Docs to Congress: Fix the Medicare Formula First

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WASHINGTON — Congress should fix Medicare's payment formula before taking on any new reforms to pay physicians on the basis of quality, medical organizations testified at a hearing of the House Ways and Means health subcommittee.

If impending cuts to the fee schedule go into effect, "physicians will be hard pressed to undertake quality initiatives such as information technology," testified Nancy H. Nielsen, M.D., trustee to the American Medical Association.

President Bush's budget request for fiscal year 2006 includes a scheduled 5.2% payment cut for physician services under Medicare. Actuaries estimate that physician payments could decline by over 30% through 2012, unless modifications are made to the sustainable growth rate (SGR), a component in the pay formula that determines each year's update.

Although the AMA has engaged in its own evidence-based, quality improvement measures, "it is critical to replace the flawed physician payment formula to allow quality initiatives to flourish," Dr. Nielsen said.

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Going ahead with pay-for-performance initiatives but not changing the formula to stave off the 5.2% cut "is unacceptable," Jerome B. Connolly, senior government relations representative with the American Academy of Family Physicians, told this newspaper.

At the hearing, pay-for-performance proposals were heavily touted as a viable payment alternative by witnesses and panel members alike. "We fundamentally have to rethink how we pay our doctors," said Subcommittee Chair Nancy L. Johnson (R-Conn.).

Some physicians perform better than others in the quality of care they deliver, Glenn M. Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC), testified.

The SGR system "fails to create appropriate incentives to improve performance," he said. MedPAC in its March report to Congress recommended a quality incentive payment system for physicians under Medicare, using various types of information technology to manage patients.

Such an approach would establish exclusive performance standards and award physicians accordingly, while establishing standards to improve quality, he said.

Rep. Pete Stark (D-Calif.), the panel's ranking member, countered that he was "reluctant to get into the quality issue." As far as reforming payments, "I think it's up to the doctors to regulate themselves."

Any type of payment system that rewards providers by improving patient care and outcomes must not be punitive or used as a control for physician volume, said William F. Gee, M.D., a urologist from Lexington, Ky., who testified on behalf of the Alliance for Specialty Medicine, adding that measures should also be specialty specific.

In addition, the reporting of quality or efficiency indicators and health outcomes data could be administratively prohibitive to many physicians, especially those in small practices that don't have electronic health records, Dr. Gee testified.

There is some evidence that pay for performance can work, at least in the private sector. Since the implementation of three major pay-for-performance contracts with Partners Healthcare System in Boston, "we have steadily improved in targeted areas," such as diabetes care, Thomas H. Lee, M.D., network president for the health care system, testified. The rate of rise in pharmacy spending under these contracts averaged about 5% in 2004, lower than the national average of 9%.

In addition, Partners has developed decision support to help guide physicians to more appropriate ordering of costly imaging tests. Early information indicates that the rate of rise for imaging is less than the national trend of 15%-18%, he said.

The contracts cover care of more than 500,000 primary care patients, and a number of referral patients to specialists. ■

Even With Large Pay Cuts, Physicians Did Not Abandon Medicare in 2002

Physicians did not run away from Medicare in 2002, despite a 5.4% cut to their payments, the Government Accountability Office reported.

In analyzing all Medicare physician claims for services provided from April 2000 to April 2002, the GAO found that the percentage of beneficiaries getting treatment actually increased—and that access increased in almost every part of the country.

For example, the percentage of beneficiaries receiving physician services during the month of April rose from 42% in 2000 to 46% in 2002.

Findings also suggest Medicare beneficiaries were less likely to be exposed to balanced billing over time, from 1.7% of claims in 2000 to 1.3% in 2002.

Since 2002, Congress has provided some temporary fixes to prevent further cuts to the fee schedule, although a 5.2% cut is expected in 2006, unless permanent measures are taken.

Several such permanent changes have been proposed, all of which are costly.

GAO has estimated that removing prescription drugs from the SGR this year—an option favored by some medical organizations—would fall short of providing the immediate fix that physicians want. Fees would continue to decline by about 5% per year from 2006 through 2010, before rendering a positive update in 2011.

The Bush administration does have current authority to remove the drugs from the formula, Bruce Steinwald, GAO's director for health care, economic and payment issues, recently testified at a hearing of the House Ways and Means Health Subcommittee.

Further, Mark McClellan, M.D., administrator of the Centers for Medicare and Medicaid Services, recently told reporters that his agency is working with the AMA to identify administrative actions to prevent the cuts.

At the least, Dr. McClellan's response "indicates that the payment issue is sharply on his radar screen," Paul Speidell, government affairs representative, Medical Group Management Association, told this newspaper.

How Sustainable Growth Rate Changes Could Affect Medicare Fees

	Minimum fee update	Number of years physicians' fees would decline
Under the current law	–5.0%	8
If spending targets were eliminated	2.1%	0
If spending targets were modified by:		
Setting allowable growth to GDP plus 1%	–5.0%	6
Resetting the spending base for SGR targets	–2.3%	6
Removing Part B drugs	–5.0%	5
Combining all three modifications above	2.2%	0

Source: Centers for Medicare and Medicaid Services

President's Budget Includes Incentives for Electronic Records

WASHINGTON — President Bush's 2006 budget request includes several initiatives to get providers to adopt standards-based, interoperable electronic health records systems.

The Agency for Healthcare Research and Quality (AHRQ) is currently directing $14 million of this year's budget to jump-start regional collaborations that would assist health care providers in employing these types of systems.

To continue these activities outside of AHRQ in 2006, the budget proposal includes a new $75 million account.

Although primary care groups have shown a great deal of interest in a national information technology (IT) health care network, language in the budget is not likely to affect the individual physician's office—at least not directly, Robert Tennant, senior policy advisor for the Medical Group Management Association (MGMA), said in an interview.

"This will be targeted to the local health information networks that David J. Brailer [the federal coordinator for health IT] has been promoting. That's very different from promoting use in an individual practice," Mr. Tennant said at the annual conference of the National Academy of Social Insurance. The hope is these initiatives will produce a network to enhance patient care and encourage practices to spend the money on infrastructures that would link them to this type of network, Mr. Tennant said.

The fact that Dr. Brailer's office is received funding at all means that this issue is on the president's radar screen, "considering that appropriations had eliminated funding for the program in 2005," Bob Doherty, senior vice president for governmental affairs and public policy with the American College of Physicians, said in an interview.

Primary care groups such as the ACP and the American Academy of Family Physicians have been actively promoting the use of IT systems to improve the quality of care. Both are collaborating with health care contractors on a federal project to test financial incentives and technology support to improve care of patients with chronic disease.

Although it's encouraging that the federal government has shown an interest in IT, Mr. Tennant noted that the proposed allocations in the 2006 budget proposal aren't nearly enough to promote its widespread use.

"To offer some perspective, one of MGMA's member practices just spent $140 million for an IT system. That's more than what the entire budget allocates for the country," he said. ■