* to comply with a 2001 Proposed Rule, clarifies and standardizes the method of indicating the ordering and supervising professionals on the CMS-1500. The Preamble of the Proposed Rule for the Medicare Physician Fee Schedule on November 1, 2001 (66 Fed Reg. 55267) stated "the billing number of the ordering physician (or other practitioner) should not be used if that person did not directly supervise the auxiliary personnel."

Transmittal 148 can be viewed at www.cms.hhs.gov/manuals/pm_trans/R148CP.pdf.

AMA's 80,000 Patient Activists Push for Federal Liability Reform

The American Medical Association's (AMA) Patient Action Network (PAN) has recruited more than 80,000 patient activists to assist with their efforts to enact federal reforms of the medical liability system. According to the AMA, "during the first year, these patients delivered more than a quarter million communications to the U.S. Congress." The AMA expects that total to increase to more than a million communications this year. As part of the PAN's campaign, the AMA has developed

Physician Action Kits to assist physicians in educating their patients about the medical liability crisis. The kits include posters, sample letters, and brochures. For more information on PAN's campaign, go to www.PatientsActionNetwork.org.

House Passes HEALTH Act as Senate Leadership Judges Likelihood of Passage in 2004

The House of Representatives has passed broad liability reform legislation as Senate Republican staffers, led by Senator Bill Frist's Office (R-TN), met with representatives from the Health Coalition on Liability and Access (HCLA) to obtain input on future strategy. The Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2004 (H.R. 4280) ensures victims are fully compensated for any and all injuries suffered, but it curbs runaway lawsuits by capping the amount of damages under "pain and suffering" and "punitive damages." The bill, which was later incorporated into H.R. 4279, also seeks to address a growing concern that frivolous lawsuits and excessive courtroom costs have put emergency room doctors and other health care specialists such as OB/GYNs on the list of endangered health care professionals. "Patients need to be treated by doctors in hospital rooms, not by trial lawyers in courtrooms," Speaker of the House Dennis Hastert (R-IL) said. "This legislation will help keep doctors on the job because critical care is in critical condition."

Chances of passage of any medical liability bill in the Senate in 2004 are unlikely. According to Senate staff who met with the HCLA—a group of more than 50 organizations representing health care providers,employers, insurers, and health care consumer seeking common sense federal medical liability reforms—it will be difficult to schedule time for debate since many important bills, such as budget bills, remain for action, and Congressional calendar days are limited in light of the fall election. The real hope is for passage of legislation in 2005.

However, with the House passage of the HEALTH Act, it may be possible to obtain Senate approval of some parts of that legislation. For example, there are two Senate bills addressing fears that an increasing number of high-risk specialist physicians are leaving their professions. In a statement on the floor of the Senate, Senator Frist cautions, "...our litigation system is increasingly forcing needed medical specialty doctors like neurosurgeons and obstetricians to drop or limit their services, to move to states not in crisis or to simply retire early from the practice of medicine. As the services these specialists provide become harder and harder to find, the sickest in our nation are hurt the most—once again demonstrating the perverse, unintended consequences of our ailing medical litigation system." The Pregnancy and Trauma Care Access Protection Act (S. 2207), introduced by Senators Judd Gregg (R-NH), Chairman of the Senate Health, Education, Labor, and Pensions Committee and John Ensign (R-NV), focuses liability reform on emergency care and OB/GYN services. However, a Democratic filibuster prevented consideration and passage of the measure in early April.

A related bill introduced by Senators Gregg and Ensign entitled the Healthy Mothers and Healthy Babies Access to Care Act (S. 2061) also failed to be considered. The bill would have limited noneconomic damages to $250,000, prescribed qualifications for expert witnesses, limited the award of punitive damages only where (1) it is proven that a person acted with

malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury the claimant was substantially certain to suffer; and (2) compensatory damages are awarded; and provided for periodic payments of future damage awards. The bill was denounced by the National Organization for Women, which claimed that it placed severe restrictions on a woman's ability to sue when she has been injured through medical malpractice or negligence in the provision of obstetrical or gynecological goods or services.

Last Acts Partnership Leads Effort to Introduce Advance Directive Proposals in Congress

Senators Bill Nelson (D-FL), Susan Collins (R-ME), and possibly John D. Rockefeller, IV (D-WV), are likely to introduce the Compassionate Care and Advance Directives Act of 2004 this spring. According to current law, Medicare- and Medicaid-participating hospitals, skilled nursing facilities, home health agencies, hospice programs, and HMOs must furnish each adult receiving medical care with written information about patient involvement in treatment decisions and must document any advance directives in the patient's medical record.

Continuing with that trend, this proposed bill would build on the 1990 Patient Self-Determination Act and amend Medicare and Medicaid, as amended by the 1997 Balanced Budget Act, to provide for:

- waivers of Medicare co-pays and deductibles for one visit with a physician to discuss advance care planning;
- improved portability of advance directives;
- a Department of Health and Human Services public education program on advance directives; and
- an information clearinghouse for consumers.

The proposal also authorizes $25 million for the public education and clearinghouse efforts. Furthermore, the General Accounting Office must conduct a study on the effectiveness of advance directives in making patients' wishes known and honored by health care providers; and conduct studies on the implementation of Medicare coverage of end-of-life planning consultations as well as the feasibility of a National Advance Directive Registry.

Similar bills (formerly entitled the Advance Planning and Compassionate Care Act) were introduced in the 105th, 106th, and 107th sessions with Senators Collins and Rockefeller, but were never reported out of their respective committees. The current proposal has been updated to include the findings of the January *JAMA* article (*Family Perspectives on End-of-Life Care at the Last Place of Care* by Teno and Clarridge, et al) on site of care that emphasizes that hospice is a good provider of end-of-life care.

According to Ellen Witman, the Last Act Partnership's Director of Advocacy, the Partnership has been working closely with Senators Collins and Nelson to introduce this bill. Sen. Rockefeller (D-WV) will probably also be on the bill as an original co-sponsor. The staff of the Partnership also worked with the American Bar Association on the bill, specifically the portability provisions. The proposed measure likely will be introduced in May 2004.

Conversations Before the Crisis Week
The Last Acts Partnership also will seek introduction of a companion piece to the Compassionate Care and Advance Directives Act of 2004. The Senate resolution, entitled *Conversations Before the Crisis* week, hopes to encourage people to spend a week discussing advance directives with their family, followed by the execution of an advance directive. It is likely that the Senate resolution will be introduced with the Advance Directive and Compassionate Care Act, but once introduced, they will move on their own.

The resolution is being introduced in a manner similar to the American Bar Association's (ABA) Advance Care Planning Week. During the third week of October, the ABA sends out packets to lawyers encouraging them to execute conversations on advance planning with their clients and hold community meetings on advance care planning. The dates of *Conversations Before the Crisis* week will be December 5-11.

AMDA is a member of Last Acts' End-of-Life Care coalition and supports *Conversations Before the Crisis* week and the Compassionate Care and Advance Directives Act of 2004.

As we go to press, the proposal was renamed and introduced as the Advance Directives Improvement and Education Act of 2004 (S. 2545).

AHRQ Study: Low Hospital Nurse Staffing Leads to Poor Outcomes

According to the report summarizing the findings of research funded by the Agency for Healthcare Research and Quality (AHRQ) and others, hospitals with low nurse staffing levels tend to have higher rates of poor patient outcomes such as pneumonia, shock, cardiac arrest, and urinary tract infections. According to author Mark W. Stanton, M.A., in the introduction of *Hospital Nurse Staffing and Quality of Care*, this valuable information on the relationship of nurse staffing levels to adverse patient outcomes can be used by decision makers to make more informed choices in terms of adjusting nurse staffing levels and increasing nurse recruitment while optimizing quality of care and improving nurse satisfaction. To view a copy of *Hospital Nurse Staffing and Quality of Care*, go to www.ahrq.gov/research/nursestaffing/nursestaff.htm.

2004 National Nursing Home Survey to Begin

The National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention, will be conducting the 2004 National Nursing Home Survey between August and December this year. This year's survey has added several items on medical directors, including questions on their education, specialty credentials, and length of service. AMDA encourages its members to complete the survey.

The latest in a series of nursing home studies, the 2004 survey will include a first-ever nationwide survey of nursing assistants. According to NCHS Chief of the Long Term Care Statistics Branch Robin Remsford, the new survey should provide NCHS with useful information on the organizational culture from the CNA perspective.

As in previous surveys conducted periodically since 1973 and most recently in 1999, the 2004 survey will obtain data on nursing homes, their residents, and staff. The survey obtains information from a

nationally representative sample of nursing homes based on interviews with the administrators and staff. The survey collects data on the facilities including bed size, ownership, number of residents, certification status, services provided, and basic charges. For residents, data are obtained on demographic characteristics, functional and health status, diagnoses, services received, and source of payment.

2004 Survey Expanded and Improved
The upcoming survey has been redesigned and expanded to better meet the data needs of researchers and health care planners. It will utilize computer-assisted personal interviewing. According to NCHS, this computerized system speeds the flow of data making it possible to release information on a timelier basis and makes it easier for respondents to participate in the survey. Another change is an increase in the current resident sample size, allowing more detailed and better information to be collected about this population.

For more information about the National Nursing Home Survey, check the NCHS web site at www.cdc.gov/nchs/about/major/nnhsd/nnhsd.htm.

Health Services Research Article: PPS Has Negative Effect on Staffing

Researchers investigating the effects of Medicare's SNF Prospective Payment System (PPS) and associated rate changes on quality of care have found that Medicare's PPS system and associated rate cuts for skilled nursing facilities have had a negative effect on staffing and regulatory compliance. Specifically, the study finds that professional staffing decreased and regulatory deficiencies increased with PPS, and that both effects were mitigated with the Balanced Budget Refinement Act rate increases. According to authors R. Tamara Konetzka, E.C. Norton, and K.E. Kilpatrick, the effects appear to increase with the percent of Medicare residents in the facility except, in some cases, at the highest percentage of Medicare. The authors note that their findings on staffing are statistically significant. The effects on deficiencies, though exhibiting consistent signs and magnitudes with the staffing results, are largely insignificant. The article entitled *Policy Research: Effects of Medicare Payment Changes on Nursing Home Staffing and Deficiencies* is published in the June 2004 issue of *Health Services Research*.

ADGAP Warns of Gap between Physician Geriatric Requirements and Aging Population

A University of Cincinnati Medical Center study contracted by the Association of Directors of Geriatric Academic Programs (ADGAP) warns that the number of nonpediatric residency and fellowship training programs including specific geriatrics content is too low to meet the needs of a growing aging population. Demographic trends and an expanding geriatric medicine knowledge base require that every physician develop skills specific to the care of the older adult, notes the report entitled *ACGME Residency Review Committees' Requirements for Geriatric Medicine Curriculum.* According to the report, the 1993 Institute of Medicine report *Strengthening Training in Geriatrics* recognized that physician training should include general geriatric medicine principles and specialty-specific topics related to aging. However, only 27 of the more than 100 nonpediatric specialties now have such requirements.

According to study authors Gregg Warshaw, MD, and Elizabeth Bragg, PhD, R.N., it is critical that programs develop challenging rotations with well-trained faculty. Externally imposed requirements for geriatric medicine training will have limited success without department chairs and program directors commitment to geriatric medicine faculty and curriculum development, as well as commitment to enhanced appreciation of geriatrics among the various subspecialties in each department. To view the study, go to www.adgapstudy.uc.edu/pdf/February2004.pdf.

National Quality Forum Report Publishes Standards

The National Quality Forum (NQF) has published its report *National Voluntary Consensus Standards for Nursing Home Care*, which details quality measures endorsed by the NQF's 200-plus member organization through its formal Consensus Development Process. CMS uses the 16 NQF-endorsed consensus standards to collect information from all nursing homes and provide the information on its website www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp. Consumers can use these publicly reported consensus standards to compare nursing homes to each other. Additionally, the consensus standards may be used by nursing homes themselves for internal benchmarking activities to gauge where to target quality improvement projects.

To order or view an executive summary of the report *National Voluntary Consensus Standards for Nursing Home Care*, go to www.qualityforum.org/txhospmeasBEACHpublicnew.pdf or www.qualityforum.org/txNursingHomesReportFINALPUBLIC.pdf.

State Governors and Budget Officers Study: States Recovering, but Face Uphill Battle

Despite the fact that revenues are coming in as projected, a survey released May 3, 2004 by the National Governors Association (NGA) and the National Association of State Budget Officers (NASBO) found state spending continues to be sluggish and rainy day funds have improved little in the last year. This biannual report, *The Fiscal Survey of States*, says that states continue to face rising health care costs and they will face fiscal difficulties for the foreseeable future.

In attempts to balance their budgets, states pared down expenses through across-the-board and targeted reductions to a wide array of programs, though to a lesser degree than recent years. In a sign of improvement, only 18 states cut their fiscal 2004 budgets, cuts totaling $4.8 billion, whereas a record 37 states slashed their budgets in 2002 and 2003. While this is an improvement, it pales from the boom years when, for example, in fiscal 2000 only one state reduced enacted budgets by only $65.5 million.
Despite extensive cost containment and federal fiscal relief, Medicaid continues to squeeze state budgets. Growing 4.4 percent in the last fiscal year and 11.9 percent in 2005, Medicaid spending continues to outpace revenue growth as 18 states anticipate Medicaid shortfalls in fiscal 2004. Without the 18-month federal fiscal relief package, state Medicaid spending would have shown double-digit growth.

As a percentage of the total Medicaid program in fiscal 2003, the shortfalls ranged from less than 1 percent to 16.4 percent of the program costs, averaging 4.6 percent. The combined amount of the shortfalls in fiscal 2003 and fiscal 2004 totals nearly $7 billion. Medicaid costs will continue to

outpace growth in state revenues into the future. Both the Congressional Budget Office and the Office of Management and Budget project long-range annual growth of between 8 percent and 9 percent. In addition to cost containment measures, about one-half of the states reported plans to generate additional Medicaid revenues, including measures to levy or taxes on health care providers, reallocate tobacco settlement funds, and increase cigarette taxes.

Unlike the last several years, fiscal 2004 revenue collections mostly met budgeted expectations, but states continue their cautious recovery given the toll that the national economic situation has taken on state revenues since 2002. In fiscal 2005, governors in 26 states have recommended tax and fee increases totaling $5.4 billion, while four governors have proposed decreases totaling $266.2 million.

"After three years during which state revenues proved exceedingly dismal, the picture is notably—but cautiously—brighter at the end of fiscal 2004. As most economic indicators continue to improve, the cyclical instability that plagued state revenues has eased and revenue collections compared to budgeted estimates contrast markedly with the past several years," the report said. "Still, the state revenue situation might be characterized both as beginning to recover and ceasing to decline."

NASBO conducted the field survey in January through April 2004 and governors' state budget officers completed the surveys. Fiscal 2003 data represent actual figures, fiscal 2004 figures are preliminary, and fiscal 2005 data reflect recommended budgets.

The survey can be viewed at www.nga.org/cda/files/FSS0404.pdf.

AHRQ To Issue Grants to Physicians to Implement E-Prescription Drug Programs

The Agency for Health Care Research and Quality plans on disseminating information on grants for physicians for implementation of an electronic prescription drug program. The grant can be used for software, hardware (including the purchase of PDAs), or training, and grantees will be responsible raising 50% matching funds from non-governmental sources. The grants were authorized by Congress with the passage of the Medicare Modernization Act of 2003. A task force is charged with having recommendations regarding this program by January 1, 2005, and national standards are to be set by January 2006. A formal announcement of the grant has not been made as of yet, but is expected to come from the Agency for Health Care Research and Quality.

RAND Panel Issues Recommendations on E-Prescribing

A RAND-sponsored panel of experts has issued 60 recommendations for comparing electronic prescribing systems and to help guide the development of electronic prescribing policy. The recommendations were published in this month's issue of *Health Affairs*.

The panel recommends that health care providers wanting to pursue electronic prescribing "should look for systems that are integrated with patients' computerized records, can list all medications that a patient currently takes, can transmit prescriptions according to established standards, and that disclose the results of any sponsorship from third parties such as health insurers or drug manufacturers," stated the *Health Affairs* website.

According to RAND Health's website the panel also recommended that "electronic prescribing systems should:

- Import patient identification and demographic data from electronic medical records used by the organization;
- Provide the patient's complete current medication list to prescribers who have care responsibility for the patient;
- Display a list of medications appropriate to the diagnosis when it is entered;
- Guard against efforts to promote specific drugs by third parties such as drug manufacturers or pharmacy benefit managers;
- Distinguish alerts based on patient safety and health outcomes from those based on formulary adherence;
- Transmit prescriptions electronically using established standards for data exchange;
- Support compliance with federal health care privacy laws and methods for checking the integrity of stored data."

The article entitled *Recommendations for Comparing Electronic Prescribing Systems: Results of an Expert Consensus Panel* can be viewed at http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.305v1/DC1.

AMDA Past President and Public Policy Chair, Cheryl Phillips, MD, CMD, is representing AMDA on a national task force led by John Derr of AHCA to report to DHHS Secretary Thompson on the long term care aspects of the Secretary's Information Technology (IT) Initiative. The initiative is associated with President Bush's Executive Order of April 27, 2004, calling for a report on IT capabilities.

More on the group's work in future issues.

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