Medicare Advantage Pay Eyed for Fee Fix Again

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WASHINGTON — With Congress scrambling to come up with the funds to avert a physician fee cut scheduled for July, it appears once again that Medicare Advantage is being eyed as a funding source by Democrats but as sacrosanct by Republicans, setting the stage for several months of political wrangling.

It also may portend a repeat of last year's battle, one that ended with President Bush refusing to sign a legislative package that restored physician reimbursement but slashed Medicare Advantage payments.

The debate was front and center at a March hearing of the House Ways and Means Committee's Subcommittee on Health where recommendations from the Medicare Payment Advisory Commission's (MedPAC) spring report to Congress were discussed, including the recommendation that Congress increase physician fees by 1.5% in 2008 and 2009.

MedPAC said in its report that it supported Medicare Advantage (MA) plans—which let beneficiaries receive coverage from private plans such as HMOs and PPOs, and from private fee-for-service insurers. The Commission also made the case that, for the third year in a row, the MA plans are overpaid relative to traditional fee-for-service (FFS) Medicare.

MedPAC Chairman Glenn Hackbarth told the subcommittee that the commission estimates that Medicare has paid the plans $10 billion more than it would have under traditional FFS for each of the last 3 years. Overall, MA plans on average will be paid 13% more than conventional Medicare providers in 2008, a 1% uptick from 2007. The profit potential in those plans has stimulated a rush into the market and huge enrollment growth—a 101% increase from 2006 to 2007, according to MedPAC. Coordinated care plans, such as HMOs and PPOs, saw only an 8% increase in enrollment during that period, although those plans still account for the largest number of beneficiaries enrolled in an MA. Currently, about 20% of Medicare enrollees are in an MA plan.

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Because MA plans are increasingly attractive to beneficiaries—they often offer additional benefits—MedPAC is concerned about the growth of the high-cost private FFS plans, said Mr. Hackbarth.

The plans are being rewarded for their costs and there is no penalty for poor quality, he said. "Payment policy is a powerful signal of what we value," Mr. Hackbarth said, adding, "The benchmarks we use are a signal of what Medicare wants to buy." The Commission "supports financial neutrality between payment rates for the FFS program and the MA program," he said.

That fact has not been lost on the subcommittee chairman, Pete Stark (D-Calif.), who has held multiple hearings questioning the value and integrity of the MA plans. Republicans defended the MA program, however. Ranking minority member Rep. Dave Camp (R-Mich.) intensely questioned Mr. Hackbarth, eliciting the admission that MA plans had been successful in rural areas. Rep. Sam Johnson (R-Tenn.) told Mr. Hackbarth that "my seniors have asked me not to mess with their Medicare Advantage plans." Rep. Johnson at one point accused the MedPAC chairman of saying that the government is a more efficient insurer than the private sector.

Mr. Hackbarth disagreed and clarified his position. "The problem with this payment system is we are rewarding inefficient private plans," he said. ■

New Medicare Chief Trades Scalpel for Bureaucrat's Pen

Dr. Jeffrey Rich is trading in his scalpel for a bureaucrat's pen in the hope that he'll give Medicare a strong and credible push into a future that will reward those who deliver high-quality care at the best cost. The cardiothoracic surgeon took over as director of the Center for Medicare Management in February.

Dr. Rich, who serves on the board of directors for the Society of Thoracic Surgeons, has delved deeply into restructuring reimbursement to reward quality care through his work with the National Quality Forum, the Hospital Quality Alliance, the Surgical Quality Alliance, and the AQA alliance, among other organizations.

He also helped launch the Virginia Cardiac Surgery Quality Initiative, which was one of the initial participants in CMS's Hospital Quality Incentive Demonstration project. Dr. Rich is currently chairman of the board of directors for the Virginia initiative and is also a member of the quality committee. On three occasions, Dr. Rich has testified before Congress on how the federal government could construct a payment system to reward quality. He also gave a congressional briefing on pay for performance.

Even so, he's often felt like an outsider, trying to get policy makers' attention. Now, he'll be on the inside. "I get a chance to open a door instead of knocking on it," Dr. Rich said in an interview, noting that he's been "knocking on doors for years."

As director of the Center for Medicare Management, he will lead several federal initiatives, such as instituting competitive bidding for durable medical equipment, implementing the Medicare Administrative Contractor program, and overseeing the development and promulgation of rules pertaining to inpatient, outpatient, and physician payments.

But his top priority is guiding the center's value-based purchasing initiative. The Virginia Cardiac Surgery Quality Initiative ably combined the CMS administrative claims database with the Society of Thoracic Surgery registry, said Dr. Rich, adding that he'd like to do something similar while at CMS.

"My hope is that we do create a value-based purchasing system with credible data and that will engender trust with providers," he said. The key will be to use "market-based approaches, not mandates."

Although he's excited about his opportunities with CMS, Dr. Rich has some sadness about his forced retirement from surgery. "It didn't feel good to resign from my practice," he said. Dr. Rich was a surgeon with a group cardiothoracic surgery practice based at Sentara Heart Hospital in Norfolk, Va.

Government ethics rules dictated that he quit, said Dr. Rich, although he added that he will be able to keep his hand in surgery by occasionally taking call when he returns home to Norfolk on the weekends after a work week split between Washington and CMS's Baltimore headquarters. That light duty has been cleared by the feds.

And, most likely, he'll be back to the operating room early next year. As with all presidential appointees, the law requires that he resign his position by the time the next president is sworn in on Jan. 20, 2009.

Although he could be kept on, Dr. Rich said "I'm not anticipating being there more than a year." ■

MedPAC Seeks to Lower Costs By Upping Primary Care Pay

WASHINGTON — Saying that primary care is undervalued, the Medicare Payment Advisory Commission might recommend that Congress increase payment for primary care and pilot test a medical home program.

MedPAC met in March to discuss various issues affecting cost, access, and quality of the Medicare program. At that meeting, a majority of the 16 commissioners present supported three draft recommendations to adjust the Medicare fee schedule upward for primary care and to start a medical home pilot. If a majority supports the final recommendations at the commission's meeting this month, they will be included in MedPAC's next report to Congress in June.

More than most people in the United States, Medicare beneficiaries rely on primary care physicians, said MedPAC staff member Christina Boccuti at the March meeting. Primary care has proven to be more efficient and less costly, noted Ms. Boccuti. The federal health program should find a way to encourage use of primary care and to reward primary care providers, especially because the field is becoming less attractive, with fewer medical school graduates seeking family practice or primary care residencies, and more internists choosing to sub-subspecialize, she said.

Currently, primary care providers are being paid only a fraction of their true value, said Ms. Boccuti. In part, the shortfall is because the fee schedule that favors medical specialties over primary care, and relative values are updated only every 5 years, which tends to magnify the difference in efficiency gains between technology-dependent specialties and primary care. If primary care providers were more justly rewarded, they could invest in health information technology and other infrastructure needed to establish medical homes, said Ms. Boccuti.

MedPAC commissioners agreed that the playing field needs to be leveled and suggested some options. Congress could make a budget-neutral adjustment to the fee schedule to increase the payment for primary care, and ask the Medicare program to more closely identify who is considered a primary care provider.

"You could look at this as us trying to make up for the past failures" of the relative value–setting process, said MedPAC Chairman Glenn Hackbarth. The increase would be a reward for the value primary care delivers to the health care system, he said. "My own view is that ultimately, we need to be about recognizing value," said Mr. Hackbarth, a health care consultant from Bend, Ore.

Dr. Nicholas Wolter, a commissioner and physician at the Billings Clinic in Montana, said that he would like to see an increase, even if it were not "budget neutral." The investment in primary care would likely drive down overall Medicare spending, said Dr. Wolter.

Commissioners also expressed support for a medical home pilot program. To participate, a physician or a practice would have to demonstrate certain essential capabilities. Although there is currently an ongoing medical home demonstration project being funded by Medicare, a pilot will bring more timely results, said Mr. Hackbarth, who explained that the difference is more than just semantic.

Pilots tend to be large in scale, with concrete parameters for participation and outcomes. If a pilot is successful, Medicare can simply expand the program, he said. ■