

A faint, semi-transparent background image of a person in a suit, possibly a lawyer or accountant, looking down at a document. The image is positioned on the left side of the slide.

The 2006 Federal Budget & MedPAC's March 2005 Report

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- 2006 Federal Budget:
 - Chronology
 - Where We Stand Right Now
- MedPAC's March 2005 Report
 - Hospitals
 - Physicians
 - Other providers

The background of the slide is a blurred image of a person in a dark suit and white shirt, possibly a politician or official, standing in a formal setting. The image is faded and serves as a backdrop for the text.

The 2006 Federal Budget

- In the beginning... there was the President's budget proposal.....(January 2005)
 - Short on details
 - \$60 billion in Medicaid cuts (over 10 years)
 - Targeted toward IGT and other mechanisms that “draw additional dollars without corresponding increases in care delivered”
 - “No” cuts in Medicare
 - Some re-organization though
 - “excellence in care”
 - “level payment playing field with *specialty* hospitals”
 - More coming on discharges to ‘post-acute’ facilities

- Then came the Congressional response.....(early February 2005)
 - Republican confidence is high.....for a budget *resolution*
 - Budget resolution contain no specifics, rather they direct Committees to make decisions
 - Budget resolutions set parameters for budget *reconciliation* legislation
 - Reconciliation language cannot be filibustered / requires simple majority
 - 5 year budget **NOT** a 10 year budget

- Then we started to get some “meat on the bones” (early March 2005)
 - Separate budget *resolutions* are passed:
 - HOUSE:
 - \$69 billion in total cuts over 5 years
 - \$20 billion from the Commerce Committee (Medicaid, MCR B)
 - » IGTs
 - » Drug payments to Pharmacists
 - » Transfer of assets rules
 - » Tiered cost sharing
 - » Has until September 16 to come up with a plan
 - \$19 billion from Ways & Means (Medicare A, entitlements)
 - » Budget Comm Chair Nussle (R-IA): *Does not think that Medicare cuts would be considered per the President’s preferences*

- Budget resolutions – Round #1 (early March 2005)
 - SENATE:
 - \$32 billion in total cuts over 5 years
 - \$15 billion from Finance Committee (Medicaid & Medicare)
 - \$14 billion from Medicaid
 - » Senate Finance Committee Chair Grassley (R-IA): *focus will be on Medicaid*
 - Budget Comm Chair Gregg (R-NH): *\$14 billion is a marginal effort given the size of the Medicaid program and its rate of growth*

- A reprieve....or the “calm before the storm”....
(mid-March 2005)
 - The Senate amends its budget resolution striking instructions to the Senate Finance Committee to find \$15 billion
 - Without compromise on a budget resolution, any cuts to Medicare or Medicaid would require (a very unlikely) 60 votes in the Senate
 - Considerably more difficult to get “serious” change on Federal Medicaid spending
 - Amendment also put into play a ‘bipartisan committee to study Medicaid’
 - Republicans still confident that there will be Medicaid cuts

- Where we stand as of 'today'....
 - Little progress
 - Conferees have not been named yet
 - Nussle and Gregg still negotiating
 - Focus may be shifting to Medicare
 - House Ways & Means still has an \$18.7b 'goal'
 - Chair Thomas - \$2-\$4b from Medicare
 - Finding \$ to fix the Physician issue

- A quick detour... Physician payments
 - Payment system is formula driven
 - Sustainable growth rate (“SGR”)
 - Essentially a volume target
 - » Over the last 10 years we have overspent the target by \$6 billion
 - » Seen as limiting in what it measures
 - » Widely viewed as a poor means to control growth
 - » Remains the law though
 - SGR would have pushed payments down in 2004 and 2005
 - MMA actually overrode the current formula and granted a 1.5% increase for 2005
 - Current regulations would decrease physician payment rates on January 1, 2006 by 5.2%
 - Requires Congressional action to correct
 - CBO estimates it will cost \$10-\$50 billion over 5 years to correct

The background of the slide is a blurred image. On the left side, there is a close-up of a person's hand holding a pen over a document. The document has some text, including 'OFFICE OF THE' and 'MEDICARE'. The rest of the background is a light, hazy gradient.

MedPAC's March 2005 Report

- Medicare Payment Advisory Commission
 - Charged by Congress:
 - Reviewing Medicare payment policies
 - Making recommendations for improvement:
 - Data sources
 - Methods
 - Increased efficiency
 - Reports to Congress every March
 - Hospitals, physicians, SNF, HHA, Outpatient dialysis
 - Recommendations *NOT* regulations
 - General:
 - It is time for CMS to start to differentiate among providers
 - Quality
 - Imaging studies
 - Measuring physician “use rates” and reporting

- Hospital inpatient & outpatient services
 - Medicare accounts for 19% of spending on personal health:
 - \$292 billion (2003)
 - 45% of Medicare expenditures are for inpatient and outpatient hospital services
 - Growth in spending projected to continue at 7.5% per year 2004-2013
 - “front-loaded” due to MMA (12% in 2004, 8% in 2005)

- Hospital inpatient & outpatient services (cont)
 - Adequacy of payments:
 - Number of Medicare hospitals increasing
 - Volume increasing
 - Quality indicators generally good
 - AHRQ (mortality)
 - QIO indicators
 - Access to capital good
 - Bond financings increased from \$15b (2000) to \$25b (2004)
 - Construction spending increased 12% in 2004
 - Margins:
 - Medicare margin continues to trend down
 - » Inpt: 5.9% (2002) to 1.3% (2003)
 - » Outpt: -9% (2002) to -11.5% (2003)
 - Decrease result of “high growth” in costs
 - » Hospitals with consistently higher costs have lower margins
 - » Due to a “lack of payment constraints”
 - » No correlation with quality

- Hospital inpatient & outpatient services (cont)
 - Recommendations:
 - 2006 increases should be market basket less 0.4%
 - 2.8% increase
 - Payments at a rate less than inflation will ‘constrain cost growth’
 - Inpatient: \$1B to \$5B over five years / Outpatient: \$250M to \$1B over five years
 - Establish payment incentives for quality
 - IOM Criteria: Clinical effectiveness, Safety, Pt-centered, Timeliness
 - No real specifics other than budget neutral
 - Hospitals should report secondary dx present on admission
 - To differentiate issues present upon admission from those that develop during stay

- Physicians

- Adequacy of payments:

- Number of participating physicians has increased
 - Access to physicians is good (phone survey)
 - Overall ratio of Medicare to private insurance remained the same (approximately 81%)

- Recommendations:

- Override the SGR formula
 - Increase rates: inflation less .8% (2.7%)
 - Increase in payments \$5b to \$10b over 5 years
 - » Partially driven by the expected SGR impact

- Physicians (cont)
 - Recommendations (cont)
 - Establish payment incentives for quality
 - Measuring physicians quality is more complex than hospitals
 - » Lack of infrastructure for gathering data
 - Alternative measures:
 - » Use of IT, e.g. computerized follow ups
 - » Further investment in response to the incentives will result in an ability to access even more complex data
 - » Support with grants and loans to providers

- Physicians (cont)

- Recommendations (cont)

- Use claims data to measure FFS utilization and share that information with physicians
 - Basically draw on the data in the system to benchmark
 - Should data be risk-adjusted?
 - How do you assign patients to a physician?
 - Gainsharing should be “de-criminalized” but regulated
 - Improve coding edits to better detect unbundling of diagnostic imaging services and reduce technical payments for multiple procedures
 - Set standards for physicians that order, interpret and perform diagnostic imaging studies\
 - Response to migration of imaging to physician offices
 - Physicians would have to be “qualified” to perform services
 - Strengthen rules that restrict investment in imaging services
 - Include PET and nuclear medicine in Stark

- SNFs & HHA
 - Recommendations:
 - 0% updates in 2006
 - Improve or reconfigure patient classification systems
 - Infuse more quality indicators into the systems