REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-11

Subject: Denial of Payment Based on Volume of Procedures Performed

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At the 2010 Annual Meeting, the House of Delegates adopted Policy D-180.982 (AMA Policy Database), which asked that the American Medical Association (AMA) study the issue of low hospital volume and the resulting restrictions on patients. The Board of Trustees referred the requested study to the Council on Medical Service for a report back to the House of Delegates at the 2011 Annual Meeting.

This informational report outlines issues regarding payment based on volume of procedures performed; highlights a New York Medicaid payment policy; reviews medical staff responsibility; stresses the importance of patient choice, access and procedural outcomes information; and summarizes related AMA policy and advocacy.

BACKGROUND

The connection between volume of procedures and quality outcomes has been associated with the term "Center of Excellence" for many decades to signify a provider that specializes in a specific type of program or service with high quality. According to the New York Health Commission, results are varied according to the specific surgical procedure, but studies generally demonstrate that better outcomes are associated with higher volume for various procedures and conditions.

The correlation between quantity and quality was acknowledged by the members of the AMA House of Delegates at the 2010 Annual Meeting who testified on Resolution 712-A-10, which established Policy D-180.982. However, many were concerned about the idea of linking payment to volume. Some speakers identified situations where this type of selective contracting could negatively impact access to care by discouraging physicians from learning new procedures, discriminating against young physicians who lack experience, hindering the practices of physicians who perform high volume surgeries at other facilities, and eliminating access to specific procedures in certain geographic regions.

Accordingly, connecting payment to volume potentially interferes with a patient's choice of provider and could impede the patient-physician relationship. In addition, research has shown that factors other than volume can impact outcomes, such as hospital patient mix and specific patient characteristics including coexisting conditions, age, socioeconomic status, and health care coverage (Gilligan et al., 2007 and Allareddy, Ward, Allareddy and Konety, 2010). Resolution 712-A-10 highlighted a New York policy linking payment to volume, but the practice of selective contracting based on volume of procedures may be replicated by other insurers and in other areas of the country.

NEW YORK MEDICAID

The New York Medicaid program is one of the largest insurance programs in the nation providing health insurance coverage to 4.9 million residents in 2010, up from 4.2 million in 2007. Various measures have been suggested to reign in the program's expenses and formal initiatives have been implemented to improve quality and reduce costs.

As highlighted in Resolution 712-A-10, effective April 1, 2010, the New York State Department of Health (NYSDOH) discontinued paying for inpatient or outpatient mastectomy or lumpectomy procedures associated with a breast cancer diagnosis provided to Medicaid fee-for-service beneficiaries performed at low-volume breast cancer facilities. Low-volume breast cancer facilities were defined as those averaging fewer than 30 mastectomy and lumpectomy procedures associated with a breast cancer diagnosis over a three-year period. The NYSDOH recommends that Medicaid fee-for-service beneficiaries requiring breast cancer surgery be directed to high-volume facilities. In addition, all managed care plans serving Medicaid beneficiaries are required to contract with hospitals and ambulatory surgery centers exceeding the average volume threshold of 30 surgeries for mastectomy and lumpectomy surgeries.

In 2010, this new Medicaid policy impacted 64 New York facilities. The NYSDOH plans to annually re-examine surgical volumes and modify the list of hospitals and ambulatory surgery centers that Medicaid can contract with for such surgeries. The evaluation of facilities was performed using the Statewide Planning and Research Cooperative System (SPARCS) database. SPARCS is a comprehensive data reporting system established in 1979 as a result of cooperation between the health care industry and the government. SPARCS collects patient-level detail on patient characteristics, diagnoses and treatment, services, and charges for every hospital discharge, ambulatory surgery patient, and emergency department admission in New York State.

MEDICAL STAFF RESPONSIBILITY

Generally, a hospital is licensed under state law to operate and provide services. Licensing of acute care hospitals is not typically procedure-specific. Therefore, the New York Medicaid program is placing procedure-specific limitations on hospitals that have been identified as low volume even though the hospitals are licensed to perform such procedures. Credentialing and recommending privileges for physicians is the responsibility of the medical staffs of the individual hospitals. Medical staffs are in the best position to evaluate the qualifications of physicians to perform procedures. Whether or not an individual hospital is in a position to provide a given service that falls under its license should be determined by the medical staff and the governing body of the organization.

PATIENT CHOICE, ACCESS AND PROCEDURAL OUTCOMES INFORMATION

The New York Medicaid program's policy to identify low hospital volume and tie it to payment results in restricting patient choice and access to health care. The AMA advocates that patients should be free to choose the physician who provides their medical care (Policy H-415.988). Patients should be able to freely make decisions about who will perform a specific procedure and where it will be performed. Resources are becoming available from various facilities that report outcomes on specific procedures and patients' assessments of care in order to assist patients in making informed decisions about their heath care. For example, collaborative efforts of the Centers for Medicare & Medicaid Services (CMS) and the Hospital Quality Alliance (HQA) created "Hospital Compare," which provides comparative information online about hospital performance. The Leapfrog Group provides a similar online service.

RELATED AMA POLICY AND ADVOCACY

The AMA Board of Trustees previously considered the issue of volume of procedures by physicians. Board Report 3-A-09, "Privileging Physicians with Low Volume Hospital Activity," focused on low volume physicians and the hospital privileging process. The report established policy outlining comprehensive privileging procedures. Specifically, the report acknowledged the fact that a physician's volume and outcomes may be independent of a specific facility, due to the physician being on staff at multiple facilities. As such, policy was established encouraging hospitals and medical staffs to use data and references, if available, from another hospital at which the applicant physician may be active as a method to verify the physician's competency within the hospital environment (Policy H-230.954).

The AMA recommends that volume indicators be applied only to those treatments where outcomes have been shown by valid statistical methods to be significantly influenced by frequency of performance. The AMA opposes volume indicators being used as the sole criterion for payment (Policy H-180.963). The AMA advocates that selective contracting decisions made by any health delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriateness by which medical services are provided. In general, no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system (Policy H-285.991).

The Board also previously considered Medicaid payment policies and utilization of services. Board Report 13-I-02, "Establishment of a National Medicaid Database," discussed the role of the federal government in developing state Medicaid policy. The report established policy recommending that the AMA develop model state legislation requiring states to create a database of outpatient encounter data to be used to monitor Medicaid payment policies and utilization of services (Policy D-290.992). The AMA Advocacy Resource Center (ARC) developed model state legislation, "Monitoring Payment Policies and Utilization of Services." The ARC cautioned that the model legislation may not be appropriate for all states due to the vast differences between the state Medicaid programs and because most states already collect such data.

The AMA supports access to affordable and adequate health care services and individual freedom of choice of physician (Policies H-373.998 and H-415.988). The AMA advocates that the relationship between a physician and a patient is fundamental and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship (Policy H-275.937[2]). The AMA opposes payment cuts in Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients (Policy H-330.932).

DISCUSSION

While the correlation between volume and outcomes is generally supported by research, there are many variables other than volume that can impact quality outcomes. As such, results are not conclusive as to the level of volume that predicts quality outcomes for every procedure. Maintaining a certain level of currency for a specific procedure appears to have an impact on quality. However, a hospital's medical staff is in the best position to evaluate the qualifications of their physicians to perform procedures and to determine if the hospital can provide a given service that falls under its license.

Related AMA policy regarding volume indicators, selective contracting, discrepancies between physician volume and facility volume, physician contracting, access to care, choice of provider, and protecting the patient-physician relationship are general (i.e., they do not refer to specific services or procedures). Given the detailed clinical nature of determining the appropriate physician volume regarding specific procedures, it would be difficult for the AMA to develop more detailed policy.

Testimony at the 2010 Annual Meeting was generally supportive of the concerns raised by Resolution 712-A-10. However, several amendments were proposed to more appropriately direct the study requested by the resolution. For example, testimony advocated that national medical specialty societies study this issue in order to focus on specific procedures since the threshold of quantity and quality varies according to procedure.

CONCLUSION

The issue of low hospital volume has been studied previously by the AMA Board of Trustees. As previously mentioned, Board Report 3-A-09, "Privileging Physicians with Low Volume Hospital Activity," established policy that acknowledges the fact that an assessment of physician's volume and outcomes may need to include data and references from multiple facilities.

The Council believes that patients should use available resources in order to compare outcomes of various medical procedures and review patient assessments of care in order to make informed decisions about their heath care. In addition, each hospital and medical staff should create its own methodologies and standards for credentialing and privileging physicians with low activity at their hospitals. These methods and standards should be tailored to the individual hospital's needs, such as a monitoring system for low-volume doctors in the absence of performance data, or creating a new, separate staff category for physicians and allied health professionals that would limit a practitioner's activities to referring and following patients, to ensure continuity of care and patient safety.

The Council agrees with testimony presented on Resolution 712-A-10 that national medical specialty societies are in the best position to study specific procedures and to determine the level of volume that correlates with high quality outcomes. Several specialty societies already provide resources to their members. For example, the American College of Cardiology studies and publishes rates of volume and outcomes for various surgical procedures in the Journal of the American College of Cardiology and the American Urological Association provides a basic ultrasound certification course for its members.

Specifically related to breast cancer and the concerns raised in Policy D-180.982, the American College of Surgeons is a member organization of the National Accreditation Program for Breast Centers (NAPBC). The NAPBC is a consortium of national professional organizations dedicated to the improvement of quality care and monitoring of outcomes for patients with diseases of the breast. The NAPBC Board has defined 27 program standards and 17 program components of care, including performance measures for high-quality breast care. The Council encourages specialty societies to continue studying and identifying the volume threshold at which specific procedures consistently result in quality outcomes in addition to providing their members with certification courses and other quality resources.