Docs to Congress: Fix the Medicare Formula First

Pushing ahead with pay-for-performance plans before changing the payment formula is 'unacceptable.'

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WASHINGTON — Congress should fix Medicare's payment formula before taking on any new reforms to pay physicians on the basis of quality, medical organizations testified at a hearing of the House Ways and Means Health Subcommittee.

If impending cuts to the fee schedule go into effect, "physicians will be hard pressed to undertake quality initiatives such as information technology," testified Nancy H. Nielsen, M.D., trustee to the American Medical Association.

President Bush's budget request for fiscal year 2006 includes a scheduled 5.2% payment cut for physician services under Medicare. Actuaries have estimated that physician payments could decline by more than 30% through 2012, unless modifications are made to the sustainable growth rate (SGR), a component in the physician pay formula that determines each year's update.

Although the AMA has engaged in its own evidence-based, quality improvement measures, "it is critical to replace the flawed physician payment formula to allow quality initiatives to flourish," Dr. Nielsen said.

Other medical organizations offered similar pleas in testimony and in statements to the subcommittee. Going ahead with pay-for-performance initiatives but not changing the formula to stave off the 5.2% cut "is unacceptable," Jerome B. Connolly, senior government relations representative with the American Academy of Family Physicians, told this newspaper.

At the hearing, pay-for-performance proposals were touted as viable payment alternatives by witnesses and panel members. "We fundamentally have to rethink how we pay our doctors," said Subcommittee Chair Nancy L. Johnson (R-Conn.).

Some physicians perform better than others in the quality of care they deliver, Glenn M. Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC), testified. The SGR system "fails to create appropriate incentives to improve performance," he said.

MedPAC in its March report to Congress recommended a quality incentive payment system for physicians under Medicare, using various types of information technology to manage patients.

Such an approach would establish exclusive performance standards and award physicians accordingly, while establishing standards to improve quality, he said.

Rep. Pete Stark (D-Calif.), the panel's ranking member, countered that he was "reluctant to get into the quality issue." As far as reforming payments, "I think it's up to the doctors to regulate themselves."

Any type of payment system that rewards providers by improving patient care and outcomes must not be punitive or used as a control for physician volume, said William F. Gee, M.D., a urologist from Lexington, Ky., who testified on behalf of the Alliance for Specialty Medicine.

In addition, the reporting of quality or efficiency indicators and health outcomes data could be administratively prohibitive to many physicians, especially those in small practices that don't have electronic health records, Dr. Gee testified.

There is some evidence that pay for performance can work, at least in the private sector. Since the implementation of three major pay-for-performance contracts with Partners Healthcare System in Boston, "we have steadily improved in targeted areas," such as diabetes care, Thomas H. Lee, M.D., network president for the health care system, testified. The rate of rise in pharmacy spending under these contracts averaged about 5% in 2004, lower than the national average of 9%.

In addition, Partners has developed decision support to help guide physicians to more appropriate ordering of costly imaging tests. Early information indicates that the rate of rise for imaging is less than the national trend of 15%-18%, he said. The contracts cover the care of more than 500,000 primary care patients, and a number of referral patients to specialists. ■

Despite Cuts, Medicare Not Abandoned

Physicians did not run away from Medicare in 2002, despite a 5.4% cut to their payments, the Government Accountability Office reported.

In analyzing all Medicare physician claims for services provided from April 2000 to April 2002, the GAO found that the percentage of beneficiaries getting treatment actually increased—and that access increased in almost every part of the country.

For example, the percentage of beneficiaries receiving physician services during the month of April rose from 42% in 2000 to 46% in 2002.

The findings also suggest that Medicare beneficiaries were less likely to be exposed to balanced billing over time, from 1.7% of claims in 2000 to 1.3% in 2002.

Since 2002, Congress has provided some temporary fixes to prevent further cuts to the fee schedule, although a 5.2% cut is expected in 2006, unless permanent measures are taken.

Several such permanent changes have been proposed—all of which are costly.

GAO has estimated that removing prescription drugs from the SGR this year—an option favored by some medical organizations—would fall short of providing the immediate fix that physicians want. Fees would continue to decline by about 5% per year from 2006 through 2010, before rendering a positive update in 2011.

The Bush administration does have current authority to remove the drugs from the formula, Bruce Steinwald, GAO's director for health care, economic and payment issues, recently testified at a hearing of the House Ways and Means Health Subcommittee.

Further, Mark McClellan, M.D., administrator of the Centers for Medicare and Medicaid Services, recently told reporters that his agency is working with the AMA to identify administrative actions to prevent the cuts.

At the very least, Dr. McClellan's response "indicates that the payment issue is sharply on his radar screen," Paul Speidell, government affairs representative with the Medical Group Management Association, told this newspaper.

How Sustainable Growth Rate Changes Could Affect Medicare Fees

	Minimum fee update	Number of years physicians' fees would decline
Under the current law	–5.0%	8
If spending targets were eliminated	2.1%	0
If spending targets were modified by:		
Setting allowable growth to GDP plus 1%	–5.0%	6
Resetting the spending base for SGR targets	–2.3%	6
Removing Part B drugs	–5.0%	5
Combining all three modifications above	2.2%	0

Source: Centers for Medicare and Medicaid Services

MedPAC Votes to Extend Specialty Hospitals Moratorium

WASHINGTON — Congress should extend the Medicare Modernization Act's moratorium on the construction of physician-owned specialty hospitals for another 18 months, a federal advisory panel has recommended.

The Medicare Payment Advisory Commission in draft recommendations had set the extension for 1 year, but later changed it to 18 months after commission members decided that more time was needed to study the full impact of these hospitals, often regarded as "cream skimmers" for attracting more profitable patients away from community hospitals. MedPAC data indicate that specialty hospitals tend to concentrate on certain diagnosis-related groups (DRGs), treating relatively lower-severity patients within them, and lower shares of Medicaid patients.

So far, they've had little financial impact on community hospitals, according to MedPAC analysts.

Commissioners at a January meeting decided to forgo tougher language that would have eliminated the "whole hospital" exemption, a provision in the self-referral regulations that allows physicians to refer patients to a hospital in which they have an investment interest as long as the interest is in the entire hospital.

Eliminating the exemption "is not the right step to take at this time due to the limited amount of data we have at this point on specialty hospitals and their performance," MedPAC chairman Glenn Hackbarth said.

To date, there's only a small sample of institutions to work on, and "we don't have a strong analytic foundation [on which] to base efficiency. With regard to quality, we haven't looked at that at all," he said.

MedPAC should readdress the issue in the future, however, "so that we could craft rules to get us the best competition without compromising clinical judgment," Mr. Hackbarth said.

Existing specialty hospitals and hospitals under development were still eligible for the whole hospital exemption under the 2003 Medicare reform law, but new hospitals were not, effectively placing a moratorium on their construction.

The original moratorium, set to expire in June, would effectively go on until Jan. 1, 2007, if MedPAC's recommendation were adopted.

In a statement, Rick Pollack, executive vice president of the American Hospital Association, commended MedPAC for extending the moratorium.

"This decision sends an important message to Congress that physician ownership and self-referral can cause serious conflict of interest concerns," commented Mr. Pollack. ■