POLICY & PRACTICE

Medicare Patients Welcome

Most physicians have kept their doors open to Medicare patients despite previous reductions in their pay, according to a study from the Center for Studying Health System Change (HSC). The proportion of U.S. physicians willing to treat Medicare patients stabilized during the last half of 2004 and the first half of 2005, with nearly 75% reporting their practices were open to all new Medicare patients. In 2004-2005, 73% of physicians reported accepting all new Medicare patients, an increase from 71% in 2000-2001, but not statistically different. Physicians' willingness to treat Medicare patients remained high, despite a 5.4% payment cut in 2002 that was not fully offset by smaller increases in subsequent years. Only 3.4% of physicians reported closing their practices to new Medicare patients in 2004-2005, also statistically unchanged from 2000-2001. Moreover, the proportion of primary care physicians accepting all new Medicare patients increased significantly from 62% in 2000-2001 to 65% in 2004-2005. "While concerns about Medicare beneficiary access have focused on physician payment, policymakers should recognize that Medicare fees are only one factor in physician decisions to accept new patients," said HSC President Paul B. Ginsburg, Ph.D.

Ban on False Information

The Health and Human Services Department may not deliberately disseminate false or misleading scientific information under a recent federal law. The provision, part of the fiscal 2006 HHS appropriations law, also prohibits the questioning of scientific advisory panel nominees about their political affiliation, voting history, and positions on topics unrelated to the capacity in which they are to serve. "If your doctor gives you misleading scientific information, it's called malpractice," said Dr. Francesca Grifo, senior scientist and director of the scientific integrity program at the Union of Concerned Scientists. "It should already have been illegal for political appointees in government posts to knowingly provide false information, so this ban at HHS represents a modest but important first step in ensuring scientific integrity in federal policy-making and better health care for us all."

Cardiac Rehab Coverage Expanded

Medicare is proposing to expand national coverage for cardiac rehabilitation services to three additional groups of beneficiaries: those who have had heart valve repair or replacement, percutaneous transluminal coronary angioplasty (PTCA), and heart or combined heart-lung transplant. "With this proposed coverage decision, [the Centers for Medicare and Medicaid Services] seeks to expand coverage to a greater number of beneficiaries with cardiac illness," said Administrator Dr. Mark B. McClellan. "But just as importantly, we hope that our proposed decision will raise the public's awareness regarding cardiac rehabilitation services in general." The agency further proposed that cardiac rehabilitation services be comprehensive and include medical evaluation, education, and nutrition services. Medicare has covered cardiac rehabilitation services for beneficiaries following heart attack, coronary artery bypass surgery, and angina since the 1980s and this coverage will continue. A comment period on the proposed decision ended Jan. 23. CMS plans to issue a final decision within 60 days of the close of the comment period.

Patterns of Trial Registration

The act of clinical trial registration alone is not a good indicator of adherence to registration policies, according to a study of the quality of information provided during the registration process, and patterns of trial registration (N. Engl. J. Med. 2005; 353:2779-87). The researchers reviewed clinicaltrials.gov records to assess patterns of completion of the "Intervention Name" and "Primary Outcome Measure" data fields for trials registered during the period from May 20 to Oct. 11, 2005. "When trial sponsors have the option of providing information of marginal clinical value in a particular data field, our findings show that some companies provide useful information and others do not," the researchers found. This may indicate varying degrees of comfort with different levels of disclosure. For example, of the 2,670 studies registered by industry between the two dates, 76% provided information in the Primary Outcome measure field, although these entries varied markedly in their degree of specificity. "It is unacceptable for a trial sponsor not to register its trial in a complete, meaningful, and timely fashion," Dr. Jeffrey Drazen and Dr. Alastair J.J. Wood wrote in a related editorial. "If a company continues to register trials using meaningless data, with no respect for the registration process and the patients who participate in those trials, investigators and patients should refuse to participate."

Top Stories of 2005

The growing number of uninsured patients, the public health impact of Hurricane Katrina, and registration for the new Medicare drug benefit were among the top health policy stories of 2005, according to an informal Commonwealth Fund/Health Affairs survey. The survey listed 15 policy stories, compiled by fund staff and journal editors, and asked Web site visitors to select the five they considered the most important. Other top vote-getters among the 1,100 respondents were stories indicating that the U.S. health care system, the most expensive in the world, doesn't perform as well as those of several other industrialized nations on various clinical indicators and in reported patient experiences, and that health care costs continue to increase.

—Jennifer Lubell

Advisory Panels Diverge on Value of Oncology Demo

BY JOYCE FRIEDEN AND JENNIFER LUBELL
Associate Editors, Practice Trends

WASHINGTON — Whether Medicare's oncology demonstration program is a good idea depends on which federal advisory committee you ask.

Members of the Practicing Physicians Advisory Council (PPAC), which advises Medicare officials on issues of concern to physicians, said they think the program—which pays hematologists and oncologists to report on whether they are following practice guidelines in the treatment of patients with certain types of cancer—is a great idea.

Medicare's demonstration project has limited the ability of both MedPAC and Congress to assess the impact of payment changes for oncology drugs.

Dr. Peter B. Bach, senior policy adviser at the Centers for Medicare and Medicaid Services (CMS), reminded council members that program participants are paid for data submission, regardless of whether the guidelines are being adhered to. "This is not pay for performance," he said.

Physicians who participate in the demonstration must report on the reason for the patient's visit, the patient's condition, and their use of clinical guidelines to treat the patient. Those who comply will receive an additional payment of $23.00.

Payments for reporting the data are tied to visits for evaluation and management by Medicare beneficiaries with any of 13 different cancers. This is a change from last year, when the payments were tied to chemotherapy visits. CMS also has replaced some of the G-codes used in the 2005 program with new G-codes, and has added 81 new codes, most of which deal with current disease status.

PPAC members said that they liked the program so much that they would like to see it extended to other specialists who treat cancer patients. For example, when it comes to prostate cancer patients, "oncologists are not the appropriate physician to evaluate [the treatment for] that cancer," said Dr. Peter D. Grimm, a radiation oncologist in Seattle. "I manage prostate cancer almost exclusively; only a very small percentage of prostate cancer patients are seen by oncologists."

Council member Dr. Barbara L. McAneny, a clinical oncologist in Albuquerque, agreed. "We're the people who find [prostate cancer] when we're looking for other stuff, or see them if they become hormone refractory and are sent on."

The council recommended that CMS open up the program to include other specialties that "have the primary responsibility for treating the particular types of cancer [involved]."

PPAC Chair Dr. Ronald D. Castellanos, a urologist in Cape Coral, Fla., said this was not the first time the issue of extending the demonstration had been raised. "We went through this last year … and there was lot of discussion about opening the program up to other specialties," he said. "As I remember, the discussion at that time was, 'This is a program for next year; next year we'll consider it.' You say you want a spectrum of care of each of these disease processes; you're not going to get that by just talking to the oncologist or the hematologist."

In contrast, members of the Medicare Payment Advisory Commission (MedPAC) said that such demonstration projects should not be used solely to increase payments for oncology services.

Instead, the secretary of the Department of Health and Human Services should use these demonstrations to test innovations in delivery of quality health care, according to MedPAC, which advises Congress on Medicare payment issues. This should result in long-term benefits to both providers and beneficiaries.

The demonstration project has limited the ability of both MedPAC and Congress to assess the impact of payment changes for oncology drugs and drug administration services, said Joan Sokolovsky, a MedPAC senior analyst. "These projects are not budget neutral. They are designed to increase payments to specific specialties," she said.

If the payment rates aren't accurate, CMS or Congress should address it, she continued. "It should not make payment policy through the creation of demonstration projects."

MedPAC Commissioner David A. Smith, a senior fellow for business and society with Demos, a research and advocacy organization in New York, thought the demonstration should be scrapped altogether.

"We're spending another $150 million of taxpayer money, and we argue—I think, convincingly … that there's no value from this demonstration." Other commissioners agreed that the project would increase costs for beneficiaries but not provide foreseeable benefits.

However, some cautioned that pulling the plug might be a premature move.

At press time, MedPAC was preparing to release a report on oncology payment issues to Congress in January, which would include its recommendation on the proper use of demonstration projects.

"By the time our report comes out, [the demonstration] will be a month and a half down the road," commented Robert D. Reischauer, Ph.D., a MedPAC commissioner and president of the Urban Institute, Washington. "I think the real issue is whether we should provide guidance for 2007 … and say something about ensuring that payments are adequate so you don't have to 'phony' them up with a demonstration."

The dilemma is finding a payment system that ensures access to quality care for oncology patients. "We still don't know what the right level is," said MedPAC Chair Glenn M. Hackbarth. ■