# Medicare Pay Fix Won't Come Easy ... or Cheap

BY JOEL B. FINKELSTEIN
*Contributing Writer*

WASHINGTON — It won't be cheap to fix Medicare's problematic physician pay formula, but lawmakers aren't saving any money by waiting to replace it either, experts testified at a hearing of the Senate Finance Committee.

"We have been kicking this can down the road for the past 5 years. This committee, and certainly Congress, understands it's not going to get any easier," said Dr. Cecil Wilson, who is board of trustees chairman for the American Medical Association.

The rising cost of health care is one of the biggest problems facing the government. At the current rate of growth, federal spending on Medicare and Medicaid will eventually consume 20% of the U.S. economy, said Peter Orszag, Ph.D., director of the Congressional Budget Office.

"In health care, we get what we provide incentives for. We currently provide lots of incentives for advanced technologies and high-end treatment, and we get a lot of that. We provide very little incentive for preventive medicine and get very little of that," testified Dr. Orszag.

Early in 2006, lawmakers asked the Medicare Physician Advisory Commission (MedPAC) to examine ways to shift those incentives. Their findings were presented to the committee a few days before MedPAC members presented the commission's annual report to Congress.

While the report represents the consensus of the commission, commissioners were unable to forge a consensus on what should be done to replace the Sustainable Growth Rate (SGR) system, MedPAC Chairman Glenn Hackbarth testified.

Instead, the commission offered lawmakers two alternative approaches—one that doesn't include an SGR-like spending target and one that does.

Eliminating spending targets altogether would require Congress to create a whole new system with incentives to physicians to provide high-quality and low-cost care, Mr. Hackbarth said. Choosing to keep spending targets would simplify payment reform but still would require changes to make the system more equitable.

In opposition to spending targets, Dr. Wilson said, "No amount of tinkering can fix what is broken beyond repair." While doctors account for a small portion of increasing premiums, they are the only group that has spending targets imposed on them, he added.

"The AMA asks that Congress ensure that physicians are treated like hospitals and other providers by repealing the SGR and enacting a payment system that provides updates that keep pace with increases in medical practice costs. We, in turn, are committed to helping assure appropriate use of services," he said.

No matter whose plan is embraced, fixing the SGR system is unlikely to come cheap. The CBO has estimated that current proposals will cost anywhere between $22 billion and $330 billion over 10 years.

"There are lots of steps, including [health information technology] and comparative effectiveness, that offer at least the potential to bend that curve over the long term, but the cost savings may not show up in the next 10 years. That is just the way it is," testified Dr. Orszag, adding that it will take time and resources to build a system in which Medicare pays for high-value instead of high-cost services.

"Given the scale of the problems that we face, we need to be trying lots of different things," he said.

There are good ideas out there, testified Mr. Hackbarth, but the Centers for Medicare and Medicaid Services is the bottleneck.

"We've got some very promising demonstrations under way, but it takes us forever to get them developed, in place, gather results, and translate them into policy," he testified. The agency doesn't have the staff or information systems to move forward expeditiously. "We're trying to run [Medicare] on the cheap. That won't work if we are trying to innovate at the same time," said Mr. Hackbarth. ■

## MedPAC Offers Choice of Two Paths

In testimony to the health subcommittee of the House Ways and Means Committee, Mr. Hackbarth explained that the MedPAC commissioners struggled with their task of choosing an alternative to the current sustainable growth rate (SGR) system. He reported that there were many tough debates, and that commissioners couldn't agree on just one solution. So instead they offered two proposals—ones they've deemed "Path 1" and "Path 2."

Path 1 calls for repealing SGR and eliminating the system of expenditures targets. The MedPAC report suggests that Congress should implement new ways to improve incentives for physicians and other providers to offer quality care to their patients at lower costs. This could be done in the following ways:

► Giving the Centers for Medicaid and Medicare Services the authority to pay providers differently based on performance measures;
► Ensuring accurate prices by identifying and correcting mispriced services;
► Encouraging coordination of care and use of care management, especially for patients with chronic conditions.

Path 1 also calls for collecting information on physicians' practice styles and sharing the results with other physicians across the country. If physicians could see how they use resources, compared with their peers, they would revise their practice styles accordingly, according to MedPAC's report.

The commission proposes that Medicare could then use the results to adjust payments to physicians and base rewards on both quality and efficiency.

Path 2 calls for pursuing the approaches in Path 1 but also including a new system of expenditure targets. The MedPAC report states that expenditure targets are necessary because they put "financial pressure on providers to change." It also recommends that targets should be applied on a geographic basis—applying the most pressure to the parts of the country where there is the highest use of the particular service and the highest contribution to Medicare spending.

Path 2, however, does go on to propose that expenditure targets should not fall solely on physicians but rather be applied to all providers in an effort to encourage different providers to work together at keeping costs as low as possible.

—Glenda Fauntleroy

# Expert Warns of Ominous Signs in Fight Against AIDS

BY BETSY BATES
*Los Angeles Bureau*

LOS ANGELES — The number of Americans diagnosed with AIDS is now approaching the 1 million mark, with more than a half-million deaths since the epidemic began and 17,000 more people dying of the disease each year, Dr. Harold Jaffe said during a plenary session at the 14th Conference on Retroviruses and Opportunistic Infections.

That mortality—58 per million—is "twice as high as any country in the European Union and 10 times as high as in the United Kingdom," said Dr. Jaffe, former director of HIV prevention for the Centers for Disease Control and Prevention and currently head of the department of public health at Oxford University, England.

A troubling jump in incidence in 2005, the latest year for which data are available, compounded by signs of risky behavioral trends in gay men, points to the critical need for community leadership, personal responsibility, and support of preventive efforts proven to work, he said.

"The need for treatment is critical, but I agree with my colleague Dr. Kevin de Kock [WHO director of HIV/AIDS] that we are not going to be able to treat our way out of this epidemic."

"I guess it seems obvious that we should be implementing what works, evaluating what might work, and stop trying to do what doesn't work," added Dr. Jaffe, who singled out federal funding for abstinence-only education as a strategy based on beliefs rather than science.

A "very comprehensive" study in press in the Cochrane Review, for example, reviewed eight published randomized controlled trials of abstinence-only programs, compared with standard sex education or safe-sex programs, involving 13,191 American youths.

With a median follow-up of 12 months, none of the abstinence-only programs demonstrated a significant decline in self-reported sexual activity or any biological outcome such as pregnancy or diagnosis with a sexually transmitted disease (STD), compared with the other approaches, said Dr. Jaffe at the conference, sponsored by the Foundation for Retrovirology and Human Health.

A recent University of Pennsylvania study of 662 African American children (median age, 12 years) did show significantly less sexual activity among those receiving abstinence-only education, compared with those exposed to other interventions; even so, nearly a third of the virgins in the abstinence-only group became sexually active over the course of the 2-year study.

Dr. Jaffe said it cannot be entirely ruled out that abstinence-only education could benefit "very specific groups," but most evidence suggests it is not efficacious.

By contrast, he pointed to condom promotion, shown to be "highly efficacious" in preventing HIV transmission, and needle- and syringe-exchange programs, which demonstrate at least modest evidence of reducing intermediate-level activities with the capacity to spread HIV, as more effective approaches. Condom distribution campaigns are currently being opposed by individuals who believe availability will undermine abstinence-only programs.

President Bush's proposed 2007 budget includes $204 million in support of abstinence-only education, while "no administration, Democrat or Republican, has ever put any [federal] money whatsoever into needle-exchange programs in this country, in contrast to many other countries," Dr. Jaffe said.

Purely behavioral interventions, primarily skill-building sessions aimed at reducing risky activities among high-risk individuals, are highly significantly efficacious in reducing unprotected sex and acquiring STDs, he said.

Finally, HIV testing by itself is a profound risk-reducing strategy, because individuals who learn they have been exposed to the virus sharply reduce behaviors that could lead to transmission to others, he noted.

Public health prevention strategies can go only so far in curbing the epidemic, emphasized Dr. Jaffe, particularly when it comes to sexual behavior change.

However, some indicators suggest that resources must be quickly marshaled to stem a rising tide of cases, especially among men who have sex with men and among African Americans and other ethnic minorities.

"We are seeing behavior trends in gay men in the United States and Western Europe that are similar to trends in the late 70s," he said. ■