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Medicare unveils bundled payment models to start in 2012

Payment bundling for physicians and hospitals is the latest Medicare initiative that aims to improve quality and coordination of care.

Physicians and hospitals will be collaborating to bid on providing high-quality, low-cost inpatient and postdischarge care to Medicare patients under a new payment option starting in 2012, the Centers for Medicare & Medicaid Services said.

Hundreds of interested hospitals and groups of physicians are expected to coordinate patient care under the new bundled payment initiative. Bundling payments is one of several models that physicians in organized medicine have encouraged the Medicare agency to use in place of traditional fee for service.

Bundling payments across episodes of care could allow physicians and hospitals to limit the use of low-value services, coordinate patient care and work together to improve efficiency.

The Medicare fee-for-service system has been blamed for rewarding volume of care instead of quality. Payment systems should encourage hospitals and physicians to collaborate better on patient care, the Medicare Payment Advisory Commission wrote in a 2008 report. In particular, bundling payments across episodes of care could allow physicians and hospitals to limit the use of low-value services, coordinate patient care and work together to improve efficiency.

The AMA is reviewing the details of the bidding process. It has urged CMS to provide technical assistance and data to interested physicians who might not have any experience with the new model.

The initiative allows physicians to redesign part of the health care system to coordinate care better, said Nancy H. Nielsen, MD, PhD, a senior adviser to the innovation center and a former AMA president.

Four ways to bundle

Hospitals and physicians can choose from four bundled payment models under a new Medicare initiative.

- Model 1 (inpatient stay only): Hospitals receive a discounted payment, but physicians receive full fee-for-service rates. CMS requires the minimum discount to Medicare to increase from 0% during the first six months to 2% in year three of the bid.
- Model 2 (inpatient stay plus postdischarge services): Hospitals and physicians receive fee-for-service rates that are retrospectively reconciled with a target price. CMS requires a 3% minimum discount to Medicare for 30 to 89 days after discharge and a 2% discount for an episode that is 90 days or longer.
- Model 3 (postdischarge services only): Hospitals and physicians receive fee-for-service rates that are retrospectively reconciled with a target price. The applicant proposes the discount amount to Medicare.
- Model 4 (inpatient stay only): A payment amount is established prospectively for the admitting hospital, and the hospital distributes pay to physicians. The applicant proposes the discount amount to Medicare, at a minimum of 3%.

Source: Centers for Medicare & Medicaid Services, fact sheet on bundled payments for Care Improvement Initiative, Aug. 23 (innovations.cms.gov/documents/pdf/fact-sheet-bundled-payment-final82311.pdf).

PCMS NEWS

2011-2012 Influenza Information

Universal Influenza Vaccine Recommendation for 2011-12 Season

During the 2011-12 influenza season, ALL people (excluding infants under six months of age and people with certain medical conditions) are now recommended to get influenza vaccine.

Healthy adults 19-49 years of age, who were not previously recommended for routine flu vaccination before 2010, are now included in the expanded recommendations.

The recommendations for administering flu vaccine to children aged 6 months through 8 years are slightly more complex, based in part on an individual's 2010-11 vaccination history.

Visit *www.CDC.gov/flu/* for more information about influenza and influenza vaccine.

New Version 5010 testing readiness fact sheet available

All covered entities under the Health Insurance Portability and Accountability Act (HIPAA) must be ready to implement the Version 5010 transaction standards on January 1, 2012.

Here are some suggested steps to take now:

- Identify the partners you currently conduct transactions with.
- Create a schedule and timeline for external testing with each partner.
- Identify priority partners to conduct testing with if you trade with a large number of business partners.
- Keep up to date on Version 5010.

Please visit the 5010 website at *www.CMS.gov/Versions5010andD0/* for the latest news and resources to help you prepare today.

Host your event at PCMS

Host your next party or conference/seminar at PCMS headquarters. Ample free parking. Contact Louise Eder on 215-563-5343, Ext. 107 to schedule an appointment.

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Editorial

Watson – Extreme evidence based medicine

By Lynn Lucas-Fehm, MD, JD

Most of us recall the literary character Dr. Watson who served as the steadfast confidant, supporter, physician and assistant to the brilliant detective Sherlock Holmes. Now there is a new Watson in our midst, an artificial intelligence computer developed by IBM and named after IBM's first president, Thomas J. Watson.

After handily defeating the formidable human Jeopardy champions, Brad Rutter and Ken Jennings, Watson's developers have expanded the computer's medical databases to create what may become the ultimate digital collection of medical information. However, what truly sets Watson apart is that it can analyze facts gathered in natural language and generate differential diagnoses. It even assigns a ranking to each diagnosis based on its understanding of medical knowledge in textbooks, journals, and case reports.

At a recent demonstration for The Associated Press, Watson was asked to consult on a fictional patient with an ophthalmic disorder. As additional symptoms, medical history and personal information was presented — blurred vision, family history of arthritis, Connecticut residence — Watson's suggested diagnoses evolved from uveitis to Behcet's disease to Lyme disease. It gave its final diagnosis a 73% confidence rating. Dr. Herbert Chase, a Columbia University medical school professor and Watson consultant, commented, "You do get eye problems in Lyme disease but it's not common… you can't fool Watson."

IBM's Dan Pelino, general manager for global healthcare, said possible future uses for Watson include allowing a doctor to connect to Watson's database by speaking into a hand-held device using speech-recognition technology with cloud computing serving as the database for the most advanced research.

There is little doubt that Watson will help physicians with a major problem in modern healthcare: information overload. The potential to have immediate access to every resource of evidence based medicine is exciting. However, Watson developers and consultants will go a step further. Dr. Chase stated that anecdotal information — such as personal blogs from medical websites — may also be included.

Chase remarked, "What people say about their treatment … it's not to be ignored just because it's anecdotal. We certainly listen when our patients talk to us, and that's anecdotal."

This is where the issue of Watson's involvement in medical practice becomes a slippery slope. Since Watson has the ability to interpret natural language will it be able to listen to patient's complaints, analyze them and give a differential diagnosis? Watson could become the ultimate physician's assistant. In fact, with the increasing reliance on "apps" one might wonder if Watson could truly become "Dr. Watson".

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I have always embraced new technology, reveling in the acquisition of every new smart phone technology, iPAD app and software innovation. However, reliance on such technology to the exclusion of the human factor in the practice of medicine may lead to increased productivity but suboptimal patient care. A balance must be achieved in the upcoming decade where technological tools are utilized to provide the physician with the evidence based medicine to assist in accurate diagnosis while allowing the irreplaceable intuition, compassion and humanity only we as physicians can provide.

Dr. Lucas-Fehm is President of PCMS.

Curbing waste and abuse under the Affordable Care Act

This year the Department of Health and Human Services (HHS) released its final rule for the Medicaid Recovery Audit Program, a key part of the Administration's initiatives to curb waste, fraud and abuse.

Created by the Affordable Care Act, the Medicaid Recovery Audit Program will help states identify and recover improper Medicaid payments. It will be largely self-funded, paying independent auditors a contingency fee out of any improper payments they recover that took place in the previous three years.

The Recovery Audit Contractors (RACs) detect and correct past improper payments. RACs review claims after payments have been made, using both simple, automated review processes and detailed reviews that include medical records.

RACs can only go three years back from the date the claim was paid, and are required to employ a staff consisting of nurses, therapists, certified coders, and a physician. Under these expansions, RACs will help identify and recover over and underpayments to providers across Medicare and Medicaid for the first time.

New Resources to Fight Fraud

The Affordable Care Act provides an additional $350 million over 10 years and an annual inflation adjustment to ramp up anti-fraud efforts, including increasing scrutiny of claims before they've been paid, investments in sophisticated data analytics, and more "feet on the street" law enforcement agents and others to fight fraud in the health care system.

These efforts build on our recently awarded predictive modeling contract under which CMS is using the kind of technology used by credit card companies to stop fraud.

Since June 30th of this year CMS has been using this technology to help identify potentially fraudulent Medicare claims and uncover fraudulent providers and suppliers, flagging both for investigation and referrals to law enforcement.

This new tool allows CMS for the first time to use real-time data to spot suspect claims and providers and take action to stop fraudulent payments before they are paid.

These efforts build on the many aspects of the Affordable Care Act that are currently working to bring down waste, fraud and abuse in the health care system. To learn about the many accomplishments the new tools have produced in preventing and fighting waste, fraud and abuse in these programs, see *www.healthcare.gov/news/factsheets/fraud09142011a.html*.

Avocations

Award winning academic physician and prolific author has a parallel life as an accomplished musician

By David Woods, PhD

Longtime PCMS member and onetime Cristol Awardee and board member Dr. Bernard Eskin is a man of both words and music. He's written 29 books and played viola and saxophone in a variety of orchestras, including a gig between high school and Princeton with legendary band leader Stan Kenton … and years later in a quartet with Albert Einstein.

A professor of obstetrics and gynecology at Drexel University College of Medicine, where in 2010 he was elected to membership in the College's Alpha Honor Medical Society, Dr. Eskin began his involvement with physician-led musical groups with the Doctors' Symphony, which, at its height, had some 80 members … many of whom, he notes, were psychiatrists.

Dr. Eskin has also been a professor of psychiatry and this finding might not be that surprising given psychiatrist-author Oliver Sachs' contention in his book *Musicophilia* that music can lift us out of depression and serve as therapy in a variety of neurologic and psychiatric conditions.

An article in the April 1976 issue of *Philadelphia Medicine* notes that "of all the physicians that put pen to music paper perhaps the most illustrious was Alexander Borodin." In that same issue, writing about the tenth anniversary of the Philadelphia Doctors' Symphony, Dr. Eskin noted that in 1965 a Dr. Michael Leveen had organized and conducted the orchestra which hired its first professional conductor that same year. In 1968 the orchestra began a series of taped TV programs.

The Symphony played mainly in schools and retirement communities and attracted an audience principally of older people; but also played for such dignitaries as a governor, a mayor, and national professional musicians.

"As we grew," says Dr. Eskin, "physician members joined other regional orchestras and I went to Main Line Symphony." The original group formed a chamber orchestra at Graduate Hospital.

While all of this was an avocation, he notes, it was certainly not dabbling: rehearsals were one or two hours, and six to eight of these were needed to prepare for a program.

Dr. Eskin, an affable octogenarian, is still in full harness at Drexel, and has by no means abandoned his passionate avocation in music, having played in Handel's Messiah at Villanova last year, where his wife Lynn, a pianist and singer, also performed.

pcms people

October 2011 PAMED Annual Meeting Happenings

The following PCMS past presidents were elected to the PAMED Board of Trustees: William A. VanDecker, MD, Medical Specialties Trustee; Enrique Hernandez, re-elected as First District Trustee; and Theodore A. Christopher, MD, as At-Large Specialties Trustee. Dr. Christopher was also re-elected as a Delegate to the AMA.

Dale Mandel, MD, and Albert S. Kroser, DO, served as Tellers/ Sergeants-at-Arms.

Enrique Hernandez, MD, Chairman; and John D. Cacciamani, Jr., MD, MBA, Vice Chairman, preside over the PCMS Delegate Caucus meetings.

Bernard A. Eskin, MD, represented PCMS as a member of the Public Health Reference Committee; and Anthony M. Padula, MD, as a member of the Bylaws Reference Committee.

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