

Bush Administration Plans Medicare Changes

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WASHINGTON, July 16 — The Bush administration says it plans sweeping changes in Medicare payments to hospitals that could cut payments by 20 percent to 30 percent for many complex treatments and new technologies.

The changes, the biggest since the current payment system was adopted in 1983, are meant to improve the accuracy of payment rates. But doctors, hospitals and patient groups say the effects could be devastating.

Federal officials said that biases and distortions in the current system had created financial incentives for hospitals to treat certain patients, on whom they could make money, and to avoid others, who were less profitable.

[Michael O. Leavitt](#), the secretary of health and human services, said the new system would be more accurate because payments would be based on hospital costs, rather than on charges, and would be adjusted to reflect the severity of a patient's illness. A hospital now receives the same amount for a patient with a particular condition, like pneumonia, regardless of whether the illness is mild or severe.

Medicare pays more than \$125 billion a year to nearly 5,000 hospitals. The new plan is not expected to save money, but will shift around billions of dollars, creating clear winners and losers. The effects will ripple through the health care system because many private insurers and state Medicaid programs follow Medicare's example.

Dr. Alan D. Guerci, president of St. Francis Hospital in Roslyn, N.Y., said the new formula would cut Medicare payments to his hospital by \$21 million, or 12 percent. "It will significantly reduce payments for cardiac care and will force many hospitals to reduce the number of cardiac procedures they perform," Dr. Guerci said.

A coalition of patient organizations, including the Parkinson's Action Network and the Society for Women's Health Research, told the government in a letter that the new system "could have a devastating impact on payment for critical treatments for seriously ill patients, with reimbursement for some essential procedures cut as much as 30 percent."

The basic payment for surgery to open clogged arteries, by inserting a drug-coated wire mesh stent, would be cut by 33 percent, to \$7,590. The payment for implanting a [defibrillator](#), like the one used by Vice President [Dick Cheney](#), would be cut 23 percent, to \$22,000, while the payment for hip and knee replacements would be reduced 10 percent, to \$14,500.

"This is a bit of a catastrophe," said Dr. Herbert Pardes, president of New York-Presbyterian Hospital. In its zeal to cut the profits of doctor-owned specialty hospitals, including cardiac hospitals, Dr. Pardes said, the government has inadvertently hit many nonprofit academic medical centers.

Drug and device makers have been lobbying Congress and the Bush administration to delay the changes to allow further analysis. Device makers are scheduled to meet with top White House officials this week. More than 200 members of Congress have signed letters supporting a one-year delay.

Peter L. Ashkenaz, a spokesman for the Medicare agency, said officials had received the letters but could not comment because they were working on a final regulation, to be issued in a few weeks.

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Hospitals and members of Congress are also complaining about the role of a government contractor that helped develop the new payment system and now stands to profit from it.

The new system is based on a commercial product developed by 3M Health Information Systems, a unit of 3M, the Minnesota-based technology company. In July 2005, the Bush administration awarded a “sole source contract” to 3M, to analyze whether it was feasible for Medicare to use a payment system modeled on the 3M product. The company said yes.

Influential members of Congress, including Senator [Charles E. Grassley](#), Republican of Iowa, the chairman of the Finance Committee, have objected to Medicare’s reliance on a proprietary system controlled by a single company.

A competing company, Ingenix, said, “The contract was awarded to 3M without the solicitation of competitive bids.” Moreover, Richard H. Anderson, chief executive of Ingenix, a unit of UnitedHealth Group, said that 3M had a conflict of interest because it was evaluating its own proprietary software as the basis for a new Medicare payment system.

The software analyzes the characteristics of each patient and assigns the case to a “diagnosis related group,” which in turn determines how much the hospital will be paid.

In recent weeks, 3M has sent out marketing materials that urge hospitals to buy 3M software and use 3M experts to help them “make a successful transition” to the new Medicare payment system.

Richard F. Averill, research director of 3M Health Information Systems, said the sole-source contract was justified and denied that his company had a conflict of interest. As an inventor of the 1983 payment system, Mr. Averill said, he and his colleagues at 3M know more about it than their competitors.

Moreover, Mr. Averill said in an interview: “The contract required us to use the 3M system in our analysis. There was no evaluation of alternatives.”

The goal of the new payment system is to pay hospitals more accurately for the cost of care. But Jayson S. Slotnik, director of Medicare policy at the Biotechnology Industry Organization, a trade group, said that payments would, in many cases, be less accurate because the government had relied on old hospital cost reports and claims data that did not reflect the use of new technology.

Without a delay, Mr. Slotnik said, hospitals can expect to see a 35 percent reduction in Medicare payments for [stroke patients](#) treated with clot-busting drugs. The basic payment for such cases is now \$11,578.

It is no surprise that the Greater New York Hospital Association, which represents many teaching hospitals in a high-cost area, objects to the new system. But hospitals in North Dakota are also concerned.

Arnold R. Thomas, president of the North Dakota Healthcare Association, said the new system would cause “radical shifts” of money among the state’s 52 hospitals. “The effects would be rather random and inequitable,” Mr. Arnold said.

When hospitals lose Medicare revenue, they often seek higher reimbursement from private insurers. J. Brian Munroe, vice president of WellPoint, one of the largest private plans, said he feared that the Medicare changes “will introduce a significant amount of disruption to the commercial health insurance marketplace, driving up health care costs and causing marketplace confusion.”