Congress Floats Medicare Payment Formula Fixes

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

Any legislative approach to fixing Medicare's sustainable growth rate system "would be prohibitively expensive," according to House Ways and Means Chair Bill Thomas (R-Calif.).

Attaining a permanent fix is possible, however, provided that Congress and the Bush administration work on efforts to combine administrative and legislative actions, Rep. Thomas and Nancy L. Johnson (R-Conn.), health subcommittee chair, wrote in a letter to Mark McClellan, M.D., administrator of the Centers for Medicare and Medicaid Services.

CMS actuaries project negative payment updates of minus 5% annually for 7 years unless the flawed sustainable growth rate is corrected.

The proposal is one of several ideas floating in Congress that seek to fix the Medicare physician fee schedule, as physicians face a looming 4.3% cut to their reimbursement in 2006. CMS actuaries project negative payment updates of minus 5% annually for 7 years, beginning in 2006, if the flawed sustainable growth rate (SGR) is not corrected.

CMS could do its part by removing prescription drug expenditures from the baseline of the SGR, something it should have the authority to do, the letter suggested. Because drugs aren't reimbursed under the fee schedule, it's illogical to include them in the expenditure total when calculating the schedule's update.

The agency should also account for the costs of new and expanded Medicare benefits, which are included in the SGR calculation, the letter stated.

On a legislative fix, Rep. Thomas wrote that "the time is ripe" to tie physician payments to quality performance. CMS demonstration projects on performance-based payments in Medicare "will provide us with the experience we need to design appropriate rewards for delivering quality care," he wrote.

At press time, Rep. Johnson was prepping to introduce a pay-for-performance bill that would repeal the SGR and base future updates for physician payments on the Medicare Economic Index (MEI).

At a recent hearing, Dr. McClellan informed Rep. Johnson that such a measure could come at a high cost: specifically, that MEI-based increases would be $183 billion over 10 years.

CMS in the meantime is working hard to remove Part B drugs from the formula, although the procedure "presents difficult legal issues that we haven't yet been able to solve." It also would not solve the entire problem, as positive updates would not take place for several years, regardless of whether CMS removed drugs prospectively or retrospectively, his testimony indicated.

Leaders on the Senate Finance Committee have since introduced a pay-for-performance bill, although it may not get the same kind of support from physician groups as the forthcoming Johnson bill.

Applying the notion that Medicare should attain better "value" for its money, the bill from Sen. Chuck Grassley (R-Iowa) and Sen. Max Baucus (D-Mont.) proposes to link a small portion of physician Medicare payments to reporting of quality data and demonstrated progress against quality and efficiency measures. The measures would focus on health care processes, structures, outcomes, patient experience of care, efficiency, and use of health information technology.

Participation in the program would be voluntary. However, those choosing not to report quality data would receive a reduced payment update.

Unlike the Johnson proposal, however, the Senate bill fails to include a fix to the SGR, Mary Frank, M.D., president of the American Academy of Family Physicians, said in a statement. Instead, the legislation "attempts to improve the payment system to physicians without attempting to stem the declining Medicare reimbursement rate."

Physicians could face lower Medicare payments and additional costs under such requirements, Dr. Frank said. While it might increase doctors' costs in order to meet and report specific care standards, the bill "doesn't help them obtain the technology to do so," she said. Without the technology to participate in the bill's proposed reporting system, physicians' reimbursement will be cut even further, hindering their ability to afford the technology. "Sound like a vicious cycle? It is," she said.

The outcome is family physicians may be forced to close their doors to Medicare beneficiaries, Dr. Frank said.

In addition, "tons of implementation questions" aren't broached in this bill, Michele Johnson, senior governmental relations representative of the Medical Group Management Association, told this newspaper.

"Right now, there are no evidence-based, valid scientific measures of efficiency, unless you're talking about clinical measures," Ms. Johnson said. It's unclear how such measures would be developed under the legislation, and how people would physically report these quality measures.

In a summary of the bill, the authors explained that they didn't address the sustainable growth rate because they wanted to limit provisions to quality improvement, value-based purchasing, and health information technology. However, "sense of the Senate" language (nonbinding language that accompanied the bill) did acknowledge that the negative physician update needed to be addressed, based on the "unsustainable" nature of the SGR.

If any language from Grassley-Baucus is approved, "it will probably be inserted into 'end of the year must pass legislation,' along with an SGR fix," Ms. Johnson stated. Standing alone, the bill is too risky on the Senate floor because it would provide Democrats with the opportunity to reopen the Medicare Modernization Act.

"They could introduce amendments stating that the government could negotiate prices with the pharmaceutical companies. The Republicans don't want that," she said. ■

Merck Loses First Vioxx Lawsuit

A jury in Texas last month awarded $253 million to the widow of a man who died after taking Vioxx (rofecoxib). The plaintiff charged that the drug maker Merck & Co. failed to warn physicians about the danger posed by Vioxx, that the drug was improperly designed, and that the company's negligence caused the death of the plaintiff's husband, Robert Ernst. Merck executives plan to appeal the verdict on the grounds that the jury was allowed to hear testimony that was both irrelevant and not based on reliable science, the company said. "While we are disappointed with the verdict, this decision should be put in its appropriate context," Kenneth C. Frazier, Merck's senior vice president and general counsel, said in a statement. "This is the first of many trials. Each case has a different set of facts. Regardless of the outcome in this single case, the fact remains that plaintiffs have a significant legal burden in proving causation." The award included $24 million in actual damages and $229 million in punitive damages. But the punitive damages could be reduced to about $2 million, according to Merck.

—Mary Ellen Schneider

Tennessee Governor Offers Options for Medicaid Reforms

BY MARY ELLEN SCHNEIDER
Senior Writer

NASHVILLE, TENN. — The Medicaid program needs to undergo some fundamental changes, including asking patients to share some of the costs, Tennessee Gov. Phil Bredesen said at the annual conference of the National Academy for State Health Policy.

"We have got to get control of the economics of the program," he said.

In Tennessee, Gov. Bredesen has come under fire for his attempts to make cuts and disenroll beneficiaries in the state's financially troubled Medicaid program, known as TennCare.

Just throwing money at the problem nationally won't work, Gov. Bredesen said. For starters, the United States already spends more than any other industrialized nation on health care and still has tens of millions of uninsured citizens. And politically, it's unlikely that an infusion of funds would be available for the program.

Instead, Gov. Bredesen suggested that policy makers need to figure out how to make the existing Medicaid funding go further.

First, he proposed that everyone should pay a little something for everything.

"Unless and until there is some economic tension in the program—unless the users make some of the choices for themselves about how scarce resources are going to be used—the system will continue to be inefficient," he said.

The Medicaid Commission, which is charged with recommending ways to cuts costs in the program, has focused mainly on changes such as negotiating better prices with drug companies and cracking down on asset transfers by Medicaid applicants. However, the commission did tackle beneficiary cost sharing in its recommendation to give states the flexibility to increase copays for some beneficiaries on nonpreferred drugs.

The best way to do that is to let beneficiaries decide what they are willing to pay for and what they aren't, he said. "This is not about being hard-hearted," he asserted.

For example, Tennessee has a number of faith-based clinics that serve the uninsured; at these clinics, everyone pays something for their care. People tend to value things that they pay a little bit for and don't value things that are completely free, Gov. Bredesen said.

Second, government purchasers should pay for the most important things first, he said. Not everything that can be categorized as health care is on an equal footing, he said. For example, providing prenatal care to pregnant women is more important than covering antihistamines, he said.

But in Tennessee, the state spends $280 million annually on two classes of drugs—antihistamines and gastric acid reducers. These two classes of drugs account for 12% of the number of prescriptions written in the TennCare program. "We need to exercise some intelligent discretion here and prioritize what we do," Gov. Bredesen said.

Third, he suggested that the Medicaid program should pay only for what works instead of paying for any new drug that comes on the market. He noted that in 2002, the Food and Drug Administration approved 78 new drugs, of which only 7 contained any new active ingredients that were classified as improvements over existing medications.

"If we limit our oversight to a policy of buy everything but just argue about discounts, we've completely lost control," Gov. Bredesen said. ■

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