

Medicare Minutes

Quality Improved in P4P Demonstration

According to the Centers for Medicare and Medicaid Services (CMS), all 10 physician groups who participated in a demonstration program to improve clinical management of diabetes patients in year 1 of the 3-year Medicare Physician Group Practice (PGP) program achieved benchmark or target performance on at least 7 of the 10 diabetes clinical quality measures. Two groups—Forsyth Medical Group and St. John’s Health System—met all 10 benchmarks and earned performance payments of \$7.3 million.

Physician groups transformed care by making lab results for diabetic patients available to physicians prior to patient encounters, preparing patients in advance for foot exams, educating patients about the importance of self-care techniques and their disease, and following up with patients between visits.

High-intensity Walking Beneficial for Seniors

According to a study published in the *Mayo Clinic Proceedings*, high-intensity walking is needed to keep blood pressure in check, maintain thigh muscle strength, and increase exercise capacity among older adults. Study participants interspersed short intervals of high-intensity walking with intervals at a lesser pace. For the full article, see: www.mayoclinicproceedings.com.

CMS Updates Part D Performance Measures

CMS has proposed new measures for its Medicare Part D performance metrics, including customer service, access to prescription drugs, and drug pricing and utilization—designed to increase trans-

parency of healthcare information. Customer-service measures include wait times and disconnect rates. Measures for access to prescription drugs include the rate of cases forwarded to independent review entities (IREs) the percentage of IRE confirmations of plans’ decisions, benefit complaints per 1000 enrolled beneficiaries, and enrollment/disrollment complaints per 1000 beneficiaries.

Consumer testing is underway, and a preview will be released to plans this fall. For more information, see: www.aishealth.com/Products/NewsPDN.html.

Increased Payments for SNF in 2008

Under new Medicare payment rates issued by CMS, Medicare payments for beneficiaries using skilled nursing facility (SNF) care to recover from serious health problems will increase by approximately \$690 million in fiscal year (FY) 2008. The new payment rates also continue to include a special adjustment to cover services required by SNF residents with HIV/AIDs. A full copy of the SNF PPS final rule is available at: www.cms.hhs.gov/snfpps/.

Impact of Medicare Part D on Kidney Failure Patients

Nearly 60% of patients with kidney failure have difficulty paying for medications while in the Medicare Part D coverage gap. Higher costs of medications for this illness send these patients to the donut hole faster, and many face significant problems accessing medications through their plan’s formulary and difficulties paying premiums or deductibles. The American Kidney Fund has developed a Medicare Part D Grant Program for Prescription Bone Disease Medications, open to eligible dialysis patients in the US. It offers up to \$2000 per year in Part D prescription assistance for the costs of bone disease medications frequently taken by dialysis patients. For such patients not currently in the coverage gap, the grants from the program can be applied to the patient share of the cost to obtain these medications. Complete eligibility requirements and applications are available at www.kidneyfund.org.

Identifying Part D–Covered Drugs

There are currently 1875 stand-alone Part D prescription drug plans across the country. According to authors of a recent article in *JAMA*, “Wide formulary variation can lead clinicians to inadvertently prescribe drugs that are not covered by insurance or that require a high copayment, increasing patients financial burden and decreasing medication adherence.” In an analysis of 72 formularies in California and Hawaii, the researchers found that coverage for 75 specific drugs ranged from 7% to 100% of formularies and averaged 69% across all drugs. Formulary coverage was highest for thiazide diuretics (90%) and beta-blockers (85%), followed by selective serotonin reuptake inhibitors (69%), calcium channel blockers (66%), angiotensin-converting enzyme (ACE) inhibitors (66%), statins (49%), and angiotensin-receptor blockers (ARBs; 39%). Less than half of drugs (45%) were widely covered. However, 7 of 8 treatment classes (excluding ARBs) had at least 1 widely covered drug. Nearly all widely covered drugs (94%) were generic drugs, and three-fourths of generic drugs (73%) were widely covered. The full article can be found at: <http://jama.ama-assn.org/content/vol297/issue23/index.dtl>.

AMA Campaigns to Ensure Equal Pay

Although pay cuts planned by Medicare to offset overspending in the federal program are double what has been proposed in the past 5 years, Congress, to date, has not addressed the issue in any legislation. The American Medical Association (AMA) contends that reimbursement for doctors is at the same rate as in 2001. The group advocates a 1.7% rise in reimbursement next year and has suggested that Congress find savings by paying Medicare Advantage plans (now reimbursed at a 12% higher rate) at the same rate as traditional fee-for-service Medicare plans.

CMS Increases Payments to Inpatient Rehab Facilities

Inpatient rehabilitation facilities (IRFs) will receive increased payments of about \$6.4 billion (3.2%) in FY 2008 under a rule that updates payment rates and mod-

ifies payment policies for services occurring between October 1, 2007, and September 30, 2008. The rule’s provisions are estimated to increase Medicare payments to approximately 1220 IRFs in FY 2008 by approximately \$150 million. Also increased is the high-cost outlier threshold to \$7362 from \$5534 in FY 2007, which will maintain estimated outlier payments at 3% of total payments under the IRF preferred provider system (PPS). Other rulings update the IRF PPS wage index, clarify criteria for short-stay transfers, and remove comorbidities in determination of the 75% rule used to classify a provider as an IRF. The ruling can be found at: www.cms.hhs.gov/apps/media/press_releases.asp.

Waiting for Medicare

A study reported in the *New England Journal of Medicine* found that adults with chronic illnesses who transition from being ineligible for Medicare to receiving Medicare benefits are hospitalized more often (20% increase) and have greater medical expenses (51% increase) than people who have had insurance. This increased use of healthcare resources continues until age 72. Adults who were 51 to 61 years of age in 1992 were followed to age 65 in 2004. Study participants either had private insurance or none at all before transitioning to Medicare. The surge in use of healthcare resources was most concentrated in those with cardiovascular disease or diabetes (2951 of the 5158 participants). Study authors noted that Medicare is taking the greatest hit when uninsured people, or those who are covered but neglect basic services because of out-of-pocket costs, wait to seek medical care until age 65. The full article is available at: <http://content.nejm.org/cgi/content/short/357/2/143>.

Important Notice About Vaccine Administrations in 2008

During 2007, while transitioning to a new Medicare policy on vaccine billing, providers were permitted to bill Part B for the administration of a Part D vaccine using a special G code (G0377). Effective January 1, 2008, physicians can no longer bill the G code to Part B; rather they must bill the patient for the vaccine and its administration, and the patient must then submit the claim to the Part D plan for reimbursement. For more information, see: www.cms.hhs.gov/MLN MattersArticles/downloads/SE0723.pdf. **MPM**