Physicians See Cut as Last Straw

Medicare *from page 1*

Stopping this cut from taking place remains the number one legislative priority of the American Academy of Neurology, he said.

About 45% of physicians surveyed by the American Medical Association in February and March of this year reported that they would either decrease or stop seeing new Medicare patients if Medicare payments were reduced by 5% in 2007. The AMA surveyed more than 8,000 physicians, including both members and nonmembers.

That trend has already begun in some communities. Dr. Michael McAdoo, a family physician in Milan, Tenn., who works in a four-physician practice, stopped taking new Medicare patients about 3 years ago. "We saw this coming," he said.

Now, with potentially deeper cuts on the horizon, he is considering stopping his hospital coverage and has begun limiting the number of Medicare patients he sees each day. In Milan, a town of about 10,000, there is only one physician in the community who is still accepting new Medicare patients. "I anticipate this will probably get worse," Dr. McAdoo said.

The proposed cuts come weeks after CMS suggested giving physicians who provide more cognitive services a bigger piece of the pie for evaluation.

The cuts are especially tough on general internists and other primary care physicians who already face difficulty in recruiting young physicians to their practices, said Dr. Yul Ejnes, an internist in Cranston, R.I., and chair of the board of governors of the American College of Physicians.

Many physicians have been willing to continue to see Medicare patients despite the falling reimbursement rates, Dr. Ejnes said, but lawmakers can't count on that indefinitely.

In his practice, about 20%-30% of his patients are Medicare beneficiaries, so Dr. Ejnes said he expects to see an impact on his bottom line due to the projected cuts. The impact could be greater if private insurance companies that tie their payment rates to Medicare choose to lower their payments at the same time.

The cuts are also likely to result in access issues beyond Medicare beneficiaries, he said. For example, if a physician has to cut back on staff because of Medicare payment cuts, that will affect all patients. And if a physician chooses to retire early, that affects thousands of patients who have to seek care elsewhere. "The impact is on the system as a whole," Dr. Ejnes said.

The proposed cut comes just a few weeks after CMS officials announced plans to change the way Medicare pays for evaluation and management services, with physicians who provide more cognitive services getting a bigger piece of the Medicare pie. But those increases to primary care physicians are likely to be nearly wiped out by the projected payment cuts based on the sustainable growth rate (SGR) formula.

And for specialties in which physicians are expected to experience cuts based on the proposed changes to the way Medicare pays for evaluation and management services, the latest SGR cut compounds the problem.

For example, Medicare payments to cardiologists could drop by about 7% next year, due to the 5.1% proposed fee schedule cut plus a proposed 1% decrease in work and practice expense relative value units for 2007, and a 1% decrease based on the implementation of imaging provisions in the Deficit Reduction Act of 2005 (DRA).

While the impact will vary among individual cardiologists based on the mix of services provided, practices with a high volume of imaging services are likely to see overall payment cuts of more than 7%, according to the American College of Cardiology.

The AMA called on Congress to stop proposed 2007 payment cut and begin to reimburse physicians based on the actual cost of providing care. AMA officials estimate that without a change to the current payment formula, Medicare payments will be cut 37% over the next 9 years, while at the same time practice costs will rise 22%.

Medicare physician payment rates are set annually based on a statutory formula. That formula adjusts the Medicare Economic Index based on how actual medical expenditures compare to a target rate—the SGR. The SGR is based in part on medical inflation, the projected growth in the domestic economy, and projected changes in the number of Medicare beneficiaries.

While there has been legislation introduced in Congress this year aimed at changing the formula that calculates physician payments under Medicare, a permanent fix to the payment problem is unlikely this year, said Dr. Larry Fields, president of the American Academy of Family Physicians.

The AAFP is pushing for a positive update of between 2% and 5% for 2007 and real engagement to permanently fix the problem next year, he said. Officials at the AAFP have commissioned a health care consulting firm, the Lewin Group, to examine alternative payment mechanisms that would not involve the use of the SGR formula, he said. They hope to use that information to work with Congress on a permanent solution next year, Dr. Fields said.

In addition to the 5.1% payment cut, the CMS proposal also seeks to expand coverage for some preventive services.

For example, the proposed rule would implement the provisions of the DRA that call for making abdominal aortic aneurysm screening a Medicare-covered preventive service.

The benefit would include a one-time ultrasound screening for beneficiaries who seek the "Welcome to Medicare" physical, along with education, counseling, and referral services. ■

New Federal Regs Aim to Speed Health IT Adoption

BY MARY ELLEN SCHNEIDER
New York Bureau

Hospitals, health plans, and other health care organizations will soon be able to assist physicians in obtaining health information technology without running afoul of federal fraud laws under regulations issued last month by the Department of Health and Human Services.

In two final regulations published in the Federal Register on Aug. 8, the Centers for Medicare and Medicaid Services and the HHS Office of Inspector General carved out new exceptions to the Stark physician self-referral law and the federal antikickback statute. Under these new exceptions, certain health care entities will be able to donate interoperable electronic health record (EHR) software and training. And hospitals and other health care organizations will also be able to provide hardware, software, and training services that are "necessary and used solely" for electronic prescribing.

The regulations did not cap the donations to physicians for electronic prescribing technology, but the government is requiring physicians to share some of the costs of donated electronic health record technology. Under the rules, physicians will be required to pay 15% of the donor's cost of the EHR technology and services.

The regulations go into effect in early October (60 days after publication in the Federal Register). The provisions related to EHR arrangements are slated to sunset on Dec. 31, 2013.

The regulations were widely praised by physician organizations and health IT industry groups for breaking down barriers to physician adoption. But Patrick Hope, legislative counsel for the American College of Physicians, said the changes aren't likely to do a whole lot to speed physician adoption of the technologies since few hospitals will be able to afford to donate the expensive technology to physicians.

"They are operating at the margins just as physician offices are," Mr. Hope said.

ACP officials are urging members of Congress to establish an add-on payment to the Medicare reimbursement for an office visit in an effort to help offset the ongoing costs of an electronic health record system, Mr. Hope said. While the regulations are helpful in removing some barriers, he said, an add-on payment would create a better business case for physician adoption of health IT.

The jury is still out as to what impact these regulations will have on physician adoption, said Chantal Worzala, senior associate director for policy at the American Hospital Association. Not all hospitals will have the financial resources to donate health IT services, she said, since only about a third of U.S. hospitals are making a profit.

But the regulations will give hospital administrators more options. "Hospitals really should have flexibility in working with community physicians," she said.

While some health plans may be interested in offering electronic prescribing products, Ms. Worzala said, hospitals are likely to want to help physicians acquire more comprehensive EHR systems.

The relaxation of the Stark physician self-referral law and the antikickback statute is a good thing, said Dr. Steven E. Waldren, assistant director of the American Academy of Family Physicians' Center for Health Information Technology, since the changes will allow more health IT resources to flow to physicians. However, he cautioned physicians not to count on getting this support.

This type of support won't be available to all physicians and in some cases may not be appropriate, he said. For example, Dr. Waldren said that some hospital electronic health record systems are not designed for the ambulatory environment and may end up costing physicians more money in the long run. The bottom line is that physicians need to continue to do their "due diligence" in researching systems, he said.

The Medicare Modernization Act of 2003 mandated that the HHS Secretary create exemptions that would allow for certain health care organizations to help furnish physician practices with electronic prescribing technology. The changes were originally outlined in a proposed rule issued last October.

Under the provisions related to electronic prescribing technology, hospitals can donate hardware, software, and services to members of their medical staffs; group practices can donate to physician members; and Medicare prescription drug plan sponsors and Medicare Advantage plans can donate to pharmacies and prescribing physicians. The Stark law exemption and antikickback safe harbors have slightly different definitions of who can donate the comprehensive electronic health record system software and training.

The electronic prescribing safe harbors and exemptions allow organizations to donate hardware, software, Internet connectivity, and training and support services. The provisions for electronic health records are slightly different and do not include hardware. ■

Index of Advertisers

Allergan, Inc.	
Corporate	19
Eli Lilly and Company	
Cymbalta	5-6
Novartis Pharmaceuticals Corporation	
Focalin	8a-8b, 9
Pfizer Inc.	
Aricept	3-4
Lyrica	24
Teva Pharmaceutical Industries Ltd.	
Azilect	16a-16d, 17
UCB, Inc.	
Keppra	13-14