Congress Once Again Averts Physician Pay 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.

This year, 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, which was signed into law by President Bush.

When the pay fix is combined with updates in evaluation and management codes announced by the Centers for Medicare and Medicaid Services (CMS), some physicians will actually see a pay increase this year. 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.

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 this year, 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."

Mr. Doherty agrees that money is the issue, not politics. Democrats, however, tend to be more concerned with the impact any SGR fix will have on beneficiaries' out-of-pocket costs, he said. Even so, "I fully expect that they will make a valiant effort to find a way out of this," said Mr. Doherty.

Physicians registered another victory with the Tax and Health Care Relief Act. Legislators directed the Health and Human Services department to establish a Medicare "Medical Home Demonstration Project." The program was developed and espoused by the ACP and the American Association of Family Physicians.

The 3-year pilot will take place in eight states. Physicians in practices of any size will be eligible to receive a payment for coordinating care for people with chronic illness. If they meet certain criteria, they will also get 80% of the savings if a hospitalization is avoided.

"Even though it's just a pilot, it creates a foundation for a fundamental revamping of Medicare payment policy," Mr. Doherty said. 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, noting 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, let alone on all of the pieces," 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 meeting this month and present their final report to Congress in March. ■

Serious Study Still Key to Passing Recert

BY SARAH PRESSMAN LOVINGER
Contributing Writer

Pass rates for the maintenance of certification exam have been declining in the past 5 years, and those who took the exam in spring 2006 had the lowest pass rate yet: Only 74% of physicians who took it made the grade.

"What we have been finding recently is that people are coming back sooner. That may lead to a lower pass rate," said Dr. Christine Cassel, president and CEO of the American Board of Internal Medicine, which administers the exams. Because the maintenance of certification (MOC) cycle length is 10 years, physicians who take the exam 7 years into the cycle "may not be as well prepared as those who have more at stake," she said.

The spring exam had the lowest pass rate in the history of the exam, which was established in 1995. According to the ABIM Web site, 92% of those taking the MOC for the first time passed the exam in 2001. The pass rate for first-timers declined steadily over the next few years, reaching 84% in 2005.

Some physicians may wonder if the lower pass rates reflect the exams. But Dr. Cassel emphasized that the exam has not become more difficult over the years. "We have studied these results very carefully," she said, adding that the ABIM uses an elaborate statistical method to ensure that exam questions are fair and the level of testing does not change.

'If you were up to date, and practicing a wide spectrum of internal medicine, then it was a reasonable task.'

DR. WHELAN

Louis Grasso, associate director for psychometrics at the ABIM, said the exam is validated by "a very rigorous process." The board specifies what types of questions the exam should contain.

Groups of practicing internists also review the questions for relevance to everyday practice. The exam is somewhat self-validating; internal reviews show that physicians with greater medical knowledge tend to score higher, Dr. Grasso said.

Pass rates also might decline if the cohort of internists taking the exam is a less-robust group than previous cohorts. As Dr. Cassel points out, internists who took the original certifying exam about 10 years ago, when internal medicine was a less competitive specialty, did not perform as well on that exam, either. If indeed the lower pass rates were achieved by a less-competitive cohort overall, that validates the fact that the exam fairly reflects the abilities of a particular group of internists.

Dr. Chad Whelan, the director of the hospitalist program at the University of Chicago, shared his thoughts on the spring 2006 exam, which he passed. "I actually thought it was very fair. It felt similar to the [certifying exam] where, if you were up to date, and practicing a wide spectrum of internal medicine, then it was a reasonable task," he said.

Dr. Cassel confirmed that the ABIM strives to include clinically relevant questions and focuses on the knowledge that physicians who are 10-20 years out of residency really should know. ■

CareFirst Physicians Receive $1.4 Million in P4P Rewards

WASHINGTON — A total of $1.4 million in pay-for-performance rewards was distributed to physicians in 20 group practices that participated in a pilot project sponsored by CareFirst BlueCross BlueShield, Dr. Jon Shematek said at a meeting on health information technology sponsored by eHealth Initiative and Bridges to Excellence.

Thirty practices initially were selected for participation in the first year of a $4.5 million, 3-year project, said Dr. Shematek, vice president for quality and medical policy at CareFirst. Eight dropped out and rewards were given to the remaining practices that met National Committee for Quality Assurance certification requirements. The practices are located primarily in Maryland but also in Delaware and the District of Columbia. The practices treat a combined total of 50,000 patients.

CareFirst used the Bridges to Excellence model program developed by a group of employers, insurers, and physicians. Standards met by physicians addressed clinical information systems, use of evidence-based medicine, patient education and support, and care management. Seventeen groups passed at a basic level, and three passed at an intermediate level, Dr. Shematek said. No groups passed at an advanced level.

Of the pilot practices, 14 had paper medical records, while 6 had partial electronic records.

Practice improvements included chronic disease registries and follow-up, electronic prescribing, follow-up of emergency department visits and inpatient admissions, improved rates of colonoscopy screening and diabetes eye exams, and enhanced patient education material. Certified practices receive program recognition via a National Committee for Quality Assurance "practice connections" seal.

Dr. Shematek said CareFirst is now looking to evaluate quality, utilization, and cost "as well as what qualitatively changed in the practice and what motivated doctors to participate."

—Nellie Bristol