MedPAC Urges 1.1% Physician Fee Boost in 2010

BY ALICIA AULT

WASHINGTON — Medicare advisers unanimously voted to recommend increasing physician fees by 1.1% next year, while expressing dismay that their June 2008 recommendation to boost primary care pay has not yet been acted upon.

The Medicare Payment Advisory Commission—better known as MedPAC—is charged with advising Congress on setting payment rates for physicians, hospitals, and other health care providers.

Under current law, Medicare physician fees are due to be reduced by 21% in 2010. MedPAC initially considered recommending that physician fees be updated by the projected change in input prices, minus an overall productivity goal that was established by the U.S. Bureau of Labor Statistics. The formula translated into a 1.1% increase, but many MedPAC commissioners were uncomfortable with the language and the possibility that it could be used to reduce fees.

Some even suggested that the panel should be considering a larger increase than 1.1%, but Chairman Glenn Hackbarth said he would not vote to approve a higher number, partly because Medicare has a statutory obligation to keep beneficiaries' Part B premiums for physician services in check. As fees rise, so do Part B premiums. And even small increases in physician fees can translate into billions more in Medicare spending, at a time when Congress is struggling to revive the faltering U.S. economy.

There seems to be no indication that Medicare reimbursement policy is leading to access problems for beneficiaries, according to reports from MedPAC staff members. A survey conducted in the early fall of 2008 found that 76% of beneficiaries said they "never" had a delay in getting an appointment for routine care,

A fall 2008 survey of Medicare beneficiaries found that 76% said they 'never' had a delay in getting an appointment, which is better than what is reported by the privately insured.

and 84% never had a delay when seeking an illness-related appointment. This is better than what has been reported by privately insured patients, said MedPAC staff member Cristina Boccuti. Medicare fees are about 80% of private pay fees.

Commissioner Nancy Kane, an associate dean of education at the Harvard School of Public Health in Boston, said that the 1.1% increase in fees would not be enough for primary care. "Primary care is in a huge state of crisis," said Ms. Kane. She asked about the progress of the federal medical home demonstration project, and expressed concern that it could be 7-10 years before Medicare rewarded physicians for participation in medical homes. "That may not be fast enough," she said, adding that the demonstration is a "drop in the pond. We need to move a whole ocean."

Mr. Hackbarth pointed out that MedPAC had recommended the pilot project to help move the process along, but acknowledged that "we're talking about a significant amount of time, still." He said he expected that interim data might support quicker action.

The panel also voted unanimously to again include its June 2008 recommendation that Congress establish a budget-neutral payment adjustment.

Primary care could get another boost if Congress follows MedPAC's recommendation to change the equipment use rate for imaging machines that cost more than $1 million. Currently, CMS pays physicians based on an estimate that magnetic resonance imaging, computed tomography, and positron-emission tomography are used an average 25 hours per week, but data suggest that 45 hours per week is a more accurate and better target, said MedPAC staff member Ariel Winter. The goal is to push physicians to be more efficient with use of the devices. Adopting the new rate would reduce the practice expense relative value unit by almost 8%.

That change would provide a savings of about $900 million annually, said Mr. Winter. The money could be reallocated to physician services, if the recommendation is adopted.

MedPAC commissioners also voted to increase hospital payments by the projected increase in the market basket, and to reward high-quality, high-performing facilities with a larger, unspecified increase.

They agreed to reduce the indirect medical education (IME) payment by 1%, which would put it at 4.5% per 10% increment in the resident:bed ratio. MedPAC staff said that the IME payment was a roughly $3 billion subsidy with little required accountability in return. The staff also said that the current rate was set at more than twice the impact of teaching on hospital costs, allowing academic centers to reap higher profits than do nonteaching facilities.

The American Hospital Association said it was happy with the vote to increase payments overall. But the IME reduction would "negatively affect the education, clinical care and research missions of teaching hospitals, including their ability to train high-quality physicians," said AHA Vice President for Policy Don May in a statement.

Payment increases to ambulatory surgery centers (ASC) have been frozen since 2003, but an increase is required by law in 2010. Although the centers are generally seen by Medicare as more efficient and less costly than hospital inpatient or outpatient departments, spending per beneficiary and the number of procedures per beneficiary continue to rise. ■

ICD-10 Code Transition Set for 2013, but Hurdles Remain

BY MARY ELLEN SCHNEIDER

In less than 5 years, physicians and other health care providers will be required to begin using a new system of code sets to report health care diagnoses and procedures.

Under a final rule published in the Federal Register, the Health and Human Services department is replacing the International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) code sets now used with a significantly expanded ICD-10 code sets. Providers and health plans will have until Oct. 1, 2013, to implement the new code sets.

In addition, HHS also issued a final rule adopting new standards for certain electronic health care transactions. The rule requires health care providers to come into compliance with the updated X12 standard, Version 5010, which includes updated standards for claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions. Use of the updated standard is necessary to use the ICD-10 code sets, according to HHS. Providers and health plans must be in compliance with the updated transaction standard by Jan. 1, 2012.

At press time, the Obama administration was in the process of reviewing and approving all new and pending regulations written under the previous administration, including the ICD-10 rules. However, a spokesman for the Centers for Medicare and Medicaid Services said that until the review is complete, it is not possible to determine which regulations are affected.

The move to the new code sets was necessary, according to HHS, to replace the outdated ICD-9 code sets. The ICD-9-CM contains about 17,000 codes, compared with 155,000 codes in the ICD-10 code sets.

"These regulations will move the nation toward a more efficient, quality-focused health care system by helping accelerate the widespread adoption of health information technology," Mike Leavitt, HHS Secretary, said in a statement. "The greatly expanded ICD-10 code sets will fully support quality reporting, pay-for-performance, biosurveillance, and other critical activities."

The final rule gives health care providers and plans almost 2 extra years to implement the Version 5010 transaction standard and a full 2 years to switch to ICD-10, compared with the timeline originally proposed last year. HHS officials said they decided to allow extra time for implementation in response to concerns that a short implementation phase would result in high implementation costs and inadequate time for training.

ICD-10 'will fully support quality reporting, pay-for-performance, biosurveillance, and other critical activities.'

MR. LEAVITT

Physician groups praised HHS for providing additional time for implementation but said other issues persist.

Officials at the American College of Physicians said that they believe that the benefits of switching to the ICD-10 code sets in the ambulatory setting do not outweigh the collective costs, said Brett Baker, director of regulatory affairs. The costs and administrative burdens related to adopting ICD-10 could slow adoption of health information technology and make it more difficult for physicians to engage in quality improvement efforts, according to ACP.

ACP is urging HHS to explore alternatives to the implementation plan outlined in the final rule. For example, the department could delay implementation of ICD-10 in the outpatient setting until a certain percentage of physicians adopted interoperable electronic health record systems. Since EHRs would ease the adoption burden for physicians, it makes sense to wait until adoption of health information technology reaches a certain threshold point, Mr. Baker said.

The Medical Group Management Association also expressed concern that physician practices will struggle to implement the new code sets. The association is calling on the federal government to develop an implementation assistance program to help physicians. If the value to the health system is as significant as HHS estimates, government officials should be prepared to invest that savings early on to ensure implementation runs smoothly, said Robert Tennant, senior policy adviser at MGMA.

HHS also should extend its outreach to the vendor community, Mr. Tennant said, since they will be the ones to provide updates to the practice management software. HHS also needs to work with private health plans to ensure there is no disruption in payments.

Mr. Tennant advised physician practices to get started by becoming familiar with the requirements and compliance dates. Next, reach out to vendors of practice management software and find out their plans for updating the software, including the timeline and costs, he said. ■

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