White House Plan Calls for Cuts to Specialists

BY MARY ELLEN SCHNEIDER

Decreased pay for subspecialists, increased pay for primary care physicians, and a potential way to get rid of the sustainable growth rate formula are addressed in the Obama Administration's proposed rule on the 2010 Medicare Physician Fee Schedule.

Physicians' organizations have sought repeal of the sustainable growth rate (SGR)—the statutory formula used to set physician payment rates under Medicare—saying that it is flawed and does not reflect the true cost of providing medical care.

One criticism is that the formula counts the price of physician-administered drugs, over which physicians have little control, as a physician service.

Since the SGR is designed to cut payments when health care expenditures rise above a certain target, the inclusion of drugs has caused physicians to exceed those targets more rapidly and has contributed to pay cuts over the years.

The removal of physician-administered drugs from the SGR should reduce the number of years that physicians see pay cuts, according to the Centers for Medicare and Medicaid Services.

And the American Medical Association is betting that the change will make it less expensive for Congress to repeal the SGR, which would also benefit physicians.

The removal of drugs from the SGR is one of several changes included in the 2010 Medicare Physician Fee Schedule proposed rule, published in the Federal Register on July 13.

A final rule is expected in November.

Even if enacted, the proposal will not stop the 21.5% pay cut slated to go into effect on Jan. 1, 2010. However, several physicians interviewed said they were hopeful that Congress would step in again this year to roll back this cut, whether through health reform legislation or in a separate bill.

While the 21.5% cut would affect physicians across the board, the rest of the fee schedule proposal affects physicians quite differently depending on their specialty. For example, the proposed rule includes plans to eliminate the use of consultation codes, increase payments for evaluation and management (E&M) services, and update the practice expense component of physician fees based on new survey data. Under the proposal, the CMS would eliminate the use of all consultation codes except telehealth codes starting Jan. 1.

At the same time, the agency would increase the work relative value units for new and established office visits, increase the work values for initial hospital and initial nursing facility visits, and incorporate the increased use of these visits into the practice expense and malpractice relative value unit calculations.

"We believe the rationale for a different payment for a consultation service is no longer supported because documentation requirements are now similar across all E&M services," the CMS wrote in the proposed rule.

The cut takes money away from specialists to provide additional compensation to primary care physicians.

DR. LAKHANPAL

Also included in the proposed rule is an increased payment for the Welcome to Medicare physical, which focuses on primary care, health promotion, and disease prevention.

The CMS estimates that the combination of the various proposals would mean a 6%-8% payment increase for primary care physicians, excluding the impact of the 21.5% cut. The combined proposals will result in a 1% cut for rheumatologists on average, according to CMS estimates that do not include the 21.5% cut. The cut represents a dangerous precedent because it pits one group of physicians against another by taking money away from specialists to provide additional compensation to primary care, said Dr. Sharad Lakhanpal, clinical professor of internal medicine at the University of Texas Southwestern Medical School in Dallas and chairman of the government affairs committee at the American College of Rheumatology.

For rheumatologists, the shift is especially frustrating, he said, because they provide mainly cognitive care but aren't getting the same payment increases that primary care physicians are getting. "Most of our work is patient care, E&M services," Dr. Lakhanpal said.

Since rheumatologists don't perform many procedures, most of their payments come from consultations. Dr. Lakhanpal said that the work involved in a consult warrants additional pay. For example, a consult with a complicated patient can be time consuming and involves reviewing sometimes extensive medical records before examining the patient. Dr. Lakhanpal said he hopes that the consult provision will not go into effect as written.

Dr. Ted Epperly, president of the American Academy of Family Physicians, said that assuming that the 21.5% cut is stopped, 2010 could be a good year for primary care. In addition to the 6%-8% increase in the fee schedule proposed rule, primary care physicians could gain 5%-10% in payments through health reform legislation pending in Congress.

These increases will be critical for primary care physicians in practice today who need money to invest in changing their practice in order to provide care under the medical home model. "It provides the fuel for transformation," Dr. Epperly said.

Equally important, he said, is that increasing the payments sends the message to medical students that primary care is a viable field and that they don't have to go into subspecialties to earn a living.

Conversely, subspecialists would lose out under the schedule proposal, experiencing either cuts or only small increases.

The fee schedule proposal also includes policy changes related to imaging. The proposed rule would cut payments for certain high-cost imaging services by assuming that imaging equipment priced at more than $1 million is used 90% of the time, compared with the current assumption of use at 50%.

The proposed change is based on studies from the Medicare Payment Advisory Commission (MedPAC) showing that the use of high-cost imaging equipment is higher than previously thought. MedPAC found that in certain markets, MRIs were being used an average of about 46 hours a week, or 92% of a 50-hour workweek. As written, the rule would not affect lower-cost imaging services such as bone density testing and ultrasound. The agency said it will continue to examine the data for equipment valued at less than $1 million but is not proposing a change at this time. The CMS noted that it does not expect the imaging proposal to create access issues in rural areas. ■

TALK BACK

What's your view of the proposal to cut Medicare pay for subspecialty physicians?

Share your thoughts!
Send e-mail to rheumatologynews@elsevier.com;
or write to rheumatologynews,
5635 Fishers Lane, Suite 6000,
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Generic Biologics Get a Boost

Creating a process at the Food and Drug Administration for approving generic biologic drugs, called follow-on biologics (FOBs), could lower biologics' cost, the Federal Trade Commission said. But the 12- to 14-year exclusivity period sought by biologics manufacturers is too long, according to the agency. FOBs wouldn't tread deep into innovative products' turf—those drugs would retain 70%-90% of their market shares and continue making substantial profits—according to the FTC. Rep. Henry A. Waxman (D-Calif.), who has introduced legislation to create a regulatory pathway for FOBs, praised the report. But the Biotechnology Industry Organization blasted it as "fundamentally flawed" and based on a "lack of true understanding of the necessary conditions to drive future biomedical breakthroughs." The full FTC report is available at www.ftc.gov/os/2009/06/P083901biologicsreport.pdf.

NIH Targets Rare Diseases

The National Institutes of Health has created a pipeline for drugs to treat rare and neglected diseases. This spring, Congress provided $24 million for the program, which focuses on collaborations among NIH researchers in these areas. The initiative is supposed to go beyond the Orphan Drug Act by offering support for preclinical research and product development. NIH will seek private companies to carry out testing with patients. The program "will develop promising treatments for rare diseases to the point that they are sufficiently 'derisked' for pharmaceutical companies, disease-oriented foundations, or others to undertake the necessary clinical trials," Dr. Alan E. Guttmacher, acting director of NIH's National Human Genome Research Institute, said in a statement. NIH estimates that there are more than 6,800 rare diseases but only about 200 of them have effective drug treatments.

Vermont Bans Most Pharma Gifts

Vermont Gov. Jim Douglas (R) has signed into law a bill that prohibits manufacturers of drugs, medical devices, and biologics from providing free gifts, including meals and travel, to physicians and other health care providers. The toughest of its kind in the nation, the legislation also requires disclosure of any allowed gifts or payments, regardless of their value. Under the stronger law, manufacturers can give physicians only gifts such as samples intended for patients, "reasonable quantities" of medical device evaluation or demonstration units, and copies of peer-reviewed articles. They still can provide scholarships or other support for medical students, residents, and fellows to attend educational events held by professional associations.

More Flu Preparation Needed

Federal and state governments need to do more to prepare for possible pandemic flu, the Government Accountability Office (GAO) said after reviewing the H1N1 flu outbreak. The office acknowledged pandemic planning throughout government but said that more efforts are needed to improve disease surveillance and detection, address issues of coordination between various governmental entities, and improve capacity for patient care in the event of a pandemic. The GAO warned that the H1N1 virus could return next fall or winter in a more virulent form.

—Mary Ellen Schneider