Congress Once Again Averts Physician Fee Cuts

BY ALICIA AULT
Associate Editor, Practice Trends

In one of its last actions, the 109th Congress approved a sweeping tax and health bill that included a 1-year delay in the scheduled cut in physician fees under the federal Medicare program.

In 2007, physicians were due to see a 5% reduction in pay, thanks to targets set by a payment formula known as the Sustainable Growth Rate (SGR). However, under the package agreed upon by the House and Senate in mid-December, physician payments will instead be frozen at 2006 rates.

The fee freeze was included in H.R. 6111, The Tax Relief and Health Care Act of 2006. The bill was signed into law by President Bush last month.

When the pay fix is combined with updates in evaluation and management codes announced by the Centers for Medicare and Medicaid Services (CMS) in November, some physicians will actually see a pay increase in 2007. In addition, physicians will receive a 1.5% bonus if they meet certain quality reporting requirements.

Family physicians and internists are expecting an average 5% increase. That increase takes into account both the fee freeze and the new Evaluation and Management (E & M) rules, which, for instance, increase pay for a mid-level office visit by about $7, or 12%.

"That is the bread and butter code of internal medicine," said Robert Doherty, a senior vice president for governmental affairs and public policy at the American College of Physicians, in an interview.

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While ACP is happy that the cuts mandated by the SGR were averted and that E & M pay is being increased, the organization is still lobbying for a new way to calculate how physicians are paid under Medicare, said Mr. Doherty.

ACP is not alone. Nearly every professional society, a majority of Senators and House members, and many academic experts agree that the SGR needs to be replaced. If nothing is done in 2007, physicians may be looking at reductions of 5%-10% in 2008.

The 2008 cut was at least partially offset by Congress in the tax package. The legislators set aside $1.35 billion from the Medicare Advantage program and applied it toward 2008 payments to physicians.

Physician groups say the Democratic takeover of Congress will not add any special impetus to SGR replacement drive.

"We have not found anyone in Congress who does not agree that this formula is perverse," said Dr. Cecil Wilson, board chair of the American Medical Association, in an interview. "The difficulty Congress has had is to find the money to do it."

In the meantime, the Medicare Payment Advisory Commission (MedPAC) has been deliberating on a potential permanent SGR replacement.

At its December meeting, MedPAC staff member Kevin Hayes presented a plan he developed in conjunction with MedPAC Chairman Glenn Hackbarth. Initially, the SGR would be kept, but physicians would be paid bonuses for high performance.

In the second phase, the SGR would be replaced with a payment formula that uses targets and payments based on regional or statewide data, not national data. All of Medicare—hospitals, pharmaceuticals, home health—not just physicians, would be included in the targets. Physicians would be rewarded or penalized based on efficiency. Opportunities to share in savings would come later.

"We are talking realistically about a process that would unfold over a period of years, and I'm thinking more like 5 or 10 years as opposed to next year," Mr. Hackbarth said.

Mr. Hackbarth noted that not all the MedPAC commissioners were convinced that the SGR should be replaced or that this phase-in was the best way to go. "I don't think there is unanimous agreement on any of these things," he said.

MedPAC also wrestled with a recommendation on physician fees for 2008. Staff member Christina Boccuti said the commission was recommending a 2% increase. That figure was derived by taking physician price inflation—an estimated 3.3%—and subtracting out the productivity goal of 1.3%.

Ms. Boccuti said the Commission estimated that this increase would be adequate. But Mr. Hackbarth noted that there was no way to predict adequacy.

"The problem that we've often faced with the physician update in recent years is that we're asked to make an update recommendation for a future year when we don't even know what the rates will be for the current year, which is at least a difficult task," he said.

MedPAC commissioners will vote on a potential SGR fix and payment rates for 2008 at its January meeting and present their final report to Congress in March. ■

Facial Capture Emerging as Patient Safety Technology

BY TODD ZWILLICH
Contributing Writer

WASHINGTON — Electronic bar codes and radiofrequency microchips are all the rage in medical error prevention, but one research team thinks avoiding mistakes may be as easy as snapping a photo.

Researchers with the MedStar Health network here are experimenting with facial-capture software that they say could quickly and inexpensively help busy nurses and physicians avoid mistakes.

The software can pick human faces out of any photo image in less than a second. It's tied into a $120 Web camera mounted behind the nurse's triage desk, and anyone who approaches the desk automatically has his or her face captured. Nurses can permanently tie a patient's face to the corresponding electronic health record with one click.

Nurses "don't have to pick up a camera, they don't have to make them say cheese, they don't have to put them in a special location. All they have to do is click on the patient's face," Dr. Michael Gillam, director of the Medical Media Lab at MedStar, said at the annual symposium of the American Medical Informatics Association.

MedStar researchers already developed a state-of-the art electronic health record system allowing doctors and nurses to view patients' full charts at a glance. The system, known as Axyzzi, was snapped up by Microsoft Corp. in July.

Now Dr. Gillam's team is hoping that the facial photo capture system can help avoid errors by capitalizing on humans' natural penchant for recognizing faces.

"The problem with a bar code is that it's not human readable," Dr. Gillam said in an interview.

MedStar developers say their software could be used to tack the right face to any medication order, blood product, or device before it goes into a patient.

"Anyone can look and see that that blood doesn't match, because that's not the right person," Dr. Gillam said.

The Medical Media Lab tested the software prototype and found that it captured the smiling faces of all 22 racially diverse adults who approached a MedStar triage desk. But the system has yet to be put into practice to see if it really enhances patient safety.

But as with most identity technology, privacy is a concern. After all, no one wants to have his or her face on permanent file simply for asking directions to the rest room. Dr. Gillam said that although the system would photograph all comers, images are quickly erased if nurses don't attach them to a medical record. ■