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The 10.1% cut, outlined in a 1,481-page rule, is a direct result of Congress failing to come up with an alternative to the Sustainable Growth Rate (SGR), the formula that sets physician payment rates partly on the growth in the gross domestic product. For the last 5 years, Congress has at the last minute disregarded the SGR and legislated temporary 1- or 2-year adjustments in payments. Last fall, legislators froze 2007 payment rates at 2006 levels, averting a slated 5% cut, but setting the stage for a 10% cut in 2008 because, by law, the 5% had to be accounted for at some point.

'We're getting tired of coming to Washington and begging them not to cut us, and then thanking them for freezing us.'

DR. KING

Physician organizations have sought a permanent replacement of the SGR, but that's unlikely as the congressional sessions wind down this year.

Instead, the battle again will be to reverse the cuts, at least for 2 years, and to find a way to cover the payments. Congress is required to offset any new spending.

The AMA has been urging lawmakers to take that money from the Medicare Advantage program, which it says is overfunded by $54 billion.

Another potential offset source is the $1.35 billion that's been set aside for the Physician Quality Reporting Initiative (PQRI). Physicians who participate in PQRI are eligible for up to a 1.5% bonus.

Dr. Flood, who is currently on the ACR's board of directors, and who practices privately in Columbus, Ohio, said that considering most rheumatologists he knows don't even participate in the PQRI, owing to a lack of available measures in rheumatology, he wouldn't mind if money earmarked for quality reporting was diverted to offset the cuts.

"I think that the Part C [Medicare Advantage] programs might be a better source but there's only so much there," he said.

Indeed, the American College of Physicians (ACP), the AMA, and other organizations have said their members are less likely to have the time or resources to participate in the PQRI if they are facing a 10% overall pay cut.

"We can't tolerate a 10% fee cut," said Dr. James King, president of the American Academy of Family Physicians, in an interview. Such a deep reduction means that physicians won't be able to keep up with practice expenses, he said.

And the yearly uncertainty is making it difficult to planahead—knowing whether to take on new Medicare patients or recruit new physicians, said Dr. King.

Dr. Flood agreed. "I don't know too many business people who are able to conduct business responsibly and be good fiduciaries of their business when they can't predict reasonably what their income is going to be in the next year. Every year now we have had to wait and see and hope and pray. . . . I think it's irresponsible to let this thing go on and on."

In a statement, Dr. David C. Dale, ACP president, said, "The cuts will accelerate the collapse of primary care, create access problems, and manufacture obstacles to fundamental reform of physician policies."

More than half of physicians said they'd limit the number of new Medicare patients if the cuts go through.

DR. DALE

Dr. Dale noted that an AMA survey found that more than half of physicians said they'd limit the number of new Medicare patients and two-thirds would defer purchase of information technology if the cuts go through.

The AAFP, ACP, AMA, and other organizations want Congress to pass legislation to provide an increase in fees for both 2008 and 2009, so that legislators do not have to revisit the issue in 2008 during the distraction of the presidential campaign, Robert Doherty, ACP senior vice president for governmental affairs and public policy, said in an interview.

And, said Dr. King, a freeze at current levels won't be enough, since expenses continue to rise. "We're getting tired of coming to Washington and begging them not to cut us, and then thanking them for freezing us."

At press time, the Senate Finance Committee was putting together a bill that would address the physician pay cuts, said ACP's Mr. Doherty. Lawmakers hoping to address the cuts—and many were motivated to do so—were facing an uphill battle against time and multiple competing legislative demands, he said.

But Dr. Flood was skeptical that lawmakers are capable of making the necessary changes.

"Many of us thought that a Democratic administration would really bring a lot of attention to [the issue of] access to care for people who need it, including seniors, and this Congress has not yet addressed that issue. . . . They haven't had the courage to step up and find an answer," he said. ■

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Medicare Outpatient Rule Hikes Pay for Infusion a Bit

BY ALICIA AULT
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The Centers for Medicare and Medicaid Services will increase payments for outpatient services by an average of 3.8% in 2008, with most of the rheumatologic, neurologic, cardiac, and gynecologic procedures covered under the payment system being slated for small to moderate increases.

Overall, hospitals will be paid about $36 billion in 2008, a 10% increase from 2007, and $1 billion more than was estimated in the proposed outpatient rule, according to CMS.

The 2008 Hospital Outpatient Prospective Payment System final rule also includes a revised method of paying for services in ambulatory surgical centers (ASCs). Starting in 2008, services performed in ASCs will be reimbursed at 65% of the rate paid for the same service in an outpatient hospital department. This rate is unchanged from the proposed rule.

Two of the rhematology-related procedures scheduled for an increase are infusions of Rituxan (rituximab) and Remicade (infliximab).

For 100 mg of Rituxan, the final rule stipulated a payment of $504.40 in 2008, a 4.7% increase over the 2007 rate. For Remicade, the payment per 10 mg will be $54.42, a 1.8% increase from 2007.

Dr. Sharad Lakhanpal, the newly elected chair of the government affairs committee at the American College of Rheumatology, said that although the increases are appreciated, the new payment is still unlikely to cover the cost of the procedure to the physician.

"You have to look at the cost of procurement of these drugs," he said. And although he said he hasn't yet seen vendors' 2008 price list for these drugs, Dr. Lakhanpal guessed that infusions like these are "being done by rheumatologists more as a service to the patients and not something that they're making a lot of money on."

In fact, in some cases, they may actually be losing money, he said.

Dr. Lakhanpal, who practices with nine other rheumatologists in Dallas, estimated that his practice conducts 10-20 infusions every day.

CMS Acting Administrator Kerry Weems said, "The revised system takes a major step toward eliminating financial incentives for choosing one care setting over another, thereby placing patients' needs first, increasing efficiencies, and leading to savings for both beneficiaries and the Medicare program."

Hospitals will be required to report on seven quality measures, including five emergency department measures pertaining to transfer of acute myocardial infarction patients, and two surgical care improvement measures. Under the proposed rule, hospitals were going to be required to report on 10 measures. Three were dropped in the final rule: administration of an ACE inhibitor to heart failure patients, empiric antibiotics for community-acquired pneumonia, and hemoglobin A_{1c} control.

Now, if hospitals do not report on the seven measures, they will get an automatic 2% reduction in inpatient pay in 2009, according to CMS.

CMS also said it was issuing three new composite ambulatory payment classification (APC) groups. The APC bundles frequently performed procedures together into a single payment, thus creating an episode-of-care-based payment.

The new APCs in the final rule are for extended outpatient visits with observation, low dose rate prostate brachytherapy, and cardiac electrophysiologic evaluation and ablation.

The agency is continuing its policy of bundling payments for certain ancillary services, to create efficiencies and to give hospitals more flexibility to manage costs.

Among the services that will now be covered by a bundled payment: image processing services, intraoperative services, imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents, and observation services.

Dr. Kim Allan Williams, nuclear cardiology director at the University of Chicago, said that bundled payments can often mean that a service is not properly reimbursed.

But under the outpatient payment system, CMS has found a way to make sure that every service is appropriately covered, said Dr. Williams in an interview.

Most cardiac procedures are slated for an increase—from a modest 1.9% for pacemaker insertion or replacement, to 5.2% for bare metal stents, to 13.3% for drug-eluting stents. Implantation of left ventricular pacing leads (add-on) will be cut by 12.4%, but that comes on the heels of 3 years of 80%-180% increases.

Some neurologic device implant procedures will also see a reimbursement increase. Neurostimulators, used primarily for lessening of symptoms of movement disorders such as Parkinson's disease and essential tremor, as well as control of epilepsy and pain, are slated for a 3.1% increase. The electrodes required with the devices will see a 3.4% rise in payment.

The changes aren't substantial enough to have any impact on the numbers of these procedures being done, said Dr. Rajesh Pahwa, director of the Parkinson's Disease and Movement Disorder Center at the University of Kansas, Kansas City.

For gynecologic procedures, endometrial ablation will get a 17.9% increase in pay, and surgical hysteroscopy a 4.2% increase. ■