Congress Floats Physician Payment Options

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Any legislative approach to fixing Medicare's sustainable growth rate system "would be prohibitively expensive," according to House Ways and Means Chair Bill Thomas (R-Calif.).

Attaining a permanent fix is possible, however, provided that Congress and the Bush administration work on efforts to combine administrative and legislative actions, Rep. Thomas and Nancy L. Johnson (R-Conn.), health subcommittee chair, wrote in a letter to Mark McClellan, M.D., administrator of the Centers for Medicare and Medicaid Services.

The proposal is one of several ideas floating in Congress that seek to fix the Medicare physician fee schedule, as physicians face a looming 4.3% cut to their reimbursement in 2006. CMS actuaries project negative payment updates of minus 5% annually for 7 years, beginning in 2006, if the flawed sustainable growth rate (SGR) is not corrected.

CMS could do its part by removing prescription drug expenditures from the baseline of the SGR, something it should have the authority to do, the letter suggested. Because drugs aren't reimbursed under the fee schedule, it's illogical to include them in the expenditure total when calculating the schedule's update.

The agency should also account for the costs of new and expanded Medicare benefits, which are included in the SGR calculation, the letter stated.

On a legislative fix, Rep. Thomas wrote that "the time is ripe" to tie physician payments to quality performance. CMS demonstration projects on performance-based payments in Medicare "will provide us with the experience we need to design appropriate rewards for delivering quality care," he wrote.

At press time, Rep. Johnson was prepping to introduce a pay-for-performance bill that would repeal the SGR and base future updates for physician payments on the Medicare Economic Index (MEI).

At a recent hearing, Dr. McClellan informed Rep. Johnson that such a measure could come at a high cost: specifically, that MEI-based increases would be $183 billion over 10 years.

CMS in the meantime is working hard to remove Part B drugs from the formula, although the procedure "presents difficult legal issues that we haven't yet been able to solve." It also would not solve the entire problem, as positive updates would not take place for several years, regardless of whether CMS removed drugs prospectively or retrospectively, his testimony indicated.

Physicians lacking the technology to participate in the bill's proposed reporting system will see their reimbursement cut even further.

In addition, he cautioned Rep. Johnson's subcommittee that removal of drugs would increase beneficiary premiums.

Physicians' groups offered support for this legislative approach at the hearing. "We're committed to improving quality of care, but to make further quality improvements, physicians must be adequately reimbursed for treating Medicare patients," John H. Armstrong, trustee to the American Medical Association, testified.

Leaders on the Senate Finance Committee have since introduced a pay-for-performance bill, although it may not get the same kind of support from physicians' groups as the forthcoming Johnson bill.

Applying the notion that Medicare should attain better "value" for its money, the bill from Sen. Chuck Grassley (R-Iowa) and Sen. Max Baucus (D-Mont.) proposes to link a small portion of physician Medicare payments to reporting of quality data and demonstrated progress against quality and efficiency measures. The measures would focus on health care processes, structures, outcomes, patient experience of care, efficiency, and use of health information technology.

Participation in the program would be voluntary. However, those choosing not to report quality data would receive a reduced payment update.

Unlike the Johnson proposal, however, the Senate bill fails to include a fix to the SGR, Mary Frank, M.D., president of the American Academy of Family Physicians, said in a statement. Instead, the legislation "attempts to improve the payment system to physicians without attempting to stem the declining Medicare reimbursement rate."

Physicians could face lower Medicare payments and additional costs under such requirements, Dr. Frank said. While it might increase doctors' costs in order to meet and report specific care standards, the bill "doesn't help them obtain the technology to do so," she said. Without the technology to participate in the bill's proposed reporting system, physicians' reimbursement will be cut even further, hindering their ability to afford the technology. "Sound like a vicious cycle? It is," she said.

The outcome is family physicians may be forced to close their doors to Medicare beneficiaries, Dr. Frank said.

In addition, "tons of implementation questions" aren't broached in this bill, Michele Johnson, senior governmental relations representative of the Medical Group Management Association, told this newspaper.

"Right now, there are no evidence-based, valid scientific measures of efficiency, unless you're talking about clinical measures," Ms. Johnson said. It's unclear how such measures would be developed under the legislation, and how people would physically report these quality measures.

In a summary of the bill, the authors explained that they didn't address the sustainable growth rate because they wanted to limit provisions to quality improvement, value-based purchasing, and health information technology. However, "sense of the Senate" language (nonbinding language that accompanied the bill) did acknowledge that the negative physician update needed to be addressed, based on the "unsustainable" nature of the SGR.

Primary care groups in June had lobbied Senate Majority Leader Bill Frist (R-Tenn.) for a pay-for-performance bill that would provide positive updates to Medicare's physician fee schedule, as well as reverse cuts that would otherwise occur under the SGR.

If any language from Grassley-Baucus is approved, "it will probably be inserted into 'end of the year must pass legislation,' along with an SGR fix," Ms. Johnson stated. Standing alone, the bill is too risky on the Senate floor because it would provide Democrats with the opportunity to reopen the Medicare Modernization Act.

"They could introduce amendments stating that the government could negotiate prices with the pharmaceutical companies. The Republicans don't want that," she said. ■

Doctors to CMS: One National Provider Identifier Only, Please

BY NELLIE BRISTOL
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WASHINGTON — The Centers for Medicare and Medicaid Services will review national provider identifier protocols that now require separate numbers for each covered entity. The requirement could mean some physicians who are also part of group practices and other arrangements would have multiple NPI numbers.

At a meeting of the Practicing Physicians Advisory Council, members brought the issue to the attention of CMS's director of program integrity, Kimberly Brandt. "The goal here was to have less numbers, not more. So I appreciate your point, and it's a very good one. And that's something I will definitely look into," Ms. Brandt said.

PPAC member Barbara McAneny, M.D., an oncologist from Albuquerque, suggested the review as part of a draft recommendation approved by the council. The recommendation suggests CMS clarify which current provider numbers would be replaced by the NPI number and which entities would need their own numbers.

Dr. McAneny also suggested CMS "put pressure" on other groups, including state licensure boards, "to eliminate some of the numbers and not to just add them on and add them on and add them on. … "

NPI enrollment began May 2 and continues through May 2007, when all providers will be required to use the system for standard electronic health care transactions. "With national standards and identifiers in place for electronic claims and other transactions, health care providers will be able to submit transactions to any health plan in the United States," CMS Administrator Mark McClellan, M.D., said in a letter to health care providers. "Health plans will be able to send standard transactions such as remittance advices and referral authorization to health care providers."

As a requirement of the Health Insurance Portability and Accountability Act, many health plans—including Medicare, Medicaid, private health insurance issuers, and health care clearinghouses—must use NPIs in standard transactions by May 2007. Small health plans have an additional year to comply. The number is intended to replace current numbers, including the unique physician identification number (UPIN).

Ms. Brandt told the advisory council that CMS is conducting a "massive outreach effort" to inform providers of the change and encourages them to apply for an NPI. Applications can be made electronically or through the mail.

To demonstrate the process of getting an NPI, PPAC Chairman Ronald Castellanos, M.D., got his number at the council's meeting, in a process that took approximately 8 minutes. "I'm not bleeding," he said when asked how painful the process was.

PPAC member Geraldine O'Shea, D.O., an internist who practices in Jackson, Calif., also tried the NPI application process. She found that it "took some effort" and was more complicated than she expected.

"It appeared to be pretty simple, but you had to have many numbers available for the filing," including a state license and a Medicare identifier. It would be helpful to have filing instructions, including a list of what is required, before starting the electronic application, Dr. O'Shea told this newspaper.

"Hopefully, that kind of instruction will be on Medlearn Matters," she said, referring to articles issued by CMS to help providers understand Medicare policy.

CMS is encouraging health plans to devise a transition plan for a system that accepts both the UPIN and NPI until the May 2007 compliance deadline. Ms. Bryant said that although a few health plans already have systems developed, most do not—including Medicare, which she said will not have the "capacity to be fully changed over" until 2007.

"We need the next year and a half to finish getting our claims-processing system completely converted over, and then we'll begin the phase-out, I would say about 6-8 months ahead" of the May 2007 deadline, she said.

CMS advises that members of groups not sign up individually now but wait until fall, when "batch enumeration" systems will be in place to accept group applications.

Once assigned an NPI, providers will have that number for the remainder of their careers and need only contact CMS to make changes. The system will be meshed with Social Security information to track provider deaths, and the agency hopes to be able to coordinate with state licensing groups as well, Ms. Brandt told the council. ■