

Health Policy Update

Physician Payment 2008 for Interventionalists: Current State of Health Care Policy

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Physicians in the United States have been affected by significant changes in the pattern(s) of medical practice evolving over the last several decades. These changes include new measures to 1) curb increasing costs, 2) increase access to patient care, 3) improve quality of healthcare, and 4) pay for prescription drugs. Escalating healthcare costs have focused concerns about the financial solvency of Medicare and this in turn has fostered a renewed interest in the economic basis of interventional pain management practices. The provision and systemization of healthcare in North America and several European countries are difficult enterprises to manage irrespective of whether these provisions and systems are privatized (as in the United States) or nationalized or semi-nationalized (as in Great Britain, Canada, Australia and France). Consequently, while many management options have been put forth, none seem to be optimally geared toward affording healthcare as a maximized individual and social good, and none have been completely enacted.

The current physician fee schedule (released on July 12, 2007) includes a 9.9% cut in payment rate. Since the Medicare program was created in 1965, several methods have been used to determine physicians' rate(s) for each covered service. The sustained growth rate (SGR) system, established in 1998, has evoked negative consequences on physician payment(s). Based on the current Medicare expenditure index, practice expenses are projected to increase by 34.5% from 2002 to 2016, whereas, if actual practice inflation is considered, this increase will be 90%. This is in contrast to projected physician payment cuts that are depicted to be 51%. No doubt, this scenario will be devastating to many practices and the US medical community at large.

Resolutions to this problem have been offered by MedPAC, the Government Accountability Office, physician organizations, economists, and various other interested groups. In the past, temporary measures have been proposed (and sometimes implemented) to eliminate physician payment cuts. At present, the US Senate and House of Representatives are separately working on 2 different mechanisms to address and rectify these cost-payment discrepancies.

The effects of both the problem and the potential solutions on interventional pain management may be somewhat greater than those on other specialties. Physician payments in interventional pain management may evidence cuts of 10% to 15%, whereas if procedures are performed in an office setting, such cuts may range from 29% to 39% over the period of the next 3 years if the proposed 9.9% cut is not reversed. Medicare cuts also impact other insurance payments, incurring a "ripple effect" such that many insurers will seek to pay at or around the Medicare rate.

In this manuscript, we discuss universal healthcare systems, the CMS proposed ruling and its attendant ripple effect(s), historical aspects of the Medicare payment system, the Sustained Growth Rate system, and the potential consequences incurred by both proposed cuts and potential solutions to the discrepant cost-payment issue(s). As well, ethical issues of policy development upon the infrastructure and practice of interventional pain management are addressed.

Key words: Health policy, physician payment policy, physician fee schedule, Medicare, sustained growth rate formula, interventional pain management, regulatory reform, ethics

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Medical practice in the United States has dramatically changed over the last several decades. Such changes include new measures to 1) curb increasing costs, 2) increase access to patients, 3) improve the quality of healthcare, and 4) pay for prescription drugs. In the western world, and specifically in the United States, more and better quality technologies and drugs are available to prevent and manage chronic illness, and these improvements are expected to reduce overall morbidity and mortality. The recent movie "Sicko" by filmmaker Michael Moore attempts to explicitly show the deficiencies of the healthcare system in the United States (1,2). Beyond the somewhat misguided information and disingenuousness, "Sicko," does raise concern about healthcare quality in the United States – and such issues are a major regard of the public and legislators, as well as administrators and practitioners within the healthcare community. A 2007 Commonwealth Fund study compared principal means of access to healthcare, efficiency, equity and healthy living in the United States with 5 other nations – Australia, Canada, Germany, New Zealand, and the United Kingdom, and ranked the US health system last. In addition to increasing healthcare costs, the United States has over 45 million people who lack health insurance and an additional 40 million who are underinsured. A major focus is on the possibility of a 'universal healthcare', sometimes seen as a magic bullet. However, all countries with universal healthcare (or some modification of this system) are also in relative crisis.

For France, which was rated as number one in healthcare services, its taxes of 44% of the gross domestic product (compared with 26% in the United States) coupled with healthcare spending of \$3,500 per capita (one of the most costly in Europe) compared to \$6,100 in the United States, with an unemployment rate of 9%, compared to less than 5% unemployment in the United States are of major concern (3). By comparison, the United States spends a higher percentage of its gross domestic product on health related services than any other country – more than 16% in 2006 (compared to France's 10.7%). The French healthcare system has been rated the best in the world in 2001 not because of its economic sustainability, but because of its universal coverage, responsive healthcare providers, patient and provider freedoms, and the health and relative longevity of the country's population (3). However, there are less than apparent contradictions to these

statistics. The World Health Organization obtains the health-related information from respective ministries of health, but generally does not independently verify the provided statistics (3). Hence, while such statistics may superficially depict a positive healthcare environment, the fiscal infrastructure of the French medical system is less than 'healthy' (4,5).

Similarly, the Canadian and British healthcare systems have also been lauded and criticized (1,6). While sometimes viewed as an idealized iteration of universal access to care, the fuzzy economics of Canada's healthcare infrastructure has been criticized for leading to poor management of healthcare delivery in a geographically broad distributional system. The increased awareness of rationing of care, lack of innovation, and delays in accessing healthcare services caused by the Canadian system have led to a growing public (and physician) interest in developing other, more market-based options. Such a turn toward a market-model mentality may lead to local governments seeking some form of privatization in an attempt to mend economic woes, shrink long waiting lists for care, and provide better distributional equity of services. The British Health Care System also suffers similar maladies (1).

Clearly, neither governmental nor privatized approaches are uniformly effective in maximizing the potential and actual benefits of healthcare – as neither can work independently of the other. As the US public is all too well aware, the regulatory burden (of healthcare issues) on the US economy is sizable, and the health industry is often viewed as among the most heavily regulated sectors of the US economy, with incurred regulatory costs that may exceed \$1 trillion (7). Using a "bottom-up" approach, it is estimated that the total cost of health services regulation exceeds \$339 billion. This figure takes into account the regulation of health facilities, health professionals, health insurance, drugs and medical devices, and the medical tort system (7). Further, this approach allows for a reasonable calculation of some tangible "good(s)" of regulation, namely \$170 billion in provided healthcare benefits. From these figures, it can be seen that the costs of health services' regulation (\$169 billion) outweigh those of provided goods by 2 to 1, and these cost the average household over \$1,500 per year. Additionally, the high cost of health services regulation is responsible for more than 7 million Americans lacking health insurance (i.e., 1 in 6 of the average daily uninsured). Conover (7) contends

that the annual net cost of health services regulation dwarfs other costs imposed by government intervention in the healthcare sector, exceeding the annual consumer expenditures on gasoline and oil in the United States. These costs are twice that of the annual output of the motion picture and sound recording industries. Conover (7) proposes the need and possible venues for reducing or eliminating these excess costs, as being an urgent matter of policy that could be achieved through medical tort reform. Contending that such reforms offer the most promising target for regulatory costs savings, Conover (7) proposes equal consideration of FDA reform, selected access-oriented health insurance regulations (e.g. mandated health benefits), quality oriented health facilities, and revision of (accreditation and licensure) regulation.

Such reforms are estimated to save approximately 20% of the \$2 trillion healthcare budget and would represent an important step towards improving the system, practice and economics of healthcare in the United States. Escalating healthcare costs have prompted concerns about the financial solvency of Medicare. With a generation of baby boomers poised to enter retirement age, and a general "graying" of the US population, the trends in healthcare spending offer a grim picture of the future of the US healthcare system's viability. Considering the rapid growth in healthcare services, global increase of costs, and questionable economic stability incurred by increasing costs of these provisions, there is a renewed call for ways to combat cost escalation, while improving access to and quality of healthcare (8). Cost-effectiveness analyses of various technologies, drugs, modalities and interventions offer policy makers important means of allocating healthcare resources so as to best utilize modern medical care and maintain equitable access to these services (9). A recent evaluation showed that much of the spending growth is associated with the care of patients who are being medically managed for 5 or more conditions (10). This reflects 2 major issues: first, that modern medicine has increased survivability of a number of disorders leading to an increase in the prevalence and co-morbidities of chronic disease, and second that this may equally reveal changes in contemporary clinical treatment thresholds. This raises important questions about how each healthcare system might define the basis of disorders and use of treatment.

DÉJÀ Vu?

On February 28, 2007, Thomas Gustafson, Acting Director of the Center for Medicare Management, stated (in a letter to Glen M. Hackbarth, Chair of the Medicare Payment Advisory Commission {MedPAC}), that the physician fee schedule update for 2008 will be set under the statutory formula, resulting in a fee schedule of -5.1%. However, this update is to be applied to an extant 2007 conversion resulting in a combined change of -9.9% with an estimated fee schedule conversion factor of \$34.1350 (11).

On July 12, 2007, the Department of Health and Human Services, Centers for Medicare and Medicaid Services released a set of proposed revisions to payment policies under the physician fee schedule and other Part B payment policies for CY2008 (12). The proposal includes a 9.9% cut in the physician payment rate, however, the actual impact of these cuts will be variable, with minor or no cuts (or even increases) for evaluation and management services, an approximate 10% cut in physician fee for other services, and significantly higher cuts for office-based procedures. This proposed rule also discusses refinements to several other economic aspects of health care (e.g.- resource-based practice expense, practice expense relative value units (RVUs), geographic practice cost indexes (GPCI) changes, malpractice RVUs, several coding issues including additional codes from the 5-year review, payment for covered outpatient drugs and biologicals, performance standards for independent diagnostic testing facilities, changes for comprehensive outpatient rehabilitation facilities (CORFs), physician self-referral issues, durable medical equipment (DME) updates, a medical economic index data change, technical corrections, and issues of therapy services as related to physician practices). If Congress responds as in prior years, the 9.9% cut may be reversed based on a corrective formula that was previously proposed. Yet, long-term sequelae, issues, and problems caused by the cuts as planned through 2016 will continue to be unresolved.

BENEFITS TO INSURERS...A "RIPPLE EFFECT."

While Medicare has been struggling to balance the budget (often on the backs of physicians) by adding yearly increases to several sectors of the healthcare system (hospitals, nursing homes, and Medicare Advantage plans), as shown in Fig. 1, private insurers

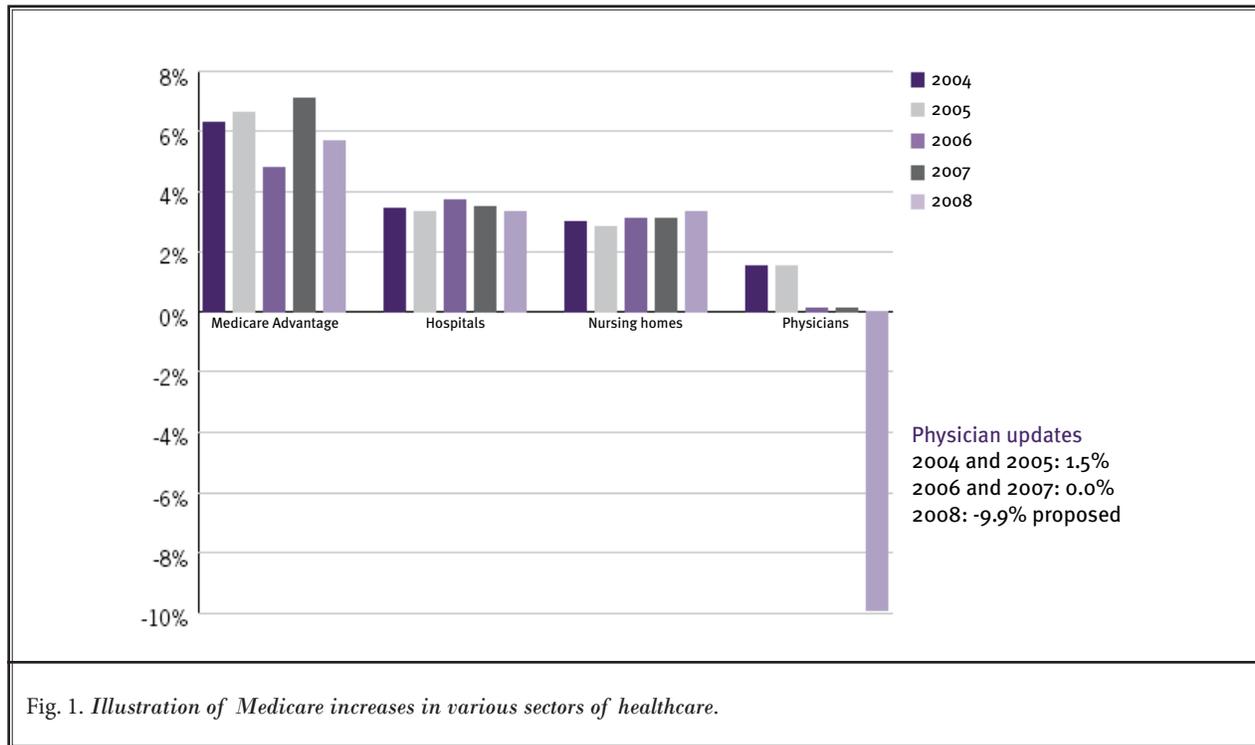


Fig. 1. Illustration of Medicare increases in various sectors of healthcare.

are reaping the benefits of double-digit yearly profit percentages, while maintaining increased percentages in premiums. Based on the CMS Office of the Actuary report, spending on physician services did not contribute to increases in healthcare costs as much as it has in the past (13). The 2006 rate of growth in physician expenditures – that is the percentage by which the total annual spending on physician services increased over the previous year – fell to its lowest point in 7 years. Approximately 21% (\$421.2 billion) of all US healthcare costs in 2005 were spent on physician and clinical services, reflecting an average growth in spending for physician and clinical services of 7.9% per year since 2000. Based on projections (14,15) and data from the CMS Office of the Actuary (13-15), approximately \$447 billion was spent on physician and clinical services in 2006 – just over 6% or approximately \$26 billion more than what was spent on these services in 2005. The primary cause for this is an unusual reduction in services provided by physicians. Investigating why price growth declined, CMS determined that many private health plans have been able to negotiate or enforce very low rates of reimbursement based on relatively stagnant Medicare payments. This is due to the ever-increasing problem of insurers using Medicare schedules as a benchmark

or even a ceiling in healthcare payment contract negotiations. According to Poisal "... private insurers have basically jumped on the coattails of Medicare." (16).

In addition, the utilization of physician services under Medicare is declining, suggesting that doctors are providing better quality care rather than simply providing more services. Thus, while concerns about increasing volume of physician services may be on the decline, a persistent caveat for monitoring healthcare economics remains in light of annual increases in physician expenditures that are outpacing the overall escalation in the costs associated with providing care. The CMS Office of the Actuary (13) projects a significant upswing in future expenses, as spending growth rates remain about two times the medical inflation rate. Even with reductions in physician fees, healthcare expenditures are expected to reach over \$4 trillion by 2016, entailing almost 20% of the gross domestic product (Table 1). Figure 2 illustrates this projected upswing in national healthcare expenditures, and depicts increases in both physician expenditures and total expenditures. Figure 3 illustrates the percent increases in total national health expenditures, hospital care, and physician and clinical services from 1993 and projected through 2016.

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Table 1. *National health expenditures (NHE), by source of funds, amounts, and average annual growth, calendar years 1993-2016*

Spending category	1993	2004	2005	2006 ^a	2007 ^a	2011 ^a	2016 ^a
NHE (billions)	\$912.6	\$1,858.9	\$1,987.7	\$2,122.5	\$2,262.3	\$2,966.4	\$4,136.9
Health services and supplies	853.2	1,738.9	1,860.9	1,987.7	2,188.9	2,778.1	3,869.9
Personal health care	773.6	1,551.3	1,661.4	1,769.2	1,885.3	2,472.6	3,449.4
Hospital care	317.2	566.9	611.6	651.8	697.5	922.3	1,287.8
Professional services	280.7	581.1	621.7	662.8	703.9	918.9	1,253.2
Physician and clinical services	201.2	393.7	421.2	447.0	474.2	612.9	819.9
Other prof. services	24.5	52.6	56.7	60.9	64.9	82.7	111.0
Dental services	38.9	81.5	86.6	92.8	98.6	125.5	163.4
Other PHC	16.2	53.3	57.2	62.0	66.2	97.9	159.0
Nursing home and home health	87.3	157.7	169.3	179.4	190.0	239.2	322.0
Home health care ^b	21.9	42.7	47.5	53.4	57.9	78.1	111.1
Nursing home care ^b	65.4	115.0	121.9	126.1	132.1	161.2	210.9
Retail outlet sales of medical products	88.4	245.5	258.8	275.2	293.9	392.1	586.4
Prescription drugs	51.0	189.7	200.7	213.7	229.5	317.5	497.5
Durable medical equipment	13.5	23.1	24.0	25.2	26.3	30.5	37.6
Nondurable medical products	23.9	32.8	34.1	36.3	38.0	44.1	51.3
Program admin. and net cost of private health insurance	52.8	135.2	143.0	156.8	167.4	217.9	295.7
Government public health activities	26.8	52.5	56.6	61.7	66.2	87.6	124.8
Investment	59.3	119.9	126.8	134.8	143.4	188.3	267.0
Research ^c	16.4	38.3	40.0	41.7	43.9	55.5	75.0
Structures and equipment	42.9	81.7	86.8	93.1	99.5	132.8	191.9
NHE per capita	\$3,468.6	\$6,321.9	\$6,697.1	\$7,092.0	\$7,498.0	\$9,525.0	\$12,782.2
Population (millions)	263.1	294.0	296.8	299.3	301.7	311.4	323.6
GDP, billions of dollars	\$6,657.4	\$11,712.5	\$12,455.8	\$13,253.0	\$13,955.4	\$16,962.8	\$21,138.7
Real NHE ^d	\$1,032.4	\$1,698.7	\$1,763.0	\$1,827.7	\$1,900.7	\$2,266.6	\$2,807.5
Chain-weighted GDP index	0.88	1.09	1.13	1.16	1.19	1.31	1.47
PHC deflator	0.81	1.16	1.20	1.24	1.29	1.50	1.84
NHE as percent of GDP	13.7%	15.9%	16.0%	16.0%	16.2%	17.5%	19.6%

Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and U.S. Department of Commerce, Bureau of Economic Analysis and Bureau of the Census.

Notes: Numbers might not add to totals because of rounding. 1993 marks the beginning of the shift to managed care.

a Projected.

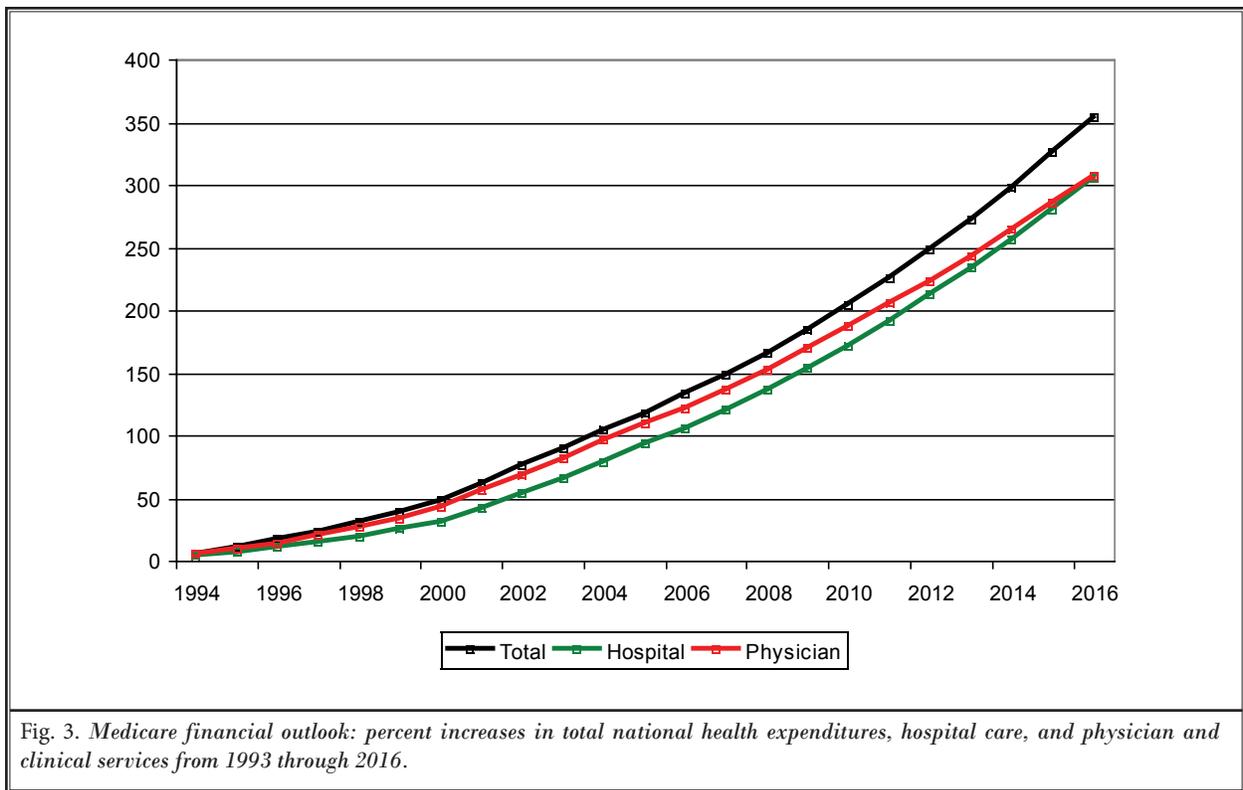
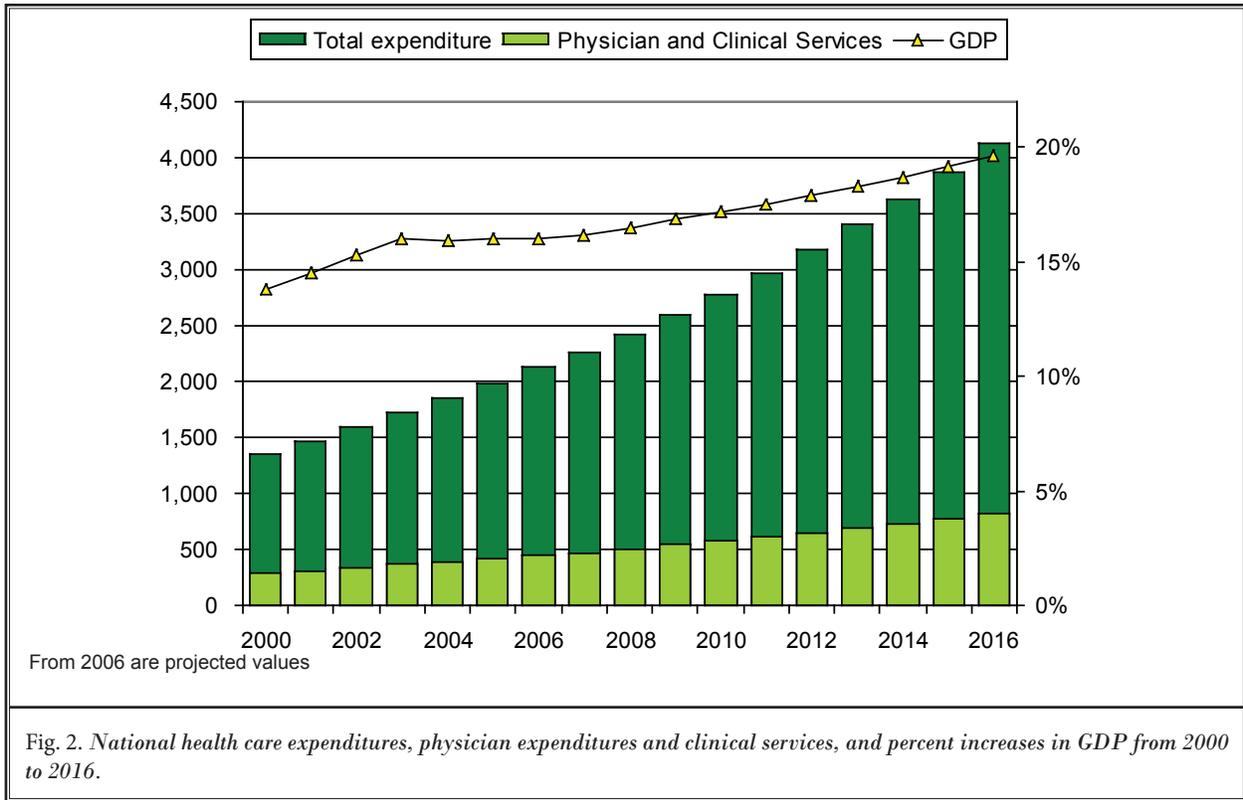
b Freestanding facilities only. Additional services are provided in hospital-based facilities and counted as hospital care.

c Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from “research expenditures” but are included in the expenditure class in which the product falls.

d Deflated using GDP chain-type price index (2000 = 100.0).

e Personal health care (PHC) chain-type index is constructed from the producer price index for hospital care, nursing home input price index for nursing home care, and consumer price indices specific to each remaining PHC component (2000 = 100.0).

Source: Ref. (15)



HOW DID WE GET HERE?

Since the inception of the Medicare program in 1965, several methods have been used to determine amounts paid to physicians for each covered service. Initially, payment systems compensated physicians on the basis of their charges, and allowed physicians to balance bill beneficiaries for the full amount above what Medicare paid for each service. While these were considered to be the “golden years” by physicians practicing in the 1960s, this halcyon era was short lived, as in 1975 — just 10 years after the inception of Medicare program — payments changed so as not to exceed the increase in the Medicare Economic Index (MEI). Nevertheless, policy failed to curb increases in costs. Consequently, from 1984 through 1991 the yearly change in fees was determined by legislation (17). In 1992, the fee schedule essentially replaced the prior payment system (that was based on physicians’ charges). Finally, after multiple attempts at modification, the system was replaced by a new mechanism — the sustainable growth rate system (SGR) in 1998.

THE SUSTAINABLE GROWTH RATE FORMULA

The sustainable growth rate formula (SGR) controls spending for physicians’ services provided under Part B of Medicare. The goals of the SGR are to 1) ensure adequate access to physician services, 2) control federal spending for those services, so as to 3) result in a predictable spending pattern.

Statistical analyses reveal that spending-per-beneficiary on services paid under the physician fee schedule grew by 65% (about 6.5% per year) from 1997 through 2005, in contrast to per-beneficiary spending in other Medicare categories, which increased by about 35% during the same period (18). The majority of the spending growth within the fee schedule was attributed to increases in both the fees themselves, and in the volume and intensity of services. While the average increase in Part B enrollment has been estimated to be 1% annually since 1997, the volume and intensity of services utilized have increased at an average of about 4.5% per year from 1997 through 2006, and are expected to show a similar pattern through 2016.

The mechanism of the SGR includes 3 components that are incorporated into a statutory formula:

- ◆ Expenditure targets, which are established by applying a growth rate (calculated by formula) to spending during a base period
- ◆ The growth rate
- ◆ Annual adjustments to payment rates for physicians’ services, which are designed to bring spending in line with expenditure targets over time.

The fee schedule also is tripartite, consisting of:

- ◆ the relative value for the services,
- ◆ a geographic adjustment,
- ◆ a national dollar conversion factor.

The relative value is also based on 3 components — physician work, practice expense, and malpractice expense — that are used to determine a value ranking for each service to which it is applied. This is used to compare the value of one service to another, thereby establishing the resource-based relative value scale (RBRVS) (18,19). On average, the work component represents 52.5% of a service’s relative value, the practice expense component represents 43.6%, and the malpractice component represents 3.9% (20).

As previously discussed, the volume and intensity of services have increased on average about 4.5% per year from 1997 through 2006. Since 2002, spending (as measured by the SGR method) has consistently been above the targets established by the formula (21-23). Figure 4 depicts changes in volume and intensity of total Medicare physician services from 1980 to 2006. Based on Congressional Budget Office (CBO) projections, Medicare spending for physicians services will increase in the coming years, but by 2012 it will be only 13% higher than it was in 2005, reflecting an average annual growth rate of less than 2%. Figure 5 illustrates SGR spending as compared to expenditure targets (24-28). Under the SGR mechanism, the adjustment factor applies only to the physician fee schedule, and not to payment rates for incident-to-services, which comprise about 15% of spending within the SGR targets (26). Many other services contribute to growth in spending such as national coverage policies, preventative services, advances in technology and drug therapy. Many other services which are not taken into consideration include increased patient needs and awareness, regulatory burden, pay for performance, accreditation, Health Insurance Portability and Accountability Act (HIPAA), and numerous other factors.

MedPAC (29) reported that since 2000, total Medicare spending for physician services has climbed more than 9% per year (Fig. 6). The Medicare trustees warn that even their unrealistically constrained estimate of Part B spending growth (due to multiple years of fee reductions mandated under current law) will still significantly outpace growth in the US economy. From 1999 to 2002, the Part B premiums also grew by an average of 5.8% per year, but the cost of living increases for social security benefits averaged only 2.5% per year, whereas, since 2002, the Part B premium has increased by 13.5% in 2004, 17.3% in 2005, and 13.2% in 2006.

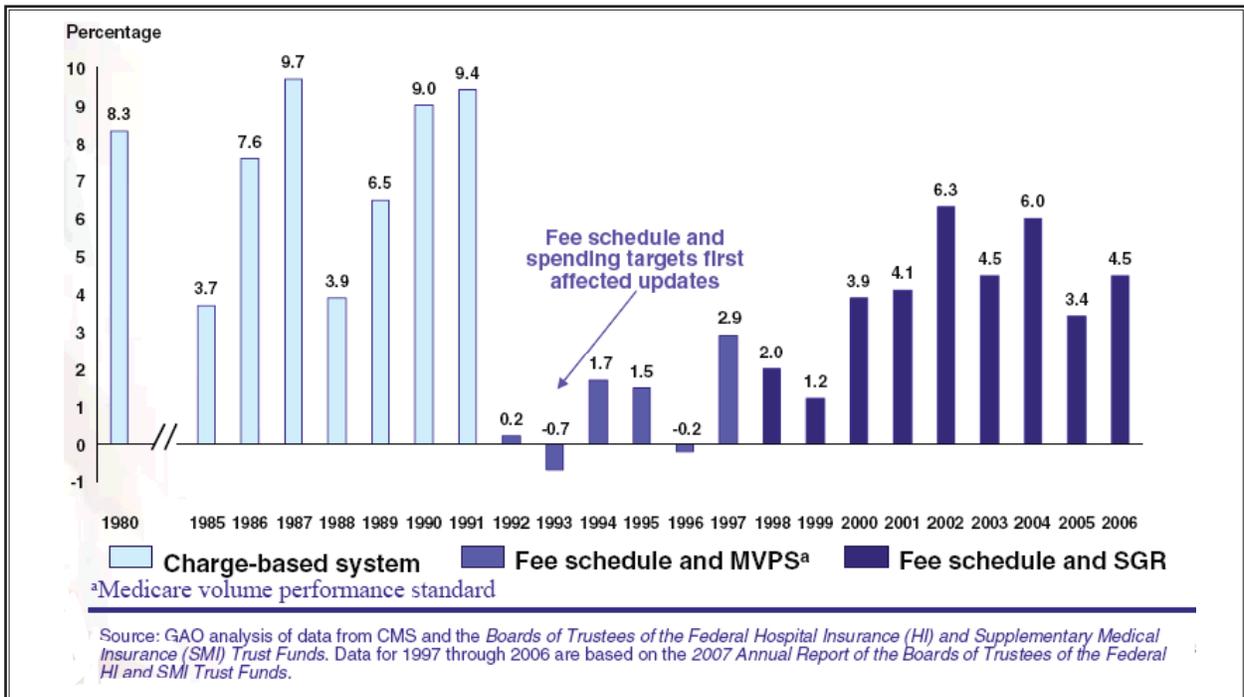


Fig. 4. Changes in volume and intensity of total Medicare physician services. 1980 to 2006.
Source: Ref. (21)

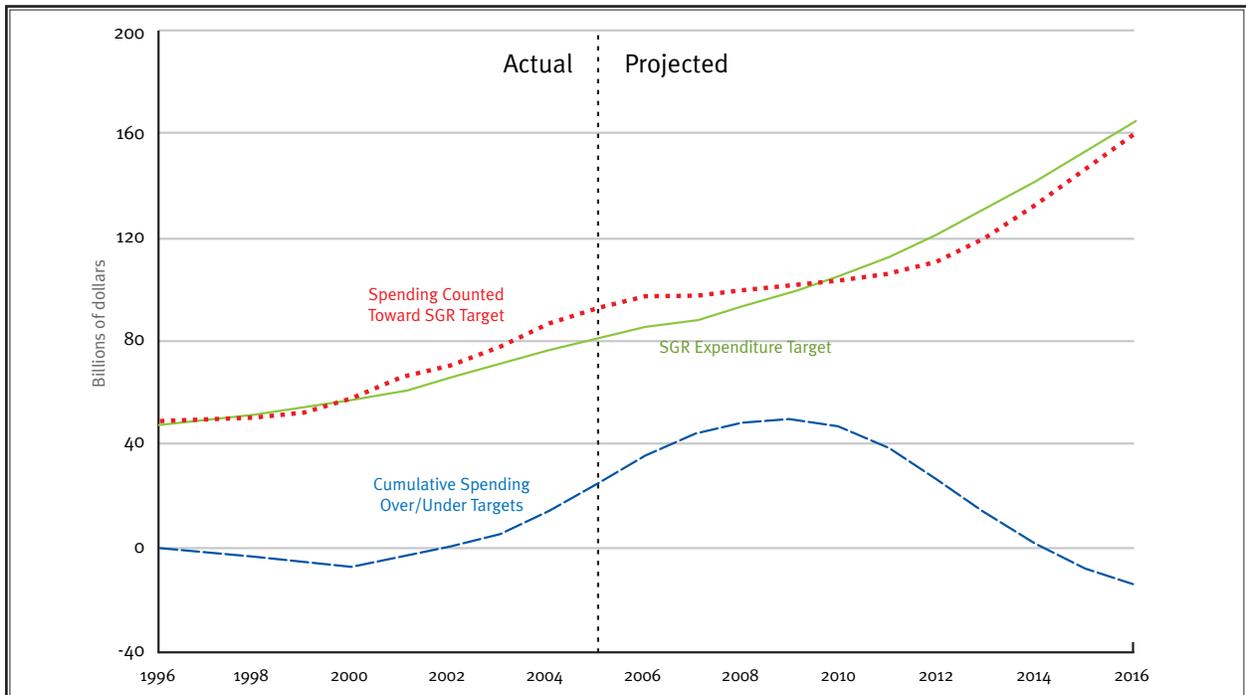


Fig. 5. Sustainable growth rate spending compared with expenditure targets.
Source: Refs. (24,27,28)

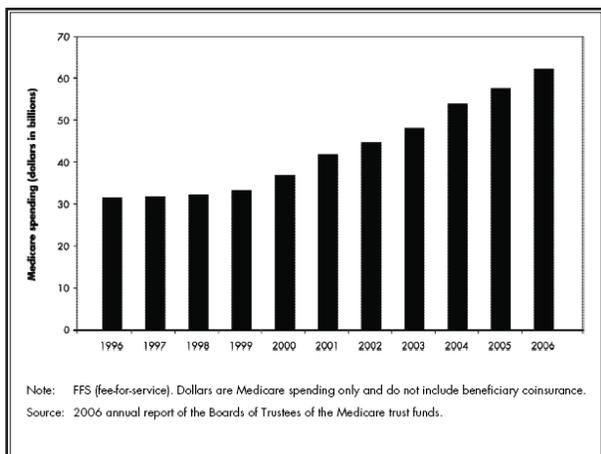


Fig. 6. FFS Medicare spending for physician services, 1996–2006.

THE CONSEQUENCES OF SGR

SGR reductions in payment rates for physician services resulted in a cut of 4.8% in 2002, with CMS deciding on sustained cuts of 4.4% in 2003 and beyond. In 2003, Congress responded by increasing payments for physician services by 1.6% instead of the projected 4.4% cut (30). In 2004 and 2005, the Medicare Modernization Act replaced the scheduled rate reduction with an increase of 1.5%. In 2006, the Deficit Reduction Act (DRA) held 2006 payment rates at their 2005 level, overriding an impending 4.4% reduction (31). In

2007, Congress again approved holding the 2007 payments at the 2005 level, thereby avoiding a proposed 5.1% reduction (32).

Legislative activity affecting the SGR produced Medicare Part B benefit growth. Due to legislative language specifying that increases in the payment rates should not be considered a change in law or regulation for purposes of determining the expenditure target, the gap between cumulative spending and the cumulative target became larger than it would have been otherwise. Under current SGR rules, growth in spending occurring as a result of those rate increases will eventually be recouped by future adjustments to payment rates.

Figure 7 shows that on the MEI, practice expenses will increase by 34.5% from 2001 to 2016; however, considering 1) the actual practice inflation with mounting healthcare costs to cover employees and families with double-digit percentage increases each year, 2) increasing shortages of nursing and medical professionals, 3) the costs of employment and 4) other inflation costs, the actual medical inflation and costs of conducting medical practice have been estimated to increase approximately 5-10% each year (with a total increase of practice costs of 90% by 2016). Unless the current law changes and the SGR formula is substantially revised, physicians will see payment cuts of 51% by 2016. This will be devastating to both many private practices, and the US medical community at large.

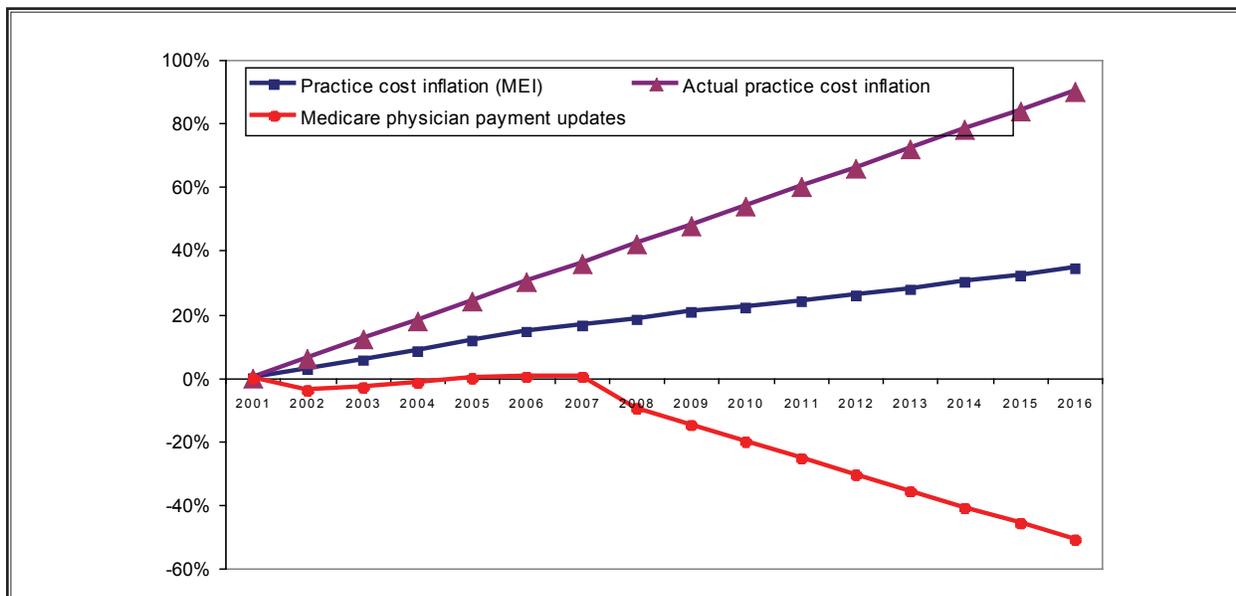


Fig. 7. Comparison of increase in practice costs and proposed Medicare cuts

THE EFFECT(S) OF 2006 CHANGES

On December 1, 2006, CMS published a Medicare physician fee schedule that allegedly would improve the accuracy of payments to physicians for services furnished to Medicare beneficiaries (25). This rule changed the entire landscape of the physician payment system, with increases for evaluation and management "services" (i.e., time and effort that physicians spend evaluating patients' condition and advising and assisting patients in managing their health), while at the same time reducing payments for procedural services, specifically the office component of the practice expenses.

This 'bottom-up' methodology based the direct proportion of the practice expense relative value units (PERVUs) on actual direct costs inputs, with the aim of producing more accurate, intuitive, and stable PERVUs. However, the data sources used to calculate resource-based PERVUs were flawed in many ways that were similar to the SGR formula (except for the congressional action eliminating 2007 cuts). Even CMS expressed concern that when combined with a proposed negative factor for CY2007 and the changes to the work – RVUs under the 5-year review, the shifts in the PERVUs that would result from the immediate implementation of their proposal could potentially disrupt many (if not most) medical practices. Therefore, CMS proposed to more gradually implement practice expense (PE) changes over a 4-year period. While these changes have negatively impacted office based practices, they have also provided some opportunity for CMS, physicians, and the RUC to identify problems in the PE data, and to make revisions in fiscal restructuring for 2008 and beyond. This also allowed an opportunity to collect additional data as needed prior and pursuant to the full implementation of any actual PE changes.

Since early 2007, CMS has been using new methods to calculate direct and indirect PE value units (RVUs), essentially incorporating the same approach used to calculate PERVUs for services that do and do not involve physician work (25). In addition, CMS adopted significant changes to physician work RVUs which affect both the physician work, and PE components of the fee schedule. Collectively, these changes represent the largest revision to the methods and data used to calculate PERVUs since CMS implemented resource-based PE payments in 1999 (25).

When fully implemented in 2010, these new methods (and data) will result in a 7% increase of PERVUs

for evaluation and management services, and a 3% increase of PERVUs for other (non-major) procedures and tests. In contrast, PERVUs for minor procedures, including interventional techniques, will decrease by 8%, and will decrease by 9% for imaging services.

TOWARD POTENTIAL SOLUTIONS

Numerous solutions to these economic problems have been advocated by MedPAC, the GAO, physician organizations, economists, and various other interested groups. MedPAC submitted a report to Congress in March 2007 assessing alternatives to the sustainable growth rate system (29). The Deficit Reduction Act of 2005 (31) required MedPAC to examine alternative mechanisms for controlling physician expenditures under Medicare. MedPAC reported that Medicare would need to change the incentives of the payment system by 1) ensuring that prices are accurate, 2) furnishing information to providers about practice (scope and style) parameters, 3) encouraging coordination and provision of primary care, and 4) aggregating and packaging services to reduce overuse. Further, MedPAC recommended that Medicare should promote quality by 1) instituting pay-for-performance, 2) encouraging the use of comparative-effectiveness information, and (where appropriate), 3) imposing standards for providers to meet as a condition for payment. MedPAC also recommended that if Medicare's fee-for-service program is to function (more) efficiently, Congress would need to provide CMS with the necessary time, financial resources, and administrative flexibility to oversee such program-wide monitoring. Finally, it became clear that CMS will need to make substantive investments in information systems, develop, update, and improve payment systems, enhance measures of quality and resources use, and contract for specialized services.

To affect positive change and maintain sustainability of system-wide stability, MedPAC offered two alternative paths for Congress to consider. The first would repeal the SGR, and no new system of expenditure targets would be implemented. Instead, Congress would accelerate development and adoption of approaches for improving incentives for physicians and other providers to furnish lower costs and higher quality care. To increase the value of Medicare in this manner would require:

- ◆ Changing the payment incentives.
- ◆ Collecting and disseminating information.
- ◆ Redoubling efforts to identify and prevent misuse, fraud, and abuse.

The second path would pursue the approaches outlined above, but would also include a new system of expenditure targets, as shown in Fig. 8 (29). MedPAC reported that if Congress were to determine that a target is necessary to ensure restraint on fee increases, such a target should embody core principles, ensuring that it would:

- ◆ encompass all of fee-for-service Medicare,
- ◆ apply the most focus in the parts of the country where service use is highest,
- ◆ establish opportunities for providers to share savings from improved efficiency,
- ◆ reward efficient care in all forms of physician practice organization,
- ◆ provide feedback using the best tools available in collaboration with private payors.

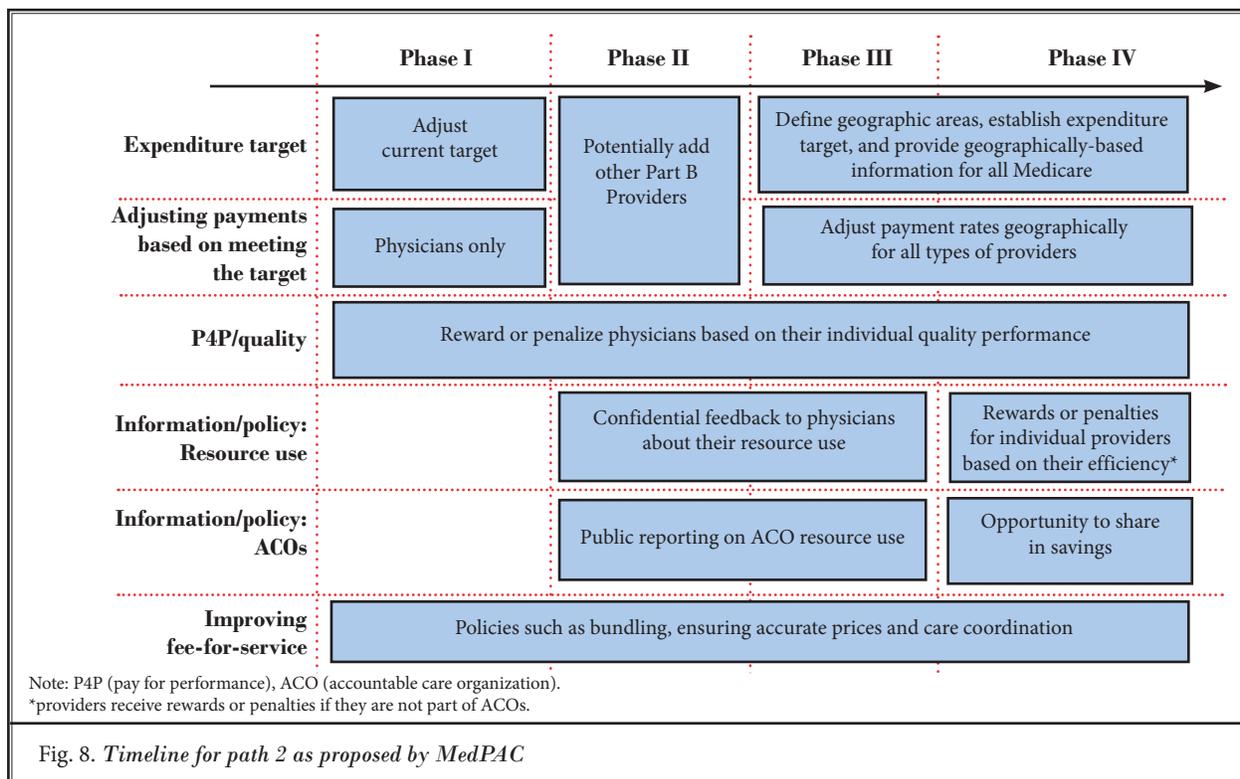
MedPAC has recommended that expenditure targets should not be borne solely by physicians. Rather, such targets should apply to all providers, so as to encourage different providers to collaborate to keep costs as low as possible, while increasing quality. This provision for collaboration would include physicians, hospitals, nursing homes, etc.

However, MedPAC has failed to consider the bureaucratic impact of Congress and CMS, and the in-

creasing pressures on physician practices, beneficiary demand for services, national coverage policies, mandated preventive services and early reports of failure of pay-for-performance.

The Congressional Budget Office has projected budget implications of change in the SGR mechanism (27,28) with 3 options from a minimum of \$31 billion and maximum of \$218 billion from 2007 to 2016.

The impending Congressional alternatives tend to be short-term. An example is the highly partisan State Children’s Health Insurance Program (SCHIP) legislation in the House of Representatives which while correcting the formula for 2 years, may also incur benefit to insurance companies which could result in tax increases and potentially invite a Presidential veto (33). At present, the US House of Representatives does not have a veto-proof majority when passing such a bill. The Senate has not incorporated physician payment into their SCHIP Bill, thus, physician payment reform could be removed from the House SCHIP Bill, and a separate physician payment reform bill may be introduced. Political pundits estimate something of a positive result arising from such a 2-year fix of SGR, rather than a permanent system-wide durable solution to these economic problems.



THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Enacted in 1997, SCHIP was one of two federal laws (the Health Insurance Portability and Accountability Act of 1996, or HIPAA, being the other) that were passed in the wake of the 1994 failure of national health reform, and which signaled an important and renewed effort by a Congress and President of different parties to find common ground in advancing US health policy (33-35). The purpose of SCHIP was to expand health insurance coverage for uninsured, targeted "low-income" children (i.e., children in families with incomes of no more than twice the federal poverty level, or 50 percentage points higher than the states medicaid eligibility level, whichever is higher (33). SCHIP is a law which in theory offers a restricted but classic illustration of how competing visions and values might be reconciled into policy that attempts to accommodate all sides in the debate over the proper role of level entitlements, federalism, and markets in US health policy. Whether applied toward a Medicaid expansion, a separate program, or both, the federal SCHIP allotment has proven to be simultaneously generous and restrictive. While it is generous in providing federal financial aid that is much higher than states' regular federal medicaid assistance rate, the allocations are also limited by a national aggregate cap unrelated to either the actual number of children who need assistance, or changes in healthcare costs.

SCHIP has had a major impact on coverage that extends well beyond its modest size because of its power to identify and enroll children that are eligible for a states' underlying Medicaid program. In 2006, the federal SCHIP program financed healthcare for approximately 6.6 million children (33). Despite welfare reform enacted between 1997 and 2004, enrollment in Medicaid and SCHIP programs increased from 21 million to 34 million [including more than 1 million parents (33)]. SCHIP can be seen as a hybrid source of funding for health coverage that has forged a path to allow states to bypass the political and social tensions that have seemingly plagued Medicaid since its enactment some 40 years ago. However, SCHIP is not without limitations. Some criticize its benefits as short-term in both vision and effect(s).

The DRA (31) altered Medicaid rules for children with disabilities, and also made other changes in the structure of Medicaid payment(s) for children. While important, the DRA does not uniformly affect all uninsured people, and there is a growing demand for bet-

ter coverage given that the health insurance picture appears worse today (for both children and adults) in absolute numbers than it did a decade ago. However, the proportion of uninsured as a percentage of the population was 14% in 1999 and 15.3% in 2005. The number of persons without insurance has risen from 38.8 million to 44.8 million during the 6-year period of 1999 to 2005 (36). This escalation was due, at least in part, to an increase in non-insured children who "fell through the cracks" when Medicaid and SCHIP failed to replace lost private coverage (37). As of 2006, federal statistics revealed that there are more than 10 million uninsured young adults in the US, at an astonishing uninsured rate of 33.2% (33). These numbers can propel more aggressive state actions toward generating reforms aimed at providing affordable insurance coverage to a more inclusive population of children and adults, regardless of age, condition, or income (38,39).

A recent study (38) reported that if Medicaid and SCHIP simply retained all the children who are enrolled (and have no alternate coverage in a given year), the number of uninsured children in the United States would fall by one-third. However, the data also suggest that if anything, the study underestimates the extent of dropout as a cause of un-insurance among children. As well, this problem may also reflect problems with citizenship documentation required for Medicaid renewal (i.e., inaccurate accounting and provision of Medicaid for illegal immigrants). However, on the whole, it appears that uninsured children who are eligible for SCHIP and Medicaid are not being appropriately enrolled.

The new SCHIP regulations that were introduced in the Senate (40) and House (41) are different; proponents claim that these regulations provide for much needed coverage, whereas opponents posit that these regulations are actually a benefit for insurers as they can drop patients' coverage and advise them to join SCHIP based on eligibility requirements for a family of 4 earning as much as \$82,000 per year. Consequently, both the House and Senate bills are facing a strong probability of Presidential veto, thereby resulting in a re-evaluation, re-drafting and re-introduction of the entire process. It has also been claimed that the SCHIP legislation now being debated in Congress bears an uncanny resemblance to the fall-back strategy of Hillary Clinton's ill-fated healthcare task force, similar to HIPAA. With an estimated cost of \$35 to \$75 billion, costing each family as much as \$847 next year on aver-

age, opponents claim that SCHIP represents the latest effort to move towards a more socialized medicine. Regardless of these claims, the reality is the SCHIP will most likely not succeed, and that any fix – short or long term – to the current policies regulating health-care insurance remains elusive.

THE IMPACT OF STARK III RULES

The proposed CMS rules for physician fee schedule also expanded the Stark regulations. Many of the proposed changes augment restrictions (12). Some of the more contentious issues include anti-markup rules, in-office ancillary services under arrangements, percentage based compensation, burden-of-proof for services rendered, obstetrical malpractice insurance subsidy, per-click leases, etc.

Anti-markup rules pertain to several types of imaging services wherein a physician can not purchase an image or an MRI and resell it to Medicare or Medicaid and profit from such a resale. Proposed regulations extend the current policy which applies only to the purchase of technical components of an imaging service such that new CMS regulations would subject the professional component of a purchase to the anti-markup rule as well. However, the anti-markup provision would not apply to the professional component of tests ordered by independent labs. In addition, CMS is also soliciting opinions as to whether it should apply the anti-markup rule(s) to technical components of any “centralized building” used by a practice pursuant to the in-office ancillary service exception to the Stark Act.

The original intent of the in-office ancillary services rule is being fortified through requirements of 1) a minimum size centralized building, 2) provision and assurance that all the equipment needed to perform the ancillary services is permanently located in the centralized building space and/or 3) that a group must have a full time employer or substantially full-time presence at the centralized building. Under-arrangements have been increasing significantly and are likely to continue to increase in the future.

CMS has stated that most of the existing under-arrangements, and per-click models would be deemed illegal under the new Stark III rules. The Stark Act previously defined “entity” as the person or group that presented the claim to Medicare, but not the person or entity actually performing the designated health service. This prompted physicians to have a financial relationship with the entity performing the service

(e.g., as a joint venture) but not with the entity billing for the service (such as a hospital). The proposed rules have expanded the definition of “entity” to include either the person or group that presented the claim to Medicare, or the person or entity actually performing the designated health service. Consequently, any type of relationship will invoke Stark Act prohibition(s).

Under the proposed rule, percentage-based compensations would also be subject to review and revocation. While percentage-based relationships may still be acceptable to determine payments for direct physician services, percentage-based payments would not be acceptable for other types of exceptions per the Stark Act. Consequently, percentage-based equipment and office space leases could be considered as potential program abuses, as would other arrangements that are not limited to direct physician services. CMS clarified that any percentage compensation arrangements may only be used to reimburse personally performed physician services, and must be based upon revenues directly resulting from the physician services, rather than revenue based on some other factor(s).

The new rules also propose that the burden of proof to demonstrate that a physician meets a Stark Act exception is now the responsibility of the physician or the party ordering (or billing for) the designated health services, rather than the government.

The proposed rule provides limitations on per use (or “per-click”) space and equipment leases and arrangements. The proposed language in the equipment and space lease exceptions clarifies that per unit-of-service rental charges are not allowed to the extent that such charges reflect services provided to patients, referred by the lessor to the lessee. CMS is also soliciting and considering opinions as to whether per-click leases should be entirely prohibited between entity lessors (such as a hospital) and physician lessees. Opponents of this rule claim that this will effectively eliminate most, if not all, per-click leases for space and equipment rentals.

CMS has determined that per the original Stark Rules, certain indirect compensation relationships would not constitute violations under the stand-in-the-shoes policy. However, CMS has determined that some of these relationships may in fact be abusive, and therefore proposed the new rule. Under the proposed rule, the owner of a clinic or foundation would “stand-in-the-shoes” of the clinic or foundation, and the relationship between clinic or foundation and physician(s) would need to meet a Stark exception as

though the clinic or foundation were a “direct employer” of the physicians.

Various other issues, a number of additional technical requirements, and requests for further discussion of CMS’ views regarding inadvertent violations of the Stark Act (and the manner of dealing with both purposive and inadvertent violations) are currently being addressed, and it remains to be seen how this discourse will affect the scope and tenor of changes to the proposed ruling.

THE EFFECTS ON INTERVENTIONAL PAIN MANAGEMENT

There have been reports of increased use and costs of interventional pain management (14,19,42-44). Although one such report (43) evaluated old(er) data somewhat inaccurately and failed to consider the impact of evidence-based guidelines on, and co-variably with cost policy, there is a growing perception of overuse and potential abuse of interventional approaches for the treatment of pain.

Thus it appears to be that increasing utilization evokes allegations (and in some case may reflect actual instances) of fraud, abuse and the provision of medically unnecessary interventional pain management services. This has led to a progressively litigious climate, and the inordinately excessive reduction of reimbursement for interventional pain management procedures, the impact of which are illustrated in Table 2 (i.e., reimbursement per procedure for commonly performed interventional procedures for physician services).

Both Fig. 9 and Table 3 illustrate the recent growth in the use of interventional techniques. Our recent studies have shown steadily progressive utilization of interventional techniques (excluding continuous epidurals, intraarticular injections, and trigger point and ligament injections) from 1998 to 2005, increasing from 1,429,277 to 4,041,464 in 2005 (an increase of 183%), with a mean average increase of 23%. Facet joint interventions and sacroiliac joint blocks showed an increase of 448%, with an annual mean increase of 56% during this period (i.e., from 274,130 to 1,501,222). Similarly, provision of all epidural interventions (including lumbar and cervical transforaminal epidurals and adhesiolysis) has increased from 802,735 in 1998, to 1,776,153 in 2005; an overall increase of 121%, with an annual increase of 15%. The proportion of facility – and non-facility – performed procedures has changed from 65% versus 35% in 1998 to 53% versus

47% in 2005. In other words, these figures indicate a 34% increase for in-office setting procedures. The use of interventional techniques has risen — the overall procedural increase indicates a 289% increase in office settings and 128% in facility settings (ASCs and HOPDs). In fact, the increases in lumbar facet joint nerve blocks and lumbar transforaminal epidurals that constitute “minor procedures” contributed to a total increase in the sustained growth rate (SGR) in 2005, and this increase in SGR was influential in prompting reimbursement cuts in 2007 (23). Growth in the volume of physician services (per Medicare beneficiary) for procedures in which interventional techniques were utilized along with evaluation and management services has increased substantially from 1999 to 2004.

If it were not for changing the formula of the practice expense from anesthesiology (which is the lowest specialty for practice expense) to all physician specialty (which takes an average of all the specialties) the fiscal cuts would have been much greater (i.e., almost double); these reimbursement changes are shown in Table 4. The implications of such cuts are highly unfavorable for both patients and physicians. Should these cuts establish a definable trend of fiscal reimbursement reduction, the evidence-based need and viability of interventional pain management will be undermined by prohibitive economics, and any utility of evidence based practice will be lost to fiscal constraint(s).

THE HORIZON

Other issues that impact cost controls are Medicare private plans or Medicare Advantage Plans, (that are also somewhat facetiously known as “Medicare Disadvantage Plans”). Private plans participate in Medicare through both the Medicare Advantage program, and as sponsors of prescription drug plans (45). According to current federal law (46,47), Medicare beneficiaries should be able to choose between the fee-for-service (FFS, i.e., Medicare program) and the alternative delivery systems that private plans can provide, as long as the choice is fiscally neutral to the program. The Medicare Modernization Act (30) established Medicare Advantage as a replacement for the Medicare Plus Choice (M+C) program. Medicare Advantage maintained existing authority for private health maintenance organizations, preferred provider organizations, as well as other coordinated care plans and private fee-for-service plans to be offered on a by-county basis (i.e., local plans). There has been sig-

Physician Payment 2008 for Interventionalists

Table 2. Physician fee schedule for top 30 interventional procedures.

CPT	Description	2006		2007		2008 Proposed (with cut)		2008 Proposed (without cut)	
		Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility
27093	injection procedure for hip arthrography – without anesthesia	\$213.44	\$69.10	\$209.19	\$72.01	\$177.50	\$64.86	\$197.07	\$72.01
27096	(G0260) injection procedure for sacroiliac joint, arthrography	\$211.27	\$65.48	\$203.13	\$68.59	\$167.26	\$61.78	\$185.70	\$68.59
62263	percutaneous epidural adhesiolysis – 2 or 3 days	\$697.13	\$352.36	\$704.89	\$376.32	\$607.95	\$337.60	\$674.95	\$374.81
62264	percutaneous epidural adhesiolysis – 1 day	\$450.04	\$221.04	\$450.60	\$230.04	\$387.78	\$205.84	\$430.52	\$228.52
62282	neurolytic epidural, L/S	\$393.61	\$123.73	\$369.50	\$131.13	\$296.63	\$119.81	\$329.33	\$133.02
62290	injection procedure for diskography each level: lumbar	\$375.52	\$166.78	\$366.09	\$172.05	\$307.56	\$153.27	\$341.46	\$170.16
62310	cervical epidural	\$247.81	\$96.95	\$241.79	\$100.81	\$202.08	\$90.12	\$224.35	\$100.05
62311	lumbar epidural	\$237.32	\$80.31	\$225.87	\$83.75	\$184.67	\$74.76	\$205.03	\$83.00
62367	electronic analysis of programmable pump	\$40.52	\$22.07	\$40.55	\$23.12	\$34.82	\$21.16	\$38.66	\$23.50
62368	electronic analysis of programmable pump with reprogramming	\$54.27	\$35.45	\$56.09	\$37.14	\$49.50	\$33.45	\$54.95	\$37.14
64400	injection, anesthetic agent; trigeminal nerve, any division or branch	\$111.43	\$58.24	\$111.80	\$61.39	\$96.60	\$55.30	\$107.25	\$61.39
64405	greater occipital nerve	\$103.47	\$67.29	\$105.73	\$70.87	\$92.51	\$64.17	\$102.70	\$71.25
64418	suprascapular nerve	\$145.43	\$66.20	\$144.77	\$70.11	\$124.25	\$63.83	\$137.95	\$70.87
64421	multiple, intercostal nbs	\$285.44	\$83.57	\$273.62	\$87.54	\$224.95	\$78.85	\$249.74	\$87.54
64450	other peripheral nerve or branch	\$95.51	\$68.01	\$100.43	\$71.63	\$90.46	\$64.52	\$100.43	\$71.63
64470	cervical and thoracic facet joint injections	\$333.19	\$96.59	\$314.55	\$101.19	\$254.99	\$91.14	\$283.09	\$101.19
64472	C/T facet joint injections – add-on	\$134.22	\$61.86	\$129.61	\$64.80	\$107.18	\$58.37	\$119.00	\$64.80
64475	lumbar facet joint injections	\$304.25	\$77.42	\$287.26	\$80.72	\$230.75	\$72.37	\$256.19	\$80.34
64476	lumbar facet joint injection – add-on	\$115.04	\$46.67	\$110.28	\$48.89	\$90.80	\$44.03	\$100.81	\$48.89
64479	C/T transforaminal epidural injections	\$355.62	\$116.13	\$336.15	\$120.89	\$270.69	\$108.21	\$300.53	\$120.14
64480	C/T transforaminal epidural injections – add-on	\$162.43	\$76.33	\$156.90	\$79.21	\$130.40	\$70.66	\$144.77	\$78.45
64483	lumbar/sacral transforaminal epidural injections	\$358.88	\$102.74	\$336.15	\$106.87	\$267.96	\$95.58	\$297.50	\$106.11
64484	lumbar/sacral transforaminal epidural injections – add-on	\$170.03	\$64.40	\$161.82	\$67.08	\$131.76	\$60.08	\$146.28	\$66.70
64510	cervical or stellate ganglion block	\$171.84	\$65.12	\$164.85	\$67.46	\$135.18	\$60.08	\$150.07	\$66.70
64520	thoracic or lumbar paravertebral sympathetic block	\$238.04	\$71.63	\$224.73	\$74.66	\$180.23	\$66.90	\$200.10	\$74.28
64612	destroy nerve, spine muscle	\$164.97	\$122.64	\$165.23	\$129.99	\$140.98	\$117.08	\$156.52	\$129.99
64622	lumbar facet joint neurolysis	\$396.50	\$164.61	\$379.73	\$172.05	\$310.29	\$153.95	\$344.49	\$170.92
64623	lumbar facet joint neurolysis – add-on	\$145.43	\$45.94	\$139.08	\$48.13	\$114.35	\$43.35	\$126.96	\$48.13
64626	cervical and thoracic facet neurolysis	\$408.08	\$197.16	\$417.25	\$225.49	\$349.89	\$202.42	\$388.45	\$224.73
64627	cervical and thoracic facet neurolysis – add-on	\$208.74	\$54.27	\$197.45	\$56.47	\$159.41	\$50.86	\$176.98	\$56.47

NA – not applicable

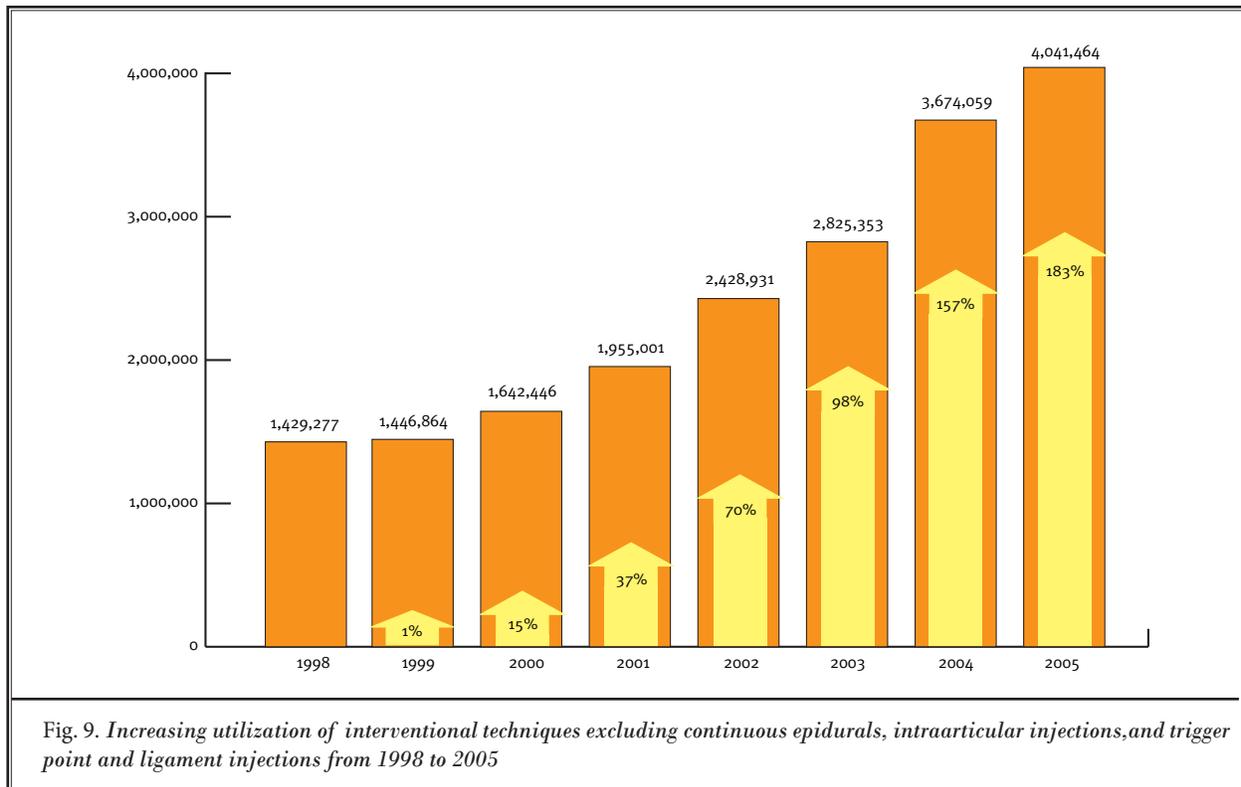


Table 3. Summary of frequency of utilizations of various categories of interventional procedures (excluding continuous epidurals, implantables, disc procedures, intraarticular injections, trigger point and ligament injections) in Medicare population from 1998 to 2005

	1998	1999	2000	2001	2002	2003	2004	2005
Epidural, spinal neurolysis, and adhesiolysis procedures	802,735 (76%)	803,078 (74%)	860,787 (79%)	1,013,552 (78%)	1,199,324 (74%)	1,370,862 (71%)	1,637,494 (65%)	1,776,153 (65%)
Facet joint interventions and SI joint blocks	274,130 (73%)	304,564 (72%)	424,796 (67%)	543,509 (62%)	708,186 (58%)	884,035 (53%)	1,354,242 (46%)	1,501,222 (47%)
Disc Procedures (Discography & Disc Decompression)	10,484 (84%)	13,113 (84%)	14,983 (87%)	17,229 (87%)	20,194 (81%)	24,362 (80%)	24,263 (79%)	27,950 (78%)
Vertebroplasty/ Kyphoplasty	0	0	3,825 (100)	20,593 (100)	25,060 (99%)	31,048 (99%)	42,882 (95%)	51,034 (95%)
Implantable and Stimulators	12,376 (100%)	12,694 (100%)	13,735 (100%)	16,840 (100%)	18,948 (100%)	24,709 (100%)	30,848 (96%)	37,013 (96%)
Other types of nerve blocks	329,552 (33%)	313,415 (33%)	324,320 (35%)	343,277 (35%)	457,219 (30%)	490,337 (28%)	583,970 (28%)	648,092 (28%)
Total	1,429,277 (65%)	1,446,864 (64%)	1,642,446 (67%)	1,955,001 (67%)	2,428,931 (62%)	2,825,353 (58%)	3,674,059 (52%)	4,041,464 (53%)

Source: Utilization data by Specialty from CMS
() shows percentage of procedures utilized in facility settings (HOPD and ASC)

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Table 4. *Impact of physician payment schedules for interventional pain management*

		2007 Final	2008 Transitional (with 9.9% cuts)	2008 (without Cuts)	Fully implemented (2007-2010) with 2008 proposed cut of 9.9% *	Fully implemented (without cuts)*
Physicians and other providers		875,000	900,000	900,000	950,000*	950,000*
Payments (Approximate)		\$61.5 billion	\$58.9 billion	\$64.8 billion	-	-
Overall cut		0	(9.9%)	0	(9.9%) for 2008	-
Facility	Epidurals	0.5% to -0.9%	-10.6% to -11.7%	-0.8% to -2.0%	-12.0% to -14.9%	-2.3% to -5.5%
	Facet blocks	0% to -0.5%	-9.9% to -10.4%	0% to -0.5%	-10.3% to -11.6%	-0.4% to -1.9%
Non-facility	Epidurals	-6.9% to -10.6%	-16.4% to -18.2%	-7.2% to -9.2%	-29.3% to -35.5%	-21.5% to -28.4%
	Facet blocks	-7.8% to -9.9%	-17.3% to -19.7%	-8.2% to -10.8%	-32.1% to -39.0%	-24.6% to -32.3%

* *projected*

nificant growth in Medicare Advantage availability in 2006 and 2007: by 2006 almost all beneficiaries had some form of MA plan available, with expansion particularly notable in rural counties. In 2007, all beneficiaries in urban counties, and 94% of those in rural counties have been shown to have at least one Medicare Advantage plan available. In April 2007, CMS reported 8.5 million participants enrolled in any form of MA, with 1.5 million enrolled in PFFS, and R-PPO enrollment just under 136,000 (45).

What Medicare pays to MA plans is variable, ranging from 110-119% of fee-for-service(s) (Fig. 10). This provides beneficiaries with benefits of low premiums, coverage for drug costs, and obviates the need for co-insurance. By law, Medicare Advantage plans must provide physicians' payments (at least) at the rate of Medicare, and while very few provide higher payments, some plans actually reduce the payment by as much as 20%. The sources and reasons for this variation remain enigmatic, as there does not seem to be any information that specifically addresses the potential discrepancies and conflict between the law and the financial performance of insurers.

In fact, complaints against Medicare Advantage plans have forced the suspension of marketing (48). The House Oversight Committee of Energy and Commerce held hearings addressing the performance of these plans. There were widespread claims and allegations of abuses and illegal behavior by insurers that were sponsoring Medicare private-fee-for-service plans. The proposed House version of the SCHIP regulation basically removes Medicare Advantage plans, although this

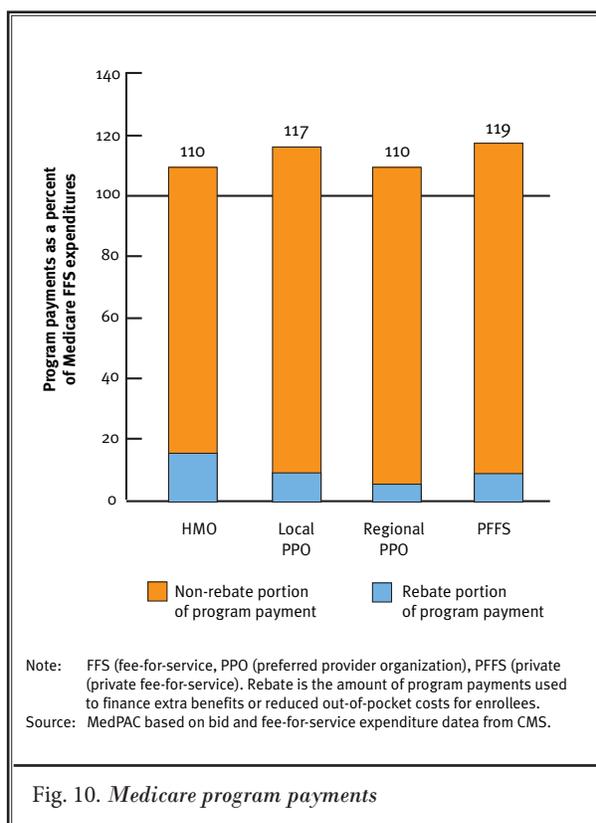


Fig. 10. *Medicare program payments*

is facing significant opposition from the public in general, and several factions within the administration.

One possible option for reimbursement includes pay-for-performance programs, but these have proven to be ineffective in many settings. Prescription drug

cost sharing is another option, with pharmacy benefits representing a potential public health tool for improving both patient treatment and adherence to treatment. In a recent study, increased cost sharing was shown to highly correlate with reductions in pharmacy use, however the long-term consequences of such benefit changes on health remain uncertain (49). In a proposed new rule, CMS refused to access reserve funds to ease Medicare physician pay cuts. The proposed rule announced that a \$1.35 billion reserve set aside by Congress last year to address physician payment and quality of care, will be re-directed toward reducing physician payment cuts. Medicare believes that it is essential to encourage improvement in the efficiency and quality of healthcare delivered to its beneficiaries. Consequently, CMS has proposed that this \$1.35 billion be used to fund bonus payments that will be made during 2009, to compensate/reward physician reporting efficiency during 2008. To reiterate, it is unclear if or how such re-allocation of these funds will positively impact physician reimbursement. What is known, however, is that the direct use of these funds to support physician reimbursement would have reduced the proposed cut in physician payment from 9.9% to 7.9%, and fostered a more equitable balancing of healthcare costs for provision(s) of medical services overall.

THE RECIPROCALITY OF POLICY AND ETHICS

It is obvious that there are discrepant issues in current health care policy that impact the scope, conduct and sustainability of interventional pain management, and much of medicine as a systematized service in the United States. Simply elucidating the deficits, conflicts and problems in policy – although important to formulating and targeting potential solutions – is insufficient to evoke meaningful change(s) unless an essential understanding of the role of policy in upholding the good(s) of medicine as a system and practice is equally well developed and delineated.

By definition, policy refers to 1) a high-level overall plan that embraces general goals and acceptable procedures (especially as promulgated by a governmental body), 2) the management of a task or practice(s) – based on specific interests of those involved, and 3) a defined course or method of action selected from various alternatives (in light of the given conditions, circumstances and/or needs/desires of those served and involved) that guides and determines present and future decisions (50). Given that 1) a practice is considered to be an exchange of “good” between indi-

viduals as defined by, and inherent to the nature of their relationship (51), 2) that the good of the practice of pain medicine should be adherent and pursuant to the goals and ends of the discipline, and that 3) these goals and ends are focused upon the relief of pain and suffering through the provision of technically right and morally good care (52), then to be both effective and ethically sound, policies that support this practice should advance and lend support to these goods and ends. In other words, policies and guidelines provide the extra-structure that supports the practice, while its infrastructure is derived from, and based upon the facts of pain, the needs of pain patients, and the intellectual and technical capabilities of (pain) medicine (53). These infra – and extra-structural components are mutually dependent – lacking internal integrity, the practice is intellectually, technically and morally hollow, and without the appropriate external fortification, the practice is weakened and disempowered. Moreover, guidelines and policies direct and ratify prudent medical practice(s), and allow the execution of therapeutic and moral agency of the physician within accepted technical and legal parameters.

Well-designed (evidence-based) guidelines and solid policies reinforce patients’ (and societal) trust in the intentions, capabilities and responsibilities of the medical system. To be sure, the role of policy, as defined, is to serve individuals within (their) society, and as such must deal with issues that impact both the clinical interactions of specific patients and physicians within medicine as a practice, as well as those issues that affect the equitable distribution and utilization of the physician, her services, and the economic factors that sustain medicine as a system. In this light, policy reform must be responsive to changing needs, knowledge and social conditions, and is nothing short of a pragmatic and moral necessity.

CONCLUSIONS

Concern over the financial solvency of interventional pain management practice(s) is generally focused on Medicare reform, and more specifically upon reforms to physician and ambulatory surgery center payment schedules. With third party payors adhering to Medicare payment parameters, and with an increasing population of Medicare-served patients with chronic conditions, interventional pain management is moving toward a critical juncture. The administration and Congress have seemingly misplaced priorities, as evidenced by increasing payments to hospitals, nurs-

ing homes, and Medicare Advantage plans, while attempting to balance the Medicare budget by restricting physicians' reimbursements (which constitute less than 20% of total healthcare payments). If this trend continues, purely economic contingencies will dictate the scope and nature of interventional pain management (if not medical practice, on the whole). Thus, despite the scientific evidence, any legitimate attempt to translate research to practice will be highly limited, if not completely prevented by the fiscal impositions of current health care policies.

In this manuscript, we have discussed both a number of factors that have affected interventional pain management, and addressed the substance and avenues toward potential solutions. Beyond a complete governmental re-organization of physician payment formulas, other vectors for positive change should also be considered; these include regulatory cost savings, medical tort reform, quality-oriented health facilities regulations, and cost-effectiveness as a price control.

For each option, and at each step in any decisional process, we must also consider the possible (healthcare and economic) consequences of the intentions and acts that direct and evoke any such changes. To maximize the health of the American population, we must equally strive to maximize the administrative and ethical "health" of its medical system. Most assuredly, we

should pursue interventions in proportion to their ability to improve positive outcomes in each and every patient – this is the basis of evidence-based practice (53). But just as evidence must be employed to avoid harmful errors of omission and commission, we must heed evidence that inattention to the administrative priorities of health care regulation can be equally harmful, refute the ethical goods of medicine, and are contrary to the public service of policy and government.

In conclusion, while this manuscript paints a somewhat grim picture, most physicians are optimistic that these problematic issues will resolve, and the US healthcare system will be resilient and continue to provide the best and most effective care to our citizens. But this cannot occur without the voices of physicians and patients being conjoined in an effort to make past and present problems apparent, engaging administration and government (at all levels) in discourse, and being actively involved in developing, planning and calling for positive change for the future.

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