

Making the Most of Medicare and Medicaid

Medicare accounted for 19 percent of spending on personal healthcare in 2003, and Medicaid and the State Children's Health Insurance Program (SCHIP) made up another 17 percent, according to the Centers for Medicare & Medicaid Services (CMS). These programs represent a large and growing percentage of the U.S. population.

But participating in Medicare and Medicaid may be more trouble than these programs are worth to many medical practices.

Participating in Medicare and Medicaid may be more trouble than these programs are worth to many medical practices. Low reimbursement rates, administrative red tape and growing concern over the possibility of federal fraud and abuse investigations are just a few of the reasons.

Low reimbursement rates, administrative red tape and growing concern over the possibility of federal fraud and abuse investigations are just a few of the reasons.

Recent healthcare reform laws have begun to address some of the problems faced by physicians who participate in Medicare, but medical organizations say a good deal more needs to be done.

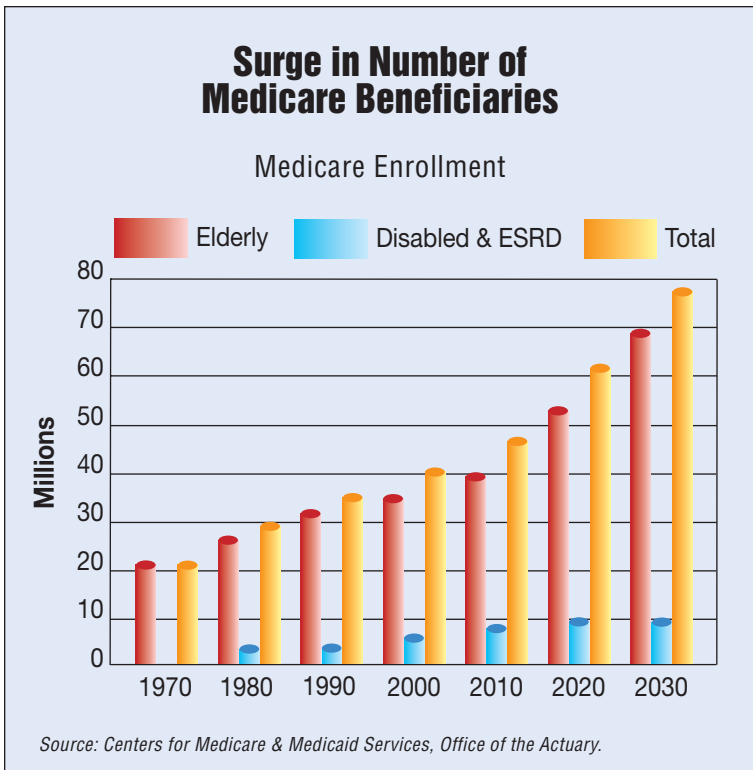
Participating in Medicare now has many downsides. A major one is that physicians face future reimbursement cuts of more than 30 percent between 2006 and 2012. The payment crisis began in 2002 when Medicare attempted to reduce physician fees by 5.4 percent.

Congress has started to mitigate some of these payment reductions. For example, it passed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The law received widespread coverage for the new prescription drug benefit it provides to Medicare patients, but it also addressed the physician payment issue. Under that measure, payments to physi-

cians increased by an average of 1.5 percent for 2005, which is a replacement for what would have been a 3.3-percent cut in physician payment rates.

Medicare Formula Seen Flawed

Organizations representing physicians are currently continuing their lobbying push for additional improvements. Without legislative changes, doctors are projected to receive the first of several consecutive 5-percent reductions in Medicare reimbursement starting in 2006. “Cumulative payment cuts of 31 percent are expected beginning in January 2006 through 2013,” said Dr. Nancy H. Nielsen, an AMA trustee, in recent testimony before the House Ways and Means Subcommittee on Health. “These cuts present a serious threat to patient access to care.”



Physicians' organizations claim that the projected cuts in Medicare payments to physicians are the result of the federal government's using a flawed physician payment formula that bases reimbursements on the gross domestic product (GDP), even though the GDP has little to do with healthcare costs. "Currently, the payment updates are tied to the economy, but the medical needs of Medicare patients do not wane when the American economy slows," Dr. Nielsen said.

Another problem is that the formula does not correctly calculate physician expenses, which have been underestimated while overestimating improvements in practice efficiency. The Medicare Payment Advisory Commission (MedPAC), an independent federal panel that advises Congress on issues affecting the Medicare program, recommends that the sustainable growth rate be replaced with a system under which yearly payment changes are based on an assessment of practice cost increases, adequacy of physician reimbursement rates and beneficiaries' access to care.

What Constitutes Medical Necessity?

Medical necessity is defined by Medicare as the need for an item or service to be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. In order for services provided to Medicare beneficiaries to be covered and reimbursed, they must be medically necessary. Additionally, the need for the item or service must be clearly documented in the patient's medical record.

In order to be considered medically necessary, healthcare items or services must meet the following requirements:

- They must be appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease or injury.
- They are provided for the diagnosis or the direct care of the patient's condition, illness, disease or injury.
- They must be provided in accordance with current standards of good medical practice.
- Services or items must not be provided primarily for the convenience of the patient or provider.
- Providers must deliver the most appropriate level of service that can be safely provided to the patient.

“It is critical to replace the flawed physician payment formula to allow quality initiatives to flourish,” Dr. Nielsen said. “Physicians will be hard pressed to undertake quality initiatives, such as information technology, if they are facing steep payment cuts.”

While information technology (IT) holds a good deal of promise with regard to making the delivery of care more efficient, the investment required to establish a fully interoperable record system is prohibitive for many group practices, Dr. William F. Jessee, president of the Medical Group Management Association (MGMA), told the subcommittee.

“While IT should help to restrain escalating costs by generating administrative savings, the vast majority of such savings will accrue to payers and others within the system, not to the physician group practices that provide the initial investment,” he said. Further, he pointed out that the projected Medicare reimbursement cuts also create an unstable economic environment, “making it virtually impossible for many group practices to pursue the types of expensive technologies that hold great promise for improving patient care and generating administrative savings.”

Coding and billing errors are another problem faced by physicians under the program. More than 9 percent of total Medicare payments in fiscal 2004 were improper, according to CMS, which surveys the payment error rate for Medicare each year. Physicians and other providers were paid either too much or too little.

Of the total payments sampled in 2004, CMS reports the following payment error traits:

- 4.1 percent of payments had errors due to insufficient documentation being submitted.
- 2.8 percent had errors due to non-responses to requests for medical records.
- 1.6 percent had errors due to medically unnecessary services.
- 0.7 percent had errors due to incorrect coding.

The American Academy of Family Physicians found that family doctors accepting new Medicare patients declined from 84 percent in 2000 to just over 76 percent in 2003. Further, MedPAC found the percentage of physicians willing to accept all new fee-for-service Medicare patients dropped from 76.4 percent in 1999 to 70.1 percent in 2002.

- 0.1 percent had other nonspecified errors.

CMS and the American Medical Association are collaborating on trying to give physicians and carriers better guidance on evaluation and management codes. The AMA intends to analyze the error report data and make improvements to the evaluation and management code instructions.

While CMS has just started its investigation into the causes of underpayments, it remains more interested in the reasons physicians and other providers in the Medicare program are being paid too much.

As a result of these payment difficulties, more physicians are evaluating whether program participation makes sense for their medical practices. The American Academy of Family Physicians (AAFP), for example, found that family physicians accepting new Medicare patients declined from 84 percent in 2000 to just over 76 percent in 2003.

Further, MedPAC found that the percentage of physicians willing to accept all new fee-for-service Medicare patients dropped from 76.4 percent in 1999 to 70.1 percent in 2002. Intended to gauge the impact of Medicare payment cuts on physicians' acceptance of new Medicare patients, the survey found that while the majority of physicians continue to accept all new fee-for-service Medicare patients, a growing percentage are either not accepting new Medicare patients or accepting new Medicare patients on a more selective basis.

While reimbursement rates have declined and are projected to decline even more unless Congress changes the law, physicians continue to treat Medicare patients. This is especially true for internal medicine practices, which have always seen a large number of older patients.

Doctors who participate in Medicare are required to accept all Medicare claims on an "assigned" basis. At the time of service, Medicare patients are required to pay only 20 percent of Medicare's approved amount once the deductible is satisfied. (The Medicare yearly deductible, which has been fixed at \$100, will increase annually with inflation starting in 2005.) If you participate in Medicare, you are not allowed to bill for more than Medicare's approved amount.

Keep in mind that CMS is permitted to pay only for services

or items that fall under the definition contained in the original Medicare legislation. Those are services and items that “are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Payment also is possible for services that Congress has added to the program.

If you decide not to participate in the program, it is possible

	Participating physician	Physician accepting assignment but not participating	Physician not accepting assignment
Amount charged	\$150	\$150	\$150
Medicare-approved amount	\$100	\$ 95	\$ 95
Limiting charge (15% more than Medicare-approved amount)	Not applicable	Not applicable	\$109.25
Medicare payment (80%)	\$80	\$76	\$76
Beneficiary coinsurance (usually 20%)	\$20	\$19	\$33.25*
How payment is made	Medicare directly pays physician. Beneficiary pays coinsurance.	Medicare directly pays physician. Beneficiary pays coinsurance.	Beneficiary pays physician limiting charge. Medicare reimburses beneficiary for its share.

*The beneficiary pays the difference between the Medicare payment to the physician and the limiting charge.

Source: United States Government Accountability Office, Centers for Medicare and Medicaid Services.

to submit claims from Medicare patients on an assigned basis or on a non-assigned basis. According to the American College of Physicians (ACP), Medicare will pay less for claims submitted by non-participating doctors than it will pay for claims by participating ones. Furthermore, Medicare pays the patient directly after it processes the claim.

But for physicians who don't participate in the program, it is possible to bill patients for as much as 115 percent of Medicare's approved amount since doctors are not limited to collecting only the beneficiary co-payment but can collect the additional amount owed from the Medicare patient at the time of service.

A report by the Kaiser Commission on Medicaid and the Uninsured indicates that low-income children and their parents represent about three-fourths of Medicaid beneficiaries. The elderly and persons with disabilities represent just one-quarter of Medicaid enrollees, but they account for 70 percent of Medicaid spending, according to the report.

As a result, Medicare patients will pay 66.25 percent more for a non-assigned claim than they would for an assigned claim that you submit as a participating physician. The total combined amount you can collect from Medicare and the patient is more than for a participating physician. But keep in mind, says ACP, that this situation "gives beneficiaries an incentive to see participating physicians." (Log on to www.acponline.org/shell/cgi/

printhappy.pl/hpp/med_options03.htm for a more detailed explanation of Medicare's participation options.)

The decision to leave the Medicare program is not one that physicians should make in haste, practice management consultants say; carefully consider all the options before doing this. For some physicians, this may be the only way to continue to see current Medicare patients. Otherwise, says ACP, you may have to take other cost-cutting steps to offset the reduced Medicare payments, such as limiting how many patients you can see or trimming staff payroll by reducing staff size in your office.

Complaints About Medicaid

Medicaid is now considered the largest public provider of health coverage. The program makes up more than 20 percent of

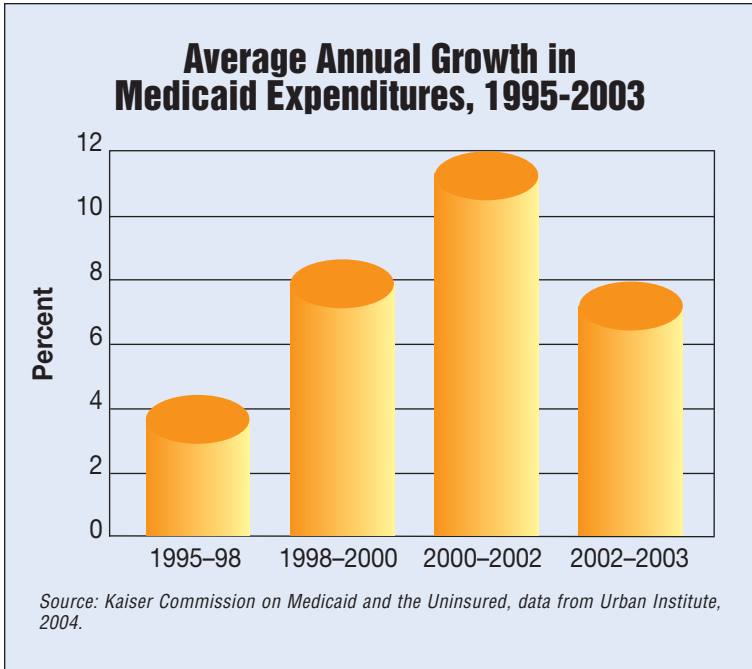
the average state's budget, according to the National Association of State Budget Officers.

The program, which is jointly funded by states and the federal government, served 52 million low-income people in fiscal 2004. It covers children, families, seniors and people with disabilities, and fills in gaps in Medicare coverage for seniors.

A report by the Kaiser Commission on Medicaid and the Uninsured indicates that low-income children and their parents represent about three-fourths of Medicaid beneficiaries. The elderly and persons with disabilities represent just one-quarter of Medicaid enrollees, but they account for 70 percent of Medicaid spending, according to the report.

Kaiser found that Medicaid played its role as a safety net, providing coverage to those facing economic declines and loss of employer-sponsored coverage, but the result was a sharp increase in program costs.

With regard to growth in the program, another report from the



Urban Institute found that Medicaid spending increased by about one-third between 2000 and 2003, an increase largely driven by greater enrollments.

The program encountered rapid increases in enrollment of children and non-disabled adults, the report points out. Increases in spending per enrollee between 2000 and 2003 were faster than inflation but slower than increases in private insurance spending.

The Medicaid program covers a range of services, including

Public Sector Will Pay Half of Health Costs in 2014

Within the next decade, public spending will account for nearly half of the nation's healthcare pie—a record portion that could have major implications for the overall national budget, federal economists predict in an article on the Health Affairs Website (www.healthaffairs.org).

The authors, economists and actuaries from the Centers for Medicare and Medicaid Services (CMS), also estimate that by 2014 health spending will constitute 18.7 percent of the gross domestic product, up from 15.3 percent in 2003. “Over the next decade, healthcare spending is expected to account for a larger portion of our economy's resources, while at the same time the public sector would fund a larger share of the nation's healthcare bill,” says lead author Stephen Heffler, director of the National Health Statistics Group at the CMS. “These trends will test society's willingness to find ways to slow cost growth without compromising quality or access.”

In the first analysis of the effect of the new Medicare prescription drug law on overall health spending, the authors say that the new drug benefit will lead to a “substantial shift” in funding from private payers and Medicaid to Medicare over the next decade. “The implementation of the Part D benefit has very little impact on overall health spending or total prescription drug spending but it has a significant impact on who is paying for prescription drugs,” Mr. Heffler says.

The study, entitled “U.S. Health Spending Projections for 2004-2014,” covers a variety of sectors in the healthcare field, examining spending trends for prescription drugs, hospitals, physicians and long-term care. Among the report's highlights:

■ **Prescription drugs.** In 2006, when the Medicare Part D benefit kicks in, there will be a large shift in funding for prescription drugs to Medicare from private payers, including private health insurance, consumer out-of-pocket payments and Medicaid. The authors project that Medicaid spending will account for 18.1 percent of prescription drug

physician and hospital care, nursing home care and prescription drug coverage. States have the responsibility to design and administer their Medicaid programs within the federal rules. States decide which services are covered and set payment rates for providers. They also decide other key policies, such as which eligibility groups receive care within a managed-care system and how the state will use Medicaid to finance a range of other medical services.

spending in 2005, a share that is anticipated to drop to 9.4 percent in 2006, when all dual-eligible Medicare and Medicaid enrollees will receive Medicare drug coverage. Private prescription drug spending will account for 76.1 percent of all drug spending in 2005, a share that is set to fall to 59 percent in 2006.

■ **Hospitals.** Spending growth will peak in 2004 at 7.0 percent and grow at an average rate of 6.2 percent over the following 10 years. Public-sector spending is projected to accelerate in 2004, with strong growth projected in both Medicare and Medicaid. Private-sector spending is expected to slow as a result of greater use of utilization management tools and increases in patient cost sharing.

■ **Home healthcare.** Home health spending will grow 13.0 percent in 2004, up from 9.5 percent in 2003. The acceleration in growth is attributable to growth in Medicare home health spending, following a one-time legislated payment reduction in 2003, as well as strong growth in Medicaid spending.

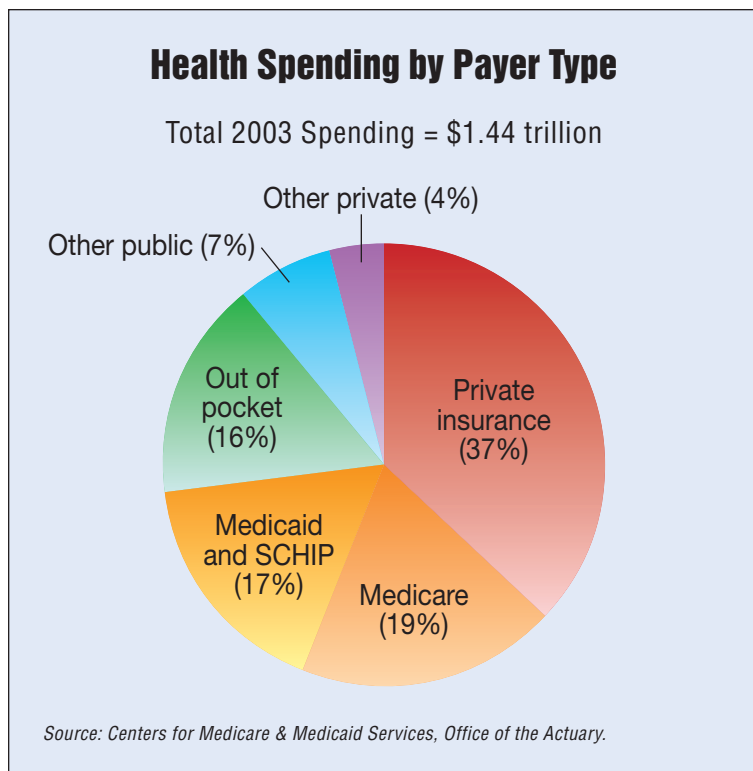
■ **Medicare managed care.** A retooled version of Medicare managed care, Medicare Advantage (MA), will be introduced in 2006. Payment increases to managed-care plans in 2004 and 2005 as well as allowance of regional preferred provider organizations will greatly increase enrollment, according to the CMS report. They forecast that MA enrollees will constitute about 30 percent of total Medicare enrollees by 2014, compared with about 12 percent in 2003.

■ **Private sector.** Private healthcare spending is expected to slow to 7.4 percent in 2004 and 6.6 percent in 2005, from a peak of 9.0 percent in 2002. The deceleration is driven almost entirely by slower growth in the use of medical care, triggered in part by the quiet reimposition of utilization management tools by payers and the increased use of cost sharing to dampen demand for discretionary health services. The authors project that private spending will dip sharply to 3.1 percent in 2006, when the Medicare Part D benefit takes effect.

Reimbursement to physicians under Medicaid, the government's program for the poor, has always been much lower than under private payers or Medicare. The reimbursement also is below what it costs practices to provide covered services. In addition, some doctors have complained of long delays in receiving their reimbursements.

Medicaid physician fees on average grew at nearly twice the rate of inflation between 1998 and 2003, but they still remain well below the rates paid by Medicare in most parts of the country, according to a June 23, 2004, article published on the Health Affairs Website (<http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.374v1>).

The increases between 1998 and 2003 exceeded the growth rate during the previous five years, in which Medicaid fees fell



on an inflation-adjusted basis, says the article, entitled “Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation.”

On average, Medicaid fees grew 27.4 percent during the 1998-2003 period. That average annual rate of 5 percent easily outpaced the 2.6 percent annual growth in the Consumer Price Index, creating overall real growth of about 14 percent during the study period. Primary-care fees increased most, growing 41.2 percent over that period. Thirty states raised their fees at or above the rate of inflation, including 10 that raised physician fees by more than 35 percent.

Many states were able to boost rates during the 1998-2003 period because of healthy revenue growth during an extended period of economic growth in an effort to improve access to basic care for Medicaid beneficiaries, the article states. But more recently, slow

economic growth has caused states to pull back on Medicaid physician payments.

“States are now dealing with the worst financial crisis since the Great Depression, and will not be in position to raise provider fees greatly, so access for Medicaid recipients may be at increasing risk,” says lead author Stephen Zuckerman, a principal research associate with the Urban Institute.

The Kaiser Commission report shows that in 2005 more states intend to reduce or freeze reimbursement to physicians than any other group, including hospitals, nursing homes and managed-care organizations. In 2004, 42 states either cut or froze physician payments.

In addition, fiscal 2005 marks the end of the temporary federal fiscal relief. The Bush administration has indicated that it plans to cut \$60 billion in federal Medicaid funds over the next 10 years. In addition, many states are facing large budget shortfalls totaling about \$40 billion, and spending for the program is

Slow economic growth has caused states to pull back on Medicaid physician payments. “States are now dealing with the worst financial crisis since the Great Depression, and will not be in position to raise provider fees greatly, so access for Medicaid recipients may be at increasing risk,” says Stephen Zuckerman, a researcher with the Urban Institute.

projected to increase faster than state revenues. Without help from Washington, states are expected to see additional reductions in their Medicaid programs, which will mean additional cuts in physician payments.

Some physicians have been able to overlook the low reimbursements, but the red tape and excessively long payment delays involved in seeing Medicaid

To determine your costs, track what has been billed, the date of service, when it was billed and when a claim has been reimbursed. Compare and contrast this information from one month to the next to get a good idea of the financial situation of your practice and the impact of Medicare and Medicaid.

patients are often just too onerous. As a result some physicians prefer not to be involved in Medicaid, says Cleveland practice management consultant Jack Valancy. That is becoming increasingly the case for specialists, who simply have stopped seeing Medicaid patients because of shockingly low reimbursements. Surveys in the past few years demonstrate that low Med-

icaid reimbursements are leading to decreases in participation across the board.

Some physicians who still see Medicaid patients decide to limit the number they will care for in their practices. Still others treat a limited number of Medicaid patients free of charge because they do not want to bother with the hassle of wrestling with Medicaid, Mr. Valancy explains.

Analyze Impact on Practice

If you are thinking about opting out of Medicare, you should do an analysis of your practice's financials. First look at your payer mix and determine what percentage are Medicare and Medicaid, private payers and managed care, says Jayme Matchinski, a healthcare attorney with the law firm of Harris Kessler & Goldstein in Chicago.

Once you've done that, determine what you are receiving from your payers and analyze your accounts receivables and liabilities. It also makes sense to look at your bad debt rate to determine whether that is increasing as a result of not being able to collect from Medicare and Medicaid.

This exercise allows you to determine what it costs to treat Medicare and Medicaid patients and whether it is viable to continue to do so. “It is very enlightening to find out what the practice is billing and what it is actually collecting,” she says. When physicians find that they can’t meet their expenses, they may have to make adjustments in the number of Medicare patients they see or opt out of the program.

As part of this process, it is important to answer the following questions:

- What are the reimbursement rates you are receiving?
- How do these reimbursement rates compare with the other insurance plans in which you participate?
- How many of the patients in your practice are covered by Medicare and/or Medicaid?

Trevor Stone, private sector advocacy manager for AAFP, says it is possible to use the analysis spreadsheet cited in the previous chapter to determine how financially beneficial it is to participate in Medicare. Log on to www.aafp.org/fpm/20041000/31cany.html to access the spreadsheet.

If physicians plan to participate in a program, it is important to look at the service mix in the practice to determine which services are more profitable, says Daniel Bernick, a principal and an attorney with The Health Care Group, a practice management firm in Plymouth Meeting, Pa. It may be necessary to either drop a service or add one, he points out.

The aim is to focus on performing the services that are well reimbursed. Perhaps it is possible to improve profitability by not spending so much time on services that are not making money for the practice.

To track the costs of the Medicare program, follow the sheets of the patient charts, which indicate the payer source, says Ms. Matchinski. This way the physician can track what has been billed, the date of service, when it was billed and when a claim has been reimbursed. If you have an automated system, you can run reports on this type of information to track revenue and cost associated with Medicare, Medicaid and all your payers.

It is important to compare and contrast this information from one month to the next to get a good idea of the financial situation of your practice and the impact of Medicare and Medicaid,

she says. “Further, it will let you know if the costs of your practice exceed what you are being paid by payers,” she adds.

With reimbursements declining, more physicians are looking at adding or increasing the scope of the practice by setting post-acute menus of care, she says. Some physicians are moving to open ambulatory surgery centers or other ancillary services to help capture some of the revenue stream from these services. (*See next chapter for more on ancillary services.*)

Mr. Stone recommends that physicians stay informed on all the changes in Medicare regulations. CMS does have an online update on Medicare coverage changes. You can register to receive these updates by logging on to www.cms.hhs.gov/maillinglists/de-

Medicare Starts Performance-Based Payments

The Centers for Medicare and Medicaid Services recently announced new initiatives to pay healthcare providers for the quality of the care they provide to seniors and people with disabilities.

The demonstration program involves 10 large physician groups across the U.S. that will participate in the first pay-for-performance initiative for physicians under the Medicare program. The groups include Park Nicollet Health Services in St. Louis Park, Minn., Dartmouth-Hitchcock Clinic in Bedford, N.H. and Geisinger Health System in Danville, Pa. CMS will reward the 10 groups that improve patient outcomes. The agency says performance payments will be derived from savings expected through improvements in care coordination for an assigned beneficiary population.

The three-year project gives physician groups a chance to demonstrate that improving care in a proactive and coordinated manner also saves money, says CMS.

The agency points out that there is good evidence that by anticipating patient needs, especially for patients with chronic diseases, health-care teams that partner with patients can intervene before expensive procedures and hospitalization are required.

CMS will reward groups that improve patient outcomes by coordinating care for chronically ill and high-cost beneficiaries in an efficient manner. The agency says because these medical groups will share in any financial savings that result from improving the quality of care, they will have incentives to use electronic records and other care-management strategies that, based on clinical evidence and patient data,

fault.asp?audience=11 and subscribing to the Medicare Learning Network.

There are still benefits for physicians who continue to participate in Medicare, says Mr. Bernick. For example, if you accept Medicare, you receive reimbursement directly from the federal government. “You don’t have to chase down the patient for payment,” he adds.

Many physicians feel that Medicare remains an important part of their patient base, and they are not sure how they would replace the patients they would lose if they stopped accepting Medicare, says Mr. Bernick. Participating in the program may not be as profitable as it was in the past, but in most cases Medi-

improve patient outcomes and lower total medical costs.

The quality measures focus on common chronic illnesses in the Medicare population, including congestive heart failure, coronary artery disease, diabetes and hypertension, as well as preventive services, such as influenza and pneumonia vaccines.

CMS has worked with the physician groups to develop a consensus around how the measures would be captured and used to assess performance and reward quality under the demonstration. It will use a total of 32 measures that focus on common chronic illnesses and preventive services. For example, preventive-care strategies include blood-pressure screening and control as well as breast and colorectal cancer screening.

Under the demonstration program, physician groups will continue to be paid on a fee-for-service basis. The groups will implement care-management strategies designed to anticipate patient needs, prevent chronic disease complications and avoidable hospitalizations and improve quality of care.

CMS selected the groups through a competitive process based on technical-review panel findings, organizational structure, operational feasibility, geographic location and implementation plan. The multi-specialty groups have at least 200 physicians and include freestanding group practices, integrated delivery systems, faculty group practices and independent practice associations. The 10 groups represent 5,000 physicians and over 200,000 Medicare fee-for-service beneficiaries. Further information on the demonstration is available at www.cms.hhs.gov/researchers/demos/pgp.asp.

care still provides a number of physicians with enough reimbursement to make it profitable, he maintains.

“Most physicians will automatically contract with Medicare. It is difficult for most family physicians to opt-out or not participate with Medicare given the large percentage of patients receiving Medicare,” says Mr. Stone.

Some beneficial changes are forthcoming under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. New Medicare beneficiaries now receive a one-time preventive history and physical exam. For doctors, this means a good opportunity to determine the overall health of the patient and provide counseling on health and wellness issues.

Physicians also feel that Medicare remains a reliable source of payment in light of the problems encountered with some other payers, says Ms. Matchinski.

Some beneficial changes also are forthcoming under the Medicare Prescription Drug, Improvement and Modernization Act of 2003. New Medicare beneficiaries now receive a one-time preventive history and physical exam. This includes height, weight and blood-pressure measurements as well as

vision and hearing tests. For doctors, this means a good opportunity to determine the overall health of the patient and provide counseling on health and wellness issues. In addition, if you determine that a patient needs more medical care on the same day as the physical, it is possible to bill Medicare for a more extensive office visit.

There also is new coverage for cardiovascular disease and diabetes screening. Under the changes, you can bill and be paid separately for the screening electrocardiogram in addition to the payment for the physical.

Doctors who are working in areas with few other providers are now receiving a 5-percent quarterly bonus payment from the federal government. In some situations, this increase may be in addition to an existing 10-percent add-on that applies to regions known as Health Professional Shortage Areas. If you believe you qualify for this bonus, be sure to check with CMS to find out exactly what you need to do to receive it.

Rural physicians should be encouraged by the increase in Medicare reimbursement, says Ms. Matchinski. “It is important

that they do receive this increase given the fact that they are covering a large geographic area,” she adds.

Further, MMA has issued 18 new codes for cancer drugs. Oncologists will now be able to receive reimbursement for administering the drugs, which they weren't able to do in the past. CMS's rule on these codes accepts the relative values, which are used to determine payment rates, for these codes that were recommended by the AMA's relative-value update committee, she explains.

CMS also established a one-year demonstration project that will provide doctors with an additional \$130 per chemotherapy recipient per treatment day. To receive this payment, the oncologist must provide Medicare with information on the patient's level of nausea, pain and fatigue.

The agency has also launched a pilot program under which participating physicians will receive higher Medicare reimbursements for meeting or exceeding defined performance standards.

Medicare undergoes frequent changes, so it is best to have someone in your office keep up with the program's coverage decisions. Sometimes these decisions are modified based on clinical evidence. It is also a good idea to attend conferences on Medicare to find out about the latest developments. Check with your state medical and specialty associations to find out about conference schedules.

Medicare Managed Care

MMA also is expected to help bolster Medicare+Choice plans, now called Medicare Advantage (MA). “Our members have responded to this legislation, expanding opportunities for beneficiaries across the country and offering a range of products,” says Karen Ignagni, president and CEO of America's Health Insurance Plans. With 141 new contract applications still pending approval for 2005, the turnaround continues, she says. When these contracts are approved, beneficiaries in 39 states will have access to MA managed-care plans.

There is an eight-year phase-in of a risk-adjustment payment method that includes adjustments for the health status of enrollees. In 2005, 50 percent of a plan's payment for each Medicare Advantage enrollee will use the new risk adjuster, while 50 percent of the payment for each enrollee will be based on the pre-

vious demographic-only system.

Physician response to the new Medicare managed-care emphasis is expected to be driven by local market circumstances. This involves the reimbursement levels in traditional Medicare compared with those of Medicare Advantage. In addition, if large numbers of Medicare beneficiaries overcome their traditional reluctance to

While physicians may be influenced by how patients react to the new Medicare Advantage program, some doctors believe that health plans initially are going to have to make participating in these plans attractive to physicians. For example, they may have to offer some type of incentive to physicians to encourage participation.

join managed-care plans and sign up with Medicare Advantage, many physicians will likely follow the patients into those plans.

While physicians may be influenced by how patients react to the new Medicare Advantage program, some doctors believe that health plans initially are going to have to make participating in these plans attractive to physicians. For example, they may have to offer some type of incentive to physicians to encourage participation.

Beneficiaries who choose a Medicare Advantage plan can obtain drug benefits as part of their overall health plan, allowing the plans to better coordinate beneficiaries' medical care and drug coverage.

Starting in January 2006, the rules create a new regional Medicare Advantage Preferred Provider Organizations (PPOs) contracting option as an additional choice for Medicare beneficiaries. The new PPOs will serve 26 regions across the U.S., which include all rural areas. All regional PPOs are required to offer the same benefits as traditional fee-for-service Medicare with simplified cost-sharing and new protections against catastrophic costs.

More Guidance for Physicians

Congress also has made some improvements with regard to the program's administrative requirements. CMS and its carriers received a good deal of criticism on how calls and inquiries from physicians have been handled. A 2004 Government Accountability Office (GAO) report, for example, found that roughly 96 percent of telephone inquiries on Medicare billing policy to car-

rier call centers received incomplete or inaccurate responses. The GAO asked four questions to Medicare carrier phone banks on how to bill the program properly.

The GAO found that only 4 percent of the responses it received in 300 test calls to 34 call centers were correct and complete. Call centers are not very good at letting physicians know why a claim was rejected, according to the report. The GAO also pointed out that CMS’s efforts to provide oversight of carrier call centers was inadequate (*see table below*).

To improve the responses to policy-oriented inquiries from providers, GAO recommended that CMS develop a process to route policy inquiries to staff with the appropriate expertise. In

Medicare Carriers Give Inaccurate Information: GAO				
Question	Correct and Complete Response	Partially Correct or Incomplete Response	Incorrect Response	Total Responses
Billing for beneficiaries transferred from one hospital to another	2	22	51	75
Billing for services delivered by therapy students	5	32	38	75
Billing for multiple surgeries for the same patient on the same day	1	36	38	75
Billing for an office visit and procedure for the same patient on the same day	4	35	36	75
Number of carrier call center responses	12	125	163	300
Percentage of carrier call center responses	4	42	54	100

Source: U.S. Government Accountability Office

addition, it recommended that CMS develop clear and easily accessible policy-oriented material to assist customer service representatives and that it also put together an effective monitoring program for its call centers.

Under MMA, responses to inquiries from physicians may be received faster since Medicare carriers are instructed to respond in writing to providers' questions within 45 days.

These responses should be clear, concise and accurate. The aim is to trim the number of instances in which providers don't receive a response. In addition, carriers must establish a "provider customer service program" to answer questions from physicians.

Carriers now must have an automated voice response system

How Medicare Audits Are Changing

The Medicare Prescription Drug Improvement and Modernization Act (MMA) made some welcome changes in the way Medicare and its carriers audit physicians.

The American College of Physicians recommends that physicians understand the Medicare medical review process and these recent improvements. CMS has acknowledged that physician education and feedback are important in solving problems with the program. Further, carriers are directed to make a reasonable effort to accommodate a doctor's request for a meeting to discuss the auditing process.

"If you are audited, you should use this information [in MMA] to ensure that your Medicare carrier follows the rules," writes Bret Baker in "A Look at Medicare's Kinder, Gentler Auditing Process" (ACP Observer, July-Aug. 2004).

As part of the improvements, CMS must establish standard methods that carriers can use when deciding how to sample a physician's claims. The aim is make sure that the contractors that Medicare carriers use treat physicians fairly.

Under the law, Medicare carriers must give physicians written notice before they conduct a post-payment audit. Further, they must explain any findings in a way that makes it easy for doctors to come up with a corrective action plan.

Another notable change is that carriers cannot retroactively apply rules that were effective after physicians provided and have been paid for a service. In addition, if funds have to be repaid, physicians may be given an extended repayment plan that can range from six months

in place on their phone lines, which permits doctors to check the status of a claim, determine patient eligibility or get information on certain types of codes.

In addition, the contractor Website should include a link to the agency for national provider information and sponsored listservs (electronic discussion groups that circulate through e-mail); local contractor information posted in a way that is easy to use and easily searchable, as well as frequently asked questions based on high-volume inquiries, which should be updated at least quarterly.

Medicare contractors also must maintain a tracking and reporting system that, among other factors, identifies the type of

to three years in cases of hardship. Further, physicians will have to pay back disputed amounts only after an independent group—not the Medicare carrier—has decided that the practice is at fault.

If physicians decide to appeal an audit decision, carriers are not allowed to collect overpayments until the initial overpayment decision is upheld at the first level of appeal. Insurance carriers cannot use attendance lists from educational sessions and seminars to target individual physicians for audits.

Carriers also must limit the use of extrapolation, a process by which they project a claim error rate identified over a limited period of time to claims submitted over a much longer period. They can use this method in cases where the physician had a sustained payment error level or where documented educational intervention has failed to correct the error.

Practice management experts recommend that you pay close attention to any mail you receive from your Medicare carrier. You do not want to ignore any inquiry letters that mention a “post-payment review.” Under law, carriers can review patient records, and you are obliged to provide the information they request.

If you don’t respond appropriately, this could lead to a more serious investigation, such as an audit. You generally have a specific time to reply to these inquiries, so make sure you read all correspondence carefully and follow through on any requests. Have someone on your staff review any material before you send it out to be sure that you have included all the information required. Finally, keep a complete copy of what you send to the carrier for your own records.

inquiry that was received; the person responsible for answering the provider inquiry, and the timeliness of the response. For details on CMS's instruction manual to contractors on its provider customer service program, click on www.cms.hhs.gov/manuals/pm_trans/r1130tn.pdf.

CMS doesn't expect carrier specialists to serve as an "extension or replacement" for a practice's billing staff. They should not provide coding guidance. CMS says that straightforward coding questions should be answered with a referral to the correct organization, such as the AMA and the American Hospital Association's Coding Clinic.

Organizations representing healthcare providers are spending a good deal of time and money trying to convince lawmakers that action has to be taken to improve the program. "The reimbursements must be appropriate so that physicians can continue to treat Medicare and Medicaid patients," says Jayme Mat-chinski, a Chicago healthcare attorney.

Medicare contractors also are expected to develop educational materials and programs for small providers, defined by law as "providers with fewer than 25 full-time equivalent employees or suppliers with fewer than 10 full-time equivalent employees." These educational events are expected to involve interactive communication

such as face-to-face training or Web-based seminars.

Contractors are expected to have at least one Internet educational offering and to offer at least one per quarter with a minimum of six events per year. If a provider lacks Internet access, contractors can charge providers a small fee to defray the cost associated with the printing of and postage for educational materials.

If you have a complex question that involves a substantial reimbursement amount, experts say it may be best to put the inquiry in writing so that you will receive a written response from the carrier. On written inquiries, contractors are expected to be able to quickly identify complex inquiries that need referrals to a specialist.

Keep in mind that under MMA, physicians receiving overpayments based on bad written advice from contractors are no longer subject to penalties or interest. Nevertheless, they must still re-

turn the overpayment.

The new law also calls on CMS to look into new documentation systems to replace current rules. Further, MMA calls for several changes to the medical review process, which Medicare uses to audit physicians. These provisions are meant to ensure that the contracts Medicare carriers use to process claims and/or to conduct audits treat physicians fairly.

Future Action

As more physicians continue to question their involvement with Medicare and Medicaid, practice management experts say it is best to be proactive if you wish to see effective changes in the programs. Take the time to understand both programs, keep abreast of changes and advocate for yourself and your peers.

Organizations representing healthcare providers are spending a good deal of time and money trying to convince lawmakers that action has to be taken to improve the program. “The reimbursements must be appropriate so that physicians can continue to treat Medicare and Medicaid patients,” Ms. Matchinski says.

To help improve physician reimbursement, you as an individual physician can take your case to your specialty society as well as to federal lawmakers, says Mr. Bernick. To the extent that your specialty is being targeted or certain codes have been unfairly targeted for payment cuts, your views have to be heard so that you are represented politically in the process of determining RVU reimbursements, he says. “If you don’t take active steps, the officials who set the reimbursements may assume that you are happy,” he adds.

Physicians and the national organizations that represent them are working with Congress and the White House to improve the Medicare reimbursement rates in 2006 and beyond. The AMA, for example, has renewed its call to Congress to improve the Medicare physician payment formula.

While Congress works to replace the payment formula, physician organizations are urging the Bush administration to remove prescription drugs administered in physician offices from the payment formula. Medicare’s coverage of costly prescription drugs administered in the physician’s office has been a significant factor in the growth of the program’s expenditures. Since

1996, the sustainable growth rate of spending for physician-administered drugs has more than doubled.

In recent testimony before Congress, MGMA argued that the expenses for these drugs reflect the acquisition of products rather than services rendered by a medical professional and therefore are different from physician services.

Groups representing primary-care physicians are lobbying for a change in the physician Medicare payment formula that would add a care management component, to reimburse doctors for services relating to coordinating and managing the care of chronically ill patients.

Primary-care physicians are lobbying for a change in the Medicare payment formula that would add reimbursement for coordinating the care of chronically ill patients. AAFP called for a blended model of payment combining a fee-for-service reimbursement system with a per-beneficiary, per-month stipend for care management, paid directly to the patient's designated personal physician.

“Rather than rewarding cost-effective care coordination and care integration, the [current] system rewards physicians for ordering tests and performing procedures,” said AAFP, in a statement addressed to the House Ways and Means Health Subcommittee.

“There is no direct compensation to physicians for the considerable time and effort of assuring that the patient’s care is organized correctly and is integrated in a way that makes sense to patients, while remaining cost-effective to the Medicare program.”

AAFP called for a blended model of payment combining a fee-for-service reimbursement system with a per-beneficiary, per-month stipend for care management, paid directly to the patient’s designated personal physician. Such an option “would enable family physicians to redesign their offices to deliver high-quality preventive and chronic care with improved outcomes for Medicare beneficiaries,” AAFP said.

Similarly, the ACP called on Congress to enact a pilot program to test the effectiveness of “an innovative patient-centered, physician-guided chronic care management program in small and mid-size medical practices, which would include financial incentives, use of health information technology and other practice im-

provements to support and strengthen” the patient-physician relationship.

Under the ACP’s proposal, patients with complex and multiple chronic diseases would be encouraged to select a personal physician whose practice would serve as their “medical home.” This practice would be “a single point of care where they can go to get treatment and trusted advice on navigating the complex healthcare system.”

Physicians who participate as a “medical home” would agree to incorporate improvements into their practices, such as clinical case-management services for complex patients; regular follow-up; use of evidence-based guidelines in clinical practice; implementation of information systems to facilitate efficient and effective care, and use of on-line clinical decision support tools to improve care quality.

Participating physicians would receive a “care management” fee to reimburse them for services relating to coordinating and managing the care of participating patients. Participating physicians would also be eligible to share in a bonus pool of payments based on performance according to accepted evidence-based clinical performance measures.

Medical organizations are urging physicians to let lawmakers know how vital improvements in Medicare are, not only to patients, but to providers as well.