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Medicare Cuts Spell Disaster: Time for Physicians to Act

Most physicians are aware that, without Congressional action, Medicare physician payment rates will be reduced 10% in 2008. The 2007 Medicare Trustee's report predicts total cuts of about 40% by 2016. The AMA and medical organizations across the country are sending the message to Congress that it is critical they take action this year to replace the cuts with positive updates based on actual practice cost increases physicians are encountering. The Medicare Payment Advisory Committee (MedPAC) has recommended Congress increase payment rates by 1.7% in 2008 in line with estimated practice cost increases. A recent AMA survey found that 60% of responding physicians reported they would have to limit the number of new Medicare patients they treat if 2008 cuts go into effect, and 77% say they will stop accepting new Medicare patients if cuts continue for 9 years.

The Medicare physician payment update formula is producing disastrous effects and must be replaced. In addition to generating the pending cuts, the formula:

- has kept average 2007 Medicare physician payment rates about the same as they were in 2001
- prevents physicians from making new investments in staff and health information technology to support quality measurement
- punishes physicians for participating in initiatives that encourage greater use of preventive care in order to reduce hospitalization
- has led to severe shortfalls in Medicare's budget for physician services that have resulted in last minute short term Congressional intervention with funding methods that have increased the duration of cuts as well as the cost of a long term solution

Patients and Physicians Will Suffer

The AMA survey found that 54% of physicians would have to reduce staff and 67% would defer purchasing information technology if payments are cut 10% in 2008. MedPAC has reported increasing numbers of Medicare beneficiaries reporting "big problems" finding new primary care and specialist physicians, and there is concern that further Medicare pay cuts will worsen patient access problems. Since TRICARE payments are linked to Medicare rates, the Military Officers Association of America has expressed concern that further pay cuts will significantly damage military beneficiaries' access to care.

Physician payment cuts would have a disastrous impact on both physicians and patients in Colorado. Specifically:

- Colorado physicians will lose $54 million for the care of elderly and disabled patients next year due to the 10% cut in Medicare payments. Colorado physicians will lose $2.1 billion for the care of elderly and disabled patients by 2016 if nine years of projected cuts become reality.
- 42,834 employees, 481,459 Medicare patients and 209,764 TRICARE patients in Colorado will be affected by these cuts.
- Data indicates that 41% of Colorado's practicing physicians are over 50, an age at which surveys

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have shown many physicians consider reducing their patient care activities. Medicare payment cuts may well exacerbate anticipated physician retirements.

- In 2008, Colorado faces cuts of an additional 0.7% on top of the 10% cuts across the country. This is a result of a 2003 Medicare law that provided a temporary increase in geographic payment adjustments for certain states. This increase is also set to expire on January 1, 2008, under current law.

Medicine fights for new approach

In an effort to stave off the impending cuts, a group of national specialty societies and the AMA have made recommendations to the Centers for Medicare and Medicaid Services (CMS) for a series of policy changes which could help avert cuts driven by the Sustainable Growth Rate (SGR) formula, thereby reducing the need for Congress to find budget offsets.

The first proposal is to apply $1.35 billion in the Physician Assistance and Quality Initiative Fund authorized to be expended in 2008 to the 2008 update. The 2006 legislation which created the fund makes this fund available to the Secretary of HHS "for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the conversion factor…", and MedPAC has recommended that the $1.35 billion "be directed entirely toward a conversion factor update for 2008."

Part B covered drugs have been included in the SGR since 1996 and have increased from 4% of the SGR target to 9% since that time. While spending on professional services per enrollee increased 6%, spending on Part B drugs grew 18%. The coalition proposes that these costs be removed retroactively to 1996 from the SGR.

The Medicare Economic Index (MEI), which is used to measure increases in practice costs for physicians, includes an automatic reduction for presumed increases in productivity. The reduction for 2008 is set at 1.45 percentage points, more than twice the 0.65 percentage points proposed reduction for other services. Adjusting the MEI by only 0.65 would reduce needed cuts.

CMS has issued more than 100 national coverage determinations that have had a significant impact on spending growth. CMS has not adjusted the SGR to reflect their actions despite the fact that some have significantly expanded coverage and added millions of dollars in spending under the SGR each year. The medical community has proposed that CMS exclude services affected by national coverage determination from SGR calculations for a period of at least two years. By excluding them for some initial time period, CMS will be able to use actual experience with the services as a basis for adding their spending to the SGR in the third or subsequent years of coverage.

All of these recommendations for policy changes under CMS' control were included in a letter to CMS Administrator Leslie Norwalk in April of this year. At the same time, intense negotiations and lobbying continue in Congress as a series of proposals have been put forward to address the impending physician payment cuts.

Physicians can learn more about the issues surrounding Medicare physician payment rates by visiting the AMA website at www.ama-assn.org and selecting "Medicare Physician Payment" under the Health Care Advocacy Agenda. The AMA Medicare Physician Payment Action Kit, which can be accessed from this site, includes additional background information about the payment formula and the impact of proposed cuts as well as a flier that physicians can download to distribute to their Medicare patients urging them to contact their members of Congress.

Physicians are also being urged to contact their U.S. senators and representatives as Congress considers proposals to address the Medicare payment issue. Physicians can easily find out who their legislators are and contact them by calling the AMA's Grassroots Hotline at 1-800-833-6354 or through the link on the DMS website—www.denvermedsociety.org.

***Denver Medical Bulletin**: Johnny E. Johnson, Jr., MD, DMS President and Publisher / Alan Y. Synn, MD, Chair of the Board / Nora E. Morgenstern, MD, President Elect / Randall M. Clark, MD, Treasurer / Kathy Lindquist-Kleissler, Executive Director / Barbara Kamerling, Program Director. The **Bulletin** is the official publication of the Denver Medical Society, established April 11, 1871, as the first medical society in the Rocky Mountain West. Published articles represent the opinions of the authors and do not necessarily represent the official policy of the Denver Medical Society. All correspondence concerning editorial content, news items, advertising and subscriptions should be sent to: The Editor, **Denver Medical Bulletin**, 1850 Williams Street, Denver, CO 80218. Phone (303) 377-1850. Fax (303) 331-9839. Web www.denvermedsociety.org. Email: dms@denvermedsociety.org. Postmaster: Send address changes to 1850 Williams Street.*

DMS Community Education Award

Each year at its annual meeting, the Denver Medical Society awards the DMS Community Education Award to a Denver organization which has undertaken a program focusing on a significant health issue that has resulted in improved public awareness and/or understanding. Past recipients have included groups such as the Colorado Domestic Violence Coalition, KUSA Breast Cancer Buddy Program, the Denver Smoke-Free Initiative, and the Kaiser Permanente Educational Theatre Program.

We would like to invite you to nominate an organization or program for this year's award which will be presented at the November 9, 2007, DMS Annual Meeting to be held at Palettes at the Denver Art Museum. The physician who nominates the winning recipient will be invited to attend the Annual Meeting with their guest.

Below are the award criteria. Nominations must be received by DMS by August 31. All nominations will be reviewed by the DMS Board of Directors, who will base their selection on the organization which best meets the award criteria. To submit a nomination please complete the form below and fax (303-331-9839) or mail (1850 Williams St., Denver, 80218) to DMS by August 31.

The criteria for the award are:

- Nominee has undertaken, in the past year, a program focusing on a significant health issue impacting the Denver Community which resulted in improved public awareness and/or understanding.
- Nominee's program was intended as a public service educational effort and was not for the purpose of selling or promoting a product or service.
- To the extent possible, nominee has attempted to evaluate the impact of their program on public awareness or behavior.
- Nominee's program relied on sound scientific and medical knowledge and presented a balanced, informed view of the subject issue.

For questions or further information, please contact Kathy Lindquist-Kleissler, DMS Executive Director, at 303-377-1850 or dms@denvermedsociety.org.

I would like to nominate the following program/organization for the
DMS Community Education Award.

Program/Organization_____

Contact:_____

Brief Description of Program's focus and fit with award criteria:

_____
_____
_____
_____
_____
_____

Name of Nominating Physician:_____
Phone:_____

PANDEMIC INFLUENZA PLANNING GUIDANCE

The following information comes from an article published by the Office of the U.S. Surgeon General.

Planning for pandemic influenza is critical. The following guidance identifies important, specific activities that can be done now to prepare for such an event. Many activities are specific to pandemic influenza, but a number also pertain to any public health or other emergency. This guidance is adapted from the *State and Local Pandemic Influenza Planning Checklist* developed by HHS and found on the federal government's pandemic influenza website (www.pandemicflu.gov). It also includes relevant elements from the *Business Pandemic Influenza Planning Checklist* and *Faith-Based & Community Organizations Pandemic Influenza Preparedness Checklist*, also from HHS and available at the aforementioned website.

This guidance is not intended to set forth mandatory requirements for you or anyone. Many of the actions listed below may not be applicable to all. You should engage in pandemic influenza planning and response actions which are within your purview, scope, training and capabilities.

What is an influenza pandemic?

A pandemic is a global disease outbreak. An influenza pandemic occurs when a new influenza virus emerges for which there is little or no immunity in the human population. The disease spreads easily person-to-person, causes serious illness, and can sweep across the country and around the world.

Historically, the 20th century saw three influenza pandemics:

- 1918 influenza pandemic caused at least 500,000 U.S. deaths and up to 40 million deaths worldwide.
- 1957 influenza pandemic caused at least 70,000 U.S. deaths and 1-2 million deaths worldwide.
- 1968 influenza pandemic caused about 34,000 U.S. deaths and 700,000 deaths worldwide.

Characteristics and challenges of a pandemic:

- *Rapid Worldwide Spread*
    - When a pandemic influenza virus emerges, its global spread is considered inevitable.
    - Preparedness activities should assume that the entire world population would be susceptible.
    - Countries might, through measures such as border closures and travel restrictions, delay arrival of the virus, but cannot stop it.
- *Health Care Systems Overloaded*
    - Most people have little or no immunity to a pandemic virus. Infection and illness rates may soar. A substantial percentage of the world's population will likely require some form of medical care.
    - Nations are unlikely to have the staff, facilities, equipment and hospital beds needed to cope with large numbers of people who suddenly fall ill.
    - Death rates may be high, and may be largely determined by four factors: (1) the number of people who become infected; (2) the virulence of the virus; (3) the underlying characteristics and vulnerability of affected populations; and (4) the degree of effectiveness of preventive measures.
    - Past pandemics have spread globally in two and sometimes three waves.
- *Medical Supplies Inadequate*
    - The need for vaccine is likely to outstrip supply.
    - The supply of antiviral drugs is also likely to be inadequate early in a pandemic.
    - A pandemic can create a shortage of hospital beds, ventilators and other supplies. Surge capacity at non-traditional sites such as schools may be created to cope with demand.
    - Difficult decisions will need to be made regarding who gets antiviral drugs and vaccines.
- *Economic and Social Disruption*
    - Travel bans, closings of schools and businesses, and cancellations of events could have major impact on communities and citizens.
    - Care for sick family members and fear of exposure can result in significant worker absenteeism.
- *Communications and Information are Critical Components of Pandemic Response*
    - Education and outreach are critical to preparing for a pandemic.
    - Understanding what a pandemic is, what needs to be done at all levels to prepare for pandemic influenza, and what could happen during a pandemic helps us make informed decisions, both as individuals and as a nation.

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Pan Flu Planning Guidance

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- Should a pandemic occur, the public must be able to depend on its government to provide scientifically sound public health information quickly, openly, and dependably.

Why is there such concern now?

Health professionals are concerned that the continued and expanded spread of a highly pathogenic avian H5N1 virus across eastern Asia and other countries represents a significant threat. The H5N1 virus has raised concerns about a potential human pandemic because:

- It is especially virulent.
- It is being spread by migratory birds.
- It can be transmitted from birds to mammals and in some limited circumstances to humans.
- Like other influenza viruses, it continues to evolve.

Since 2003, a growing number of human H5N1 cases have been reported in Azerbaijan, Cambodia, China, Egypt, Indonesia, Iraq, Thailand, Turkey and Vietnam. More than half of the people infected with the H5N1 virus have died. Most of these cases are believed to have been caused by exposure to infected poultry. The concern is the H5N1 will evolve into a virus capable of human-to-human transmission. In that likelihood, physicians may be asked to care for the sick, following strict public health protocols. That is why preparing the physician community is so essential.

As part of a contract between the Colorado Department of Public Health and Environment, CMS and DMS are working to educate and enable Colorado physicians to understand their role in preparing for pandemic flu or other disaster. DMS members will soon be receiving a CD containing a Physician Disaster Planning Tool Kit including information and resources to assist them in planning for their businesses, their families, and their community.

For those who would like to volunteer to respond to a disaster or emergency within Colorado, the Disaster Medical Assistance Team of Colorado (known as Colorado DMAT) has been contracted by the State to manage the Colorado Public Health and Medical Volunteer System (PHMVS). They will make training available so medical professionals are able to respond safely and effectively to any disaster. Call 303-286-7002 or go to http://covolunteers.state.co.us/. To keep abreast of all health alerts, you can sign up for the Denver Health Alert Network (HAN) by calling 303-436-5680 or by contacting Stephanie.stark@dhha.org.

2007 CMS Annual Meeting

Celebrate the Inauguration

of

DMS Past President David Downs, MD
Colorado Medical Society President

Participate in the Election

DMS member Robert Bogin, MD
is running for CMS President-Elect

Add Your Voice

September 7-9, Sheraton
Steamboat Springs

Contact DMS for
registration information. (303) 377-1850 or
dms@denvermedsociety.org.

NEW DENVER AREA MEDICAL OFFICE BUILDINGS

1 Eagle Bend Medical Plaza
- E-470 and Gartrell Road
- Aurora, CO
- 65,000 SF Class A MOB

2 Jordan Medical Plaza
- E-470 and Jordan Road
- Parker, CO
- 65,000 SF Class A MOB

3 Exempla Lutheran Medical Center Southwest
- C-470 and Bowles Avenue
- Littleton, CO
- 65,000 and 45,000 SF Class A MOB

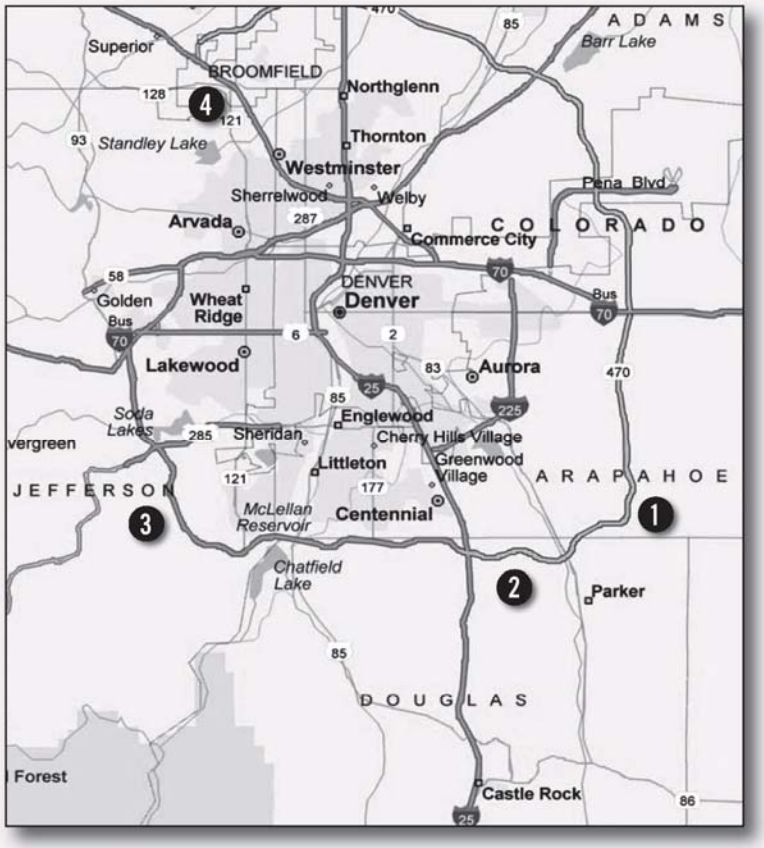
4 MainStreet Medical Plaza
- Highway 36 and Interlocken Loop
- Broomfield, CO
- 50,000 SF Class A MOB

Lauth offers four new strategic locations in the Denver Metro Area for the expansion or relocation of your medical practice, all of which benefit from:

- Strong area demographics
- Above average household income
- Market demand for medical services

As a fully integrated development and construction firm, Lauth's experienced Healthcare team offers:

- Feasibility and planning
- Site selection and acquisition
- Development and construction
- Marketing and leasing
- Ownership and financing
- Asset and property management



For leasing and project information:

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