Medicare Payment Situation Makes Planning Difficult

BY MARY ELLEN SCHNEIDER
New York Bureau

Doubt and low morale are rampant in many primary care practices in light of the uncertainty surrounding Medicare physician payment rates this year.

Although members of Congress averted a 10% cut in the Medicare physician fee schedule, replacing it instead with a 0.5% increase, that increase is mandated only until midyear. Congress must act again by July to keep an ever-deeper cut from going through.

The uncertainty is making it difficult for physicians to plan ahead even a year at a time, and is causing some to avoid taking on new Medicare patients.

Dr. Fred Ralston Jr., a general internist in Fayetteville, Tenn., and chair of the health and public policy committee of the American College of Physicians, rarely sees new patients in his established practice. However, given the recent lack of action to reform payments, he has decided to stop accepting new Medicare patients in his practice.

Although his eight-physician primary care group won't drop any current patients, he said that taking on new Medicare patients, with their complex problems, amounts to "charity."

"The reimbursement for those with multiple problems is very limited compared to several less complex younger patients who could be seen in the same [amount of] time," Dr. Ralston said.

Other physicians made the decision not to take new Medicare patients years ago. Dr. Andrew Merritt, a family physician in Marcellus, N.Y., closed his practice to Medicare patients about 5 years ago because of the uncertainty of the payment situation.

As a result, Medicare now makes up less than 20% of his practice, and the current payment situation hasn't had a large impact on his bottom line. But if payments were to worsen significantly, he might be forced to consider other changes to his practice, such as limiting patients to presenting one problem at each appointment.

The fiscal situation makes rational long-term financial planning almost impossible, Dr. Ralston said. He estimates that in a practice in which almost two-thirds of the revenue goes to overhead, a 10% cut would mean about 30% off the bottom line.

For example, Dr. Ralston and the other physicians in his practice purchased an electronic medical record system because they thought it would help them to provide better care to patients. But it was probably a foolish economic decision, he said, because they don't know whether they will have the revenue to pay for it.

"It continues the uncertainty of what the practice income will be," said Dr. Yul Ejnes, an internist in Cranston, R.I., and a member of the ACP Board of Regents. "We're all small businesses."

Practices can't do anything aggressive in terms of practice development and growth, he said. For example, it's difficult for a practice that needs to recruit new physicians to guarantee a competitive pay package when they can't estimate how much money will be coming in, he said.

It also affects the morale of physicians, especially those who care for the chronically ill elderly population, Dr. Ejnes said.

Dr. Robert Lebow, a solo internist and geriatrician in Southbridge, Mass., finds the Medicare payment situation to be demoralizing.

Dr. Lebow, who still accepts new Medicare patients, said the flat payments are an added insult to the enormous paperwork burden and constant questioning of orders by payers. Dr. Lebow estimates that he spends an extra 1-2 hours a day completing paperwork for insurance companies.

And he is concerned about what this will mean to the future of primary care. Even as some payments for cognitive services have increased slightly in recent years, many physicians feel that it's too little, too late, he said.

Dr. Lebow, who is 63 years old, worries that there will be no one to replace him when he retires. "There are very few young people in primary care," he said. ■

Medicare Training, Brochures Available

The Centers for Medicare and Medicaid Services offers an updated Web-based training course to explain Medicare's coverage and billing for women's preventive health services.

The 90-minute course features billing guidelines for services including mammographies, pelvic exams, and bone density measurements.

For more information, contact the CMS by visiting http://cms.meridianksi.com.

CMS also has updated preventive services brochures for health professionals in the following areas: expanded benefits, diabetes-related services, cancer screenings, adult immunizations, bone mass measurements, glaucoma screenings, and smoking and tobacco-use cessation counseling.

To download the brochures or view them online, visit www.cms.hhs.gov/MLNProducts/MPUB/list.asp. ■

Health Care Spending Varies Widely According to Region

BY MARLENE PITURRO
Contributing Writer

Dramatic regional differences exist in the way in which severely chronically ill patients, who consume 75% of Medicare's budget, are treated in their last 2 years of life, according to a report based on data from nearly 5 million Medicare enrollees.

The authors compared Medicare's regional spending and concluded that the program will "reimburse about $50,000 more for health care services during the lifetime of a 65-year-old in Miami" than it will reimburse for a person of the same age in Minneapolis.

The report, "Care of Patients with Severe Chronic Illness," is the latest release from the Dartmouth Atlas of Health Care, which has measured variations in health care resource utilization by geographic area, cost, and quality since 1993.

In particular, the current report is based on the records of 4.7 million Medicare enrollees who died between 2000 and 2003, and who had at least 1 of 12 chronic illnesses. It includes data from more than 4,300 hospitals in 306 regions.

Patients living in high-spending cities such as Manhattan, Los Angeles, and Miami have more doctor visits, hospitalizations, ICU stays, diagnostic tests, and procedures than do such patients in efficient areas such as Salt Lake City and Rochester, Minn. The report recognized Intermountain Health in Salt Lake City and the Mayo Clinic in Rochester, Minn., for organizing and delivering high-quality, efficient care.

Medicare could save $34.3 billion on hospitalizations and $5.8 billion on physician visits annually (30% and 34%, respectively), if all providers followed the organized care models practiced in lower-spending regions, according to the report.

"High-spending states have many more physicians and acute care hospital beds on a per capita basis than do low-spending states, and the current payment system ensures that they stay busy," said Dr. Elliott Fisher, professor of medicine and community and family medicine at Dartmouth Medical School, Hanover, N.H.

The differences in cost and utilization between efficient and resource-rich areas for severe chronic illness are most dramatic in the last 6 months of life: 6.5 hospital days in Colorado, compared with 19.4 days in New York City; a 74% variation in Medicare spending of $21,599 for lowest utilization areas, compared with $37,622 for highest.

And, according to the report, higher utilization does not buy longer life or better quality of life. Those with chronic illnesses in high-rate regions have slightly shorter life expectancies and less satisfaction with their care than do those in lower-spending regions.

Dr. David Wennberg, chief science and products officer of Boston-based Health Dialog, noted that "Medicare fee for service pays doctors and hospitals to do tests and procedures."

Dr. Wennberg argued that waste and overuse are generated by supply and demand. "Where there is greater capacity, more care is delivered—whether or not it is warranted."

The report indicated that the overuse of acute care hospitals and medical specialists in managing chronic illness is worsening.

A troubling consideration for physicians is the report's statement that "the country has a current surplus of physicians and is likely to have enough physicians to meet U.S. needs through 2020. Because of the evidence that more intensive care may worsen outcomes, we believe that policy makers should respond to the current calls for increasing the supply of physicians by 15% to 30% with caution."

The report's focus on an ever-increasing level of care intensity for the severely chronically ill could be reversed if Medicare changes its payment incentives.

Or, as Dr. Wennberg put it: If Medicare's current payment model "moves beyond fee for service and hears the clarion call for change, billions of dollars a year can be saved and quality improved." ■