Congress Passes 18-Month Medicare Fee Fix

BY MARY ELLEN SCHNEIDER
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Washington's summer wrangling paid off for physicians as Congress successfully overrode President Bush's veto of legislation to stop a 10.6% cut to Medicare physician payments.

The legislation (H.R. 6331), which originally passed both the House and Senate by veto-proof margins in early July, extends the 0.5% Medicare pay increase in place for the first half of 2008 through the end of the year and gives physicians a 1.1% raise for next year.

The bill relies on cuts to the Medicare Advantage program to fund the pay update, authorizes increased bonus payments under the Physician Quality Reporting Initiative (PQRI), and delays implementation of the Competitive Acquisition Program for durable medical equipment.

H.R. 6331 (the Medicare Improvements for Patients and Providers Act) passed the House by an overwhelming margin in late June, but failed to get enough votes in the Senate for cloture, which would have closed debate and allowed for an up-or-down vote. Following the July 4th recess and a week of intense lobbying by physician and patient groups, the Senate reconsidered the bill on July 9. At that time, a number of Republican senators changed their votes to help pass the bill.

The Democrats also racked up an extra vote when Sen. Edward M. Kennedy (D-Mass.) returned to the Senate for the first time since having surgery for a brain tumor in order to help pass the bill. In the final tally, the bill passed 69-30. Days later, President Bush vetoed the bill, but the House and Senate acted quickly to override the veto.

The American College of Rheumatology praised Congress for its passage of the H.R. 6331. Without that legislation, physicians would be facing a cumulative 16% cut by January, which most rheumatologists would be unable to absorb, said Dr. Sharad Lakhanpal, chairman of the government affairs committee of the American College of Rheumatology. Some rheumatologists already are limiting the number of new Medicare patients they see, and problems accessing rheumatologists would have gotten worse if the cut had been fully implemented, he said.

While the 1.1% payment increase for 2009 is welcome, he said, many physicians are frustrated that they have had their pay frozen for the last years. During that same time they have had to absorb increased-costs in rent, salaries, equipment, and insurance. "We are actually behind," said Dr. Lakhanpal, a rheumatologist in Dallas.

ACR officials are hopeful that the 18-month payment fix will give Congress time to work out a permanent solution.

The American Medical Association applauded the "courage" of senators who switched their votes to support the bill, but also is seeking a long-term solution, said Dr. J. James Rohack, AMA president-elect. The baby boomers will begin to enroll in Medicare around the time the fix expires.

Physicians groups have long objected to the Sustainable Growth Rate formula used to calculate physician payments under Medicare. The formula links physician pay to the gross domestic product and critics say it does not take into account the actual costs of medical practice.

A permanent fix should take into consideration the effort required to care for a patient, in the same way that hospitals receive higher payments for caring for sicker patients, he said. While physicians applaud the efforts of lawmakers to secure a 1.1% increase in payment for 2009, this comes as hospitals are projected to receive a 3% increase in payments from Medicare in 2009.

Congress finances the pay increases for physicians in part through controversial cuts to Medicare Advantage plans. Officials at America's Health Insurance Plans, which represents the health insurance industry, estimated that the bill will cut nearly $14 billion from the Medicare Advantage plans over the next 5 years. The inclusion of these cuts in the bill slowed its passage in the Senate and caused President Bush to veto the legislation.

In addition to the physician pay provisions, the legislation also includes increased patient benefits, most notably a phase-out of higher copayments for psychiatric services under Medicare. It also authorizes coverage by Medicare of new preventive services recommended by the U.S. Preventive Services Task Force.

The bill also encourages physicians and other providers to use electronic prescribing by providing incentives to those who e-prescribe and imposing penalties on those who do not. The bill calls for providing a bonus of 2% to physicians who use e-prescribing in 2009 and 2010, a bonus of 1% in 2011 and 2012, and a bonus of 0.5% in 2013. Physicians who don't use e-prescribing will be paid 1% less starting in 2012 with that amount increasing to 2% by 2014.

The bill allows the Health and Human Services secretary to exempt physicians on a case-by-case basis if complying with e-prescribing would be a "significant hardship," such as a physician practicing in a rural area without sufficient Internet access.

The bill would delay the first round of Medicare's competitive acquisition program until 2009. Critics of the program, which began July 1, have said that it makes it too difficult for vulnerable seniors to get supplies, including diabetes testing supplies. The bill also establishes an ombudsman for the program, who would be responsible for responding to complaints and inquiries from suppliers and individuals.

Just days before the passage of H.R. 6331, officials at the Centers for Medicare and Medicaid Services released the 2009 Medicare Physician Fee Schedule proposed rule including new measures for the PQRI, new requirements for physicians offering diagnostic testing services, and plans to reevaluate services and supplies potentially valued incorrectly. For PQRI, the agency is recommending 56 new measures for 2009, bringing the total number to 175.

Officials at the Centers for Medicare and Medicaid Services also are proposing new "measures groups" to allow physicians report on subsets of measures related to a condition. New measures groups for 2009 include coronary artery disease, coronary artery bypass surgery, HIV/AIDS, rheumatoid arthritis, care during surgery, and back pain. ■

What Happens to My Claims Now?

Now that H.R. 6331 is law, Medicare contractors are working to make sure physicians are paid at the correct rate.

However, it may take up to 10 business days for some contractors to begin paying claims at the higher (0.5%) rate, according to CMS. Once the local contractors start paying claims at the increased rate, they will go back and reprocess any claims paid at the lower amount.

Most claims will be automatically reprocessed, but a few providers may need to contact their local contractor for direction on getting their claims adjusted. For example, physicians who have submitted charges that are lower than the Medicare fee schedule amount will need to contact their local contractor, CMS said. In addition, nonparticipating physicians who submitted unassigned claims at the reduced nonparticipation amount will need to request an adjustment from the carrier.

There may be some variation in how different contractors handle this process, said Brett Baker, director of the regulatory affairs at the American College of Physicians, with some paying claims at the new amount immediately and others taking slightly longer to retool their systems. But for the most part, physicians won't need to take any additional steps to ensure they receive their full payments, he said.

CMS Has Based Coverage Decisions on Inappropriate Data

BY LEANNE SULLIVAN
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Data reviewed by the Centers for Medicaid and Medicare Services to inform Medicare coverage decisions reflect significantly different populations from the Medicare population, a recent analysis has shown.

The Medicare Evidence Development and Coverage Advisory Committee (MedCAC) reviews the literature described in a technology assessment and votes on the evidence to determine the health benefit of the procedure or device, wrote Sanket S. Dhruva and Dr. Rita F. Redberg, both of the University of California, San Francisco, which, along with the Robert Wood Johnson Foundation, provided support for the study. Dr. Redberg is a member of MedCAC, but had no financial conflicts of interest.

To examine whether the data used by MedCAC was generalizable to the Medicare population, Mr. Dhruva and Dr. Redberg looked at all six MedCAC decisions involving a cardiovascular product or service and analyzed the sample size, demographics, inclusion criteria, study location, and outcome stratification of the relevant technology assessments. The data included 141 peer-reviewed reports and 40,009 patients (Arch. Intern. Med. 2008;168:136-40).

Participants in the technology assessments had a mean age of 61 versus a mean age of 72 for Medicare beneficiaries. Several trials excluded older patients, but "the mean age in studies with explicit age exclusions (59.0 years) and those without such exclusions (61 years) did not differ," the authors wrote. Also, overall, 75.4% were men, versus 44% of Medicare beneficiaries.

The population from which MedCAC draws its data differs from the Medicare population in age, sex, and health.

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Clinical trial location also differed. Of 135 studies that reported location, 37% took place at least partly in the United States. However, most (51%) were done in Europe, 9% in Asia, and 7% in other locations. Overall, 40% of the technology assessment study participants were U.S. residents, compared with 100% of the Medicare population.

In addition, many of the trials excluded patients with renal insufficiency, arrhythmias, and diabetes.

The study concluded that the data used by MedCAC "are derived from populations that differ significantly from the Medicare beneficiary population in terms of age, sex, country of residence, and comorbid conditions." Trial patients are "younger, healthier, male, non-U.S. populations," with a "persistent underrepresentation of women and elderly" in clinical trials in general, the authors noted.

The authors suggested all future studies include demographic data, as "the accuracy and risk-benefit profiles of many diagnostic tests and therapies differ substantially by age and often by sex." They also suggested the CMS require data on women and the elderly, or for the CMS to issue coverage decisions dependent on the addition of subgroup data within a specified period of time. ■