Fee Cuts May Hurt Recruitment

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"The unresolved flaw in the SGR shows fundamental disrespect of physicians by this Congress and its predecessors," said Dr. Joseph Flood, chair of the government affairs committee of the American College of Rheumatology and a rheumatologist in Columbus, Ohio. "I think physicians are fed up with worrying each year about whether they can sustain a business in the next year without any firm indication of what the cash flow from government-sponsored programs will be."

This is made worse because rheumatologists are trying to do more for their aged and complicated Medicare patients with fewer resources, he said.

Even with the temporary payment fixes that have been commonplace over the last 5 years, physicians and patients are struggling. Some rheumatologists are unable to accept new Medicare patients to their practices, Dr. Flood said. And down the line talented young people may shy away from pursuing careers in medicine. What's needed from Congress is a permanent fix to the payment system, he said.

But a permanent fix is unlikely to come this year or even before the 2008 presidential election, said Dr. Rick Kellerman, president of the American Academy of Family Physicians. However, there is an understanding among most members of Congress that significant payment cuts are not realistic, and some type of temporary fix must be passed this year, he said.

"Physicians are going to have to gear up to encourage Congress to avert the cut," Dr. Kellerman said.

Dr. Kellerman envisions a 1- or 2-year positive update to the fee schedule. A 2-year fix would be better, he said, since physicians and policy makers are wasting so much time addressing the payment issue each year. As a result, he said, other important issues such as expanding health care coverage for the uninsured, health information technology adoption, medical education funding, and primary care workforce issues have not been given their due.

Even with the temporary fixes over the last 5 years, some rheumatologists have been unable to accept new Medicare patients to their practices.

Although a temporary payment fix is expected to be passed by Congress this year, it is also likely to have certain strings attached to it in terms of quality reporting requirements, predicted Dr. Bruce Sigsbee, a neurologist and a member of the Medical Economics and Management Committee of the American Academy of Neurology.

The projected cuts would also threaten to derail the voluntary CMS' Physician Quality Reporting Initiative (PQRI) that began July 1, said Dr. Richard Hellman, president of the American Association of Clinical Endocrinologists.

The Physician Quality Reporting Initiative gives physicians a chance to earn up to a 1.5% bonus payment on all of their allowed Medicare charges as long as they report on certain quality indicators. Officials at the CMS have touted the program as the first step in aligning payments and quality.

But a significant payment cut could hamper those efforts, Dr. Hellman said, noting that physicians are unlikely to put the effort into a time-consuming, resource-intensive program where they can earn a 1.5% bonus when facing a 9.9% payment cut at the same time.

The proposed rule also addresses the continuance of PQRI in 2008, and outlines new quality measures for next year. CMS officials are also considering the feasibility of accepting clinical data from electronic health records. The agency will weigh whether to accept data on a limited number of ambulatory care PQRI measures for which data may also be submitted under the current Doctors Office Quality Information Technology Project (DOQ-IT). In 2008, submission through an electronic health record would be an alternative to the current claims-based reporting of data.

The proposed rule also outlines ways the agency would like to test the use of clinical data registries to report PQRI data. The testing, which would begin 2008, would evaluate methods for physicians to report data to clinical data registries and the registries to submit the data on the physician's behalf to CMS. For example, the Society of Thoracic Surgeons has a national database registry that collects quality data on cardiac surgeries, including two PQRI quality measures. However, under the current setup for 2007 and 2008, physicians must report these measures separately to CMS through the claims-based reporting process.

CMS officials are proposing to fund the bonus payments for the 2008 PQRI program by using $1.35 billion provided by Congress as part of the Physician Assistance and Quality Initiative Fund.

In the proposed rule, CMS stated that the bonus payments were likely to be about 1.5% of allowed Medicare charges, not to exceed 2%.

That decision was criticized by the American Medical Association, which said the $1.35 billion should be used to reduce the projected 2008 physician pay cut. CMS estimates the $1.35 billion would reduce the projected cut by about 2%.

"The AMA and 85 other physician and health professional organizations sent a letter strongly urging the Administration to use this money to help Medicare physician payments keep pace with increases in practice costs. The Medicare Payment Advisory Commission made a similar recommendation," Dr. Cecil B. Wilson, AMA board member, said in a statement. "CMS has chosen to spend all of the money to provide just 1.5% to 2% to physicians who report on certain quality measures."

The proposed rule also made a number of other policy changes including revising the methodology used to determine the average sales price for Part B drugs purchased in bundling arrangements. CMS is proposing to require drug manufacturers report price concessions proportionately to the dollar value of the units of each drug sold under the bundling arrangement. The aim is to ensure that the average sales price better reflects the true costs paid by physicians when purchasing drugs, according to CMS. ■

Hospitals Looking at Physicians as Partners, Not Employees

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Hospitals are getting smart instead of angry about competition from physicians.

"A lot of care is moving from the hospital to the ambulatory sector, some of which is still under the auspices of the hospital, but increasingly into doctor's offices, into physician-owned ambulatory surgery centers, imaging centers, testing facilities," Dr. Robert Berenson, a senior fellow at the Washington-based think tank the Urban Institute, said at a press briefing on health care costs that was sponsored by the Center for Studying Health System Change.

Physicians often set up these centers in part out of frustration with hospital bureaucracy, but also in response to economic pressures, said Adam Feinstein, a managing director at Lehman Brothers where he coordinates the health care facilities research team.

"Physician incomes have been going down. They have been looking to make up for the lost income, and they're competing more aggressively with the hospitals," he said.

'What we have seen over the last 5-8 years is tremendous interest on the part of hospitals and systems to do joint ventures with physicians.'

Over the past 10 years, the number of ambulatory surgery centers has doubled to approximately 5,000. There are now almost as many surgery centers as there are hospitals in the country. By comparison, there are only about 100 specialty hospitals in the United States, despite all the political attention they get.

Jeff Schaub, who rates acute care hospitals for the international credit rating firm Fitch Ratings, pointed out that when hospital leadership does not focus on "what their physicians are doing and want to do, we have seen dozens of places have their outpatient surgery volumes cut in half because docs have gone out and put up buildings."

To counteract such trends, "what we have seen over the last 5-8 years is tremendous interest on the part of hospitals and systems to do joint ventures with physicians, figuring that they would rather lose half the business than all of it," he said.

Alternatively, some hospitals have tried to integrate physicians into more of the business decisions, hoping to create a more comfortable environment for them to work and minimizing their desire to go off on their own, Mr. Schaub said.

"It is really interesting how things come full circle," said Mr. Feinstein. "Hospitals were letting doctors partner with them back in the mid-1990s, there was a lot of scrutiny over this so everyone stopped doing it, and now here we are again and everyone is doing it."

There are similarities, but some important differences this time around, Mr. Schaub said.

"In the 1990s, everybody was buying practices just because everybody else was buying practices. Now what I see is a much more strategic focus, whether it's service-line related or to head off entrepreneurs splitting off or to focus on a particular geography, hospitals in a lot of markets are being more selective than they were 10 years ago," he said. ■