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<http://select.nytimes.com/mem/tnt.html?tntget=2006/08/03/washington/03medicare.html&tntemail1=y&emc=tnt&pagewanted=print>

Article on the original plans by the Administration: <http://www.gpcal.org/documents/bushmedchangesJuly17.pdf>

Scaling Back Changes to Medicare Payments

By [ROBERT PEAR](#)

WASHINGTON, Aug. 2 — Under intense pressure from health care lobbyists and lawmakers, the Bush administration says it will scale back and delay proposed changes in Medicare payments to hospitals that would have created clear winners and losers.

The proposals would have cut payments by 20 percent to 30 percent for many complex treatments and new technologies. Hospitals will instead see much smaller cuts or even small increases for many of those procedures. Some of the changes will be phased in over three years.

Doctors, hospitals, consumer groups and members of Congress had said the proposed cuts would be devastating. Under the proposals, they said, patients would have had less access to some services like cardiac care.

On Tuesday night, the Bush administration issued a final rule that reaffirmed the overall goal of more accurate payments while backing away from many of the proposed changes, including a sweeping revision in the classification of patients intended to account for the severity of their illnesses.

The reaction from Wall Street analysts on Wednesday was positive.

“The final rule significantly moderates proposed cuts for cardiac procedures,” Citigroup said in a note to investors. Lehman Brothers described the final rule as “a win for cardiac and orthopedic device companies, specialty hospitals and general acute care hospitals.” The Prudential Equity Group said the final rule, which takes effect on Oct. 1, was “favorable for device manufacturers” like Boston Scientific, Medtronic and St. Jude Medical.

Stephen J. Ubl, president of the Advanced Medical Technology Association, which represents hundreds of device makers, said he was pleased that the Bush administration and Medicare officials had responded to the industry’s concerns.

The new rule removes “a dark cloud” that had been hovering over the industry, Mr. Ubl said, adding, “The worst is behind us.”

The industry’s lobbying campaign offers a case study in how to influence the government on complex technical issues that have implications worth billions of dollars to a politically potent sector of the economy.

Rather than just filing comments on the proposed rule, the health care industry mobilized a political campaign that combined advertising and lobbying to beat back the proposed cuts. Lobbyists wrote dozens of letters to the Medicare agency, stoked concern on Capitol Hill, ran advertisements and met with White House officials including Rob Portman, the new director of the [Office of Management and Budget](#).

Under the proposal, published in April, the basic Medicare payment for surgery to open clogged arteries, by inserting a drug-coated wire mesh stent, would have been cut by 33 percent, to \$7,590. The final rule calls instead for a cut of 3 percent, so Medicare will pay about \$11,000.

The payment for implanting a [defibrillator](#), like the one used by Vice President [Dick Cheney](#), would have been cut 23 percent under the proposal, to \$22,000. The final rule calls for a cut of 2 percent, so Medicare will pay about \$27,750.

Under the final rule, hospitals will receive much smaller increases than originally proposed for treating some conditions, like pneumonia and chronic obstructive pulmonary disease.

[Michael O. Leavitt](#), the secretary of health and human services, said the current payment system was full of biases and distortions that encouraged hospitals to provide “treatments that happen to be the most profitable.”

Federal officials said the new payments would be more accurate because they would be based on estimated hospital costs, rather than inflated charges. In revising its proposal, the government significantly modified its method of estimating costs, to include more data from high-cost hospitals. The resulting changes will be smaller than originally proposed and will be put into effect gradually over three years, rather than all at once.

Dr. [Mark B. McClellan](#), administrator of the Centers for Medicare and Medicaid Services, said the final rule would mean “smaller changes in payment, up or down, than the proposed rule.”

Medicare pays more than \$125 billion a year to nearly 5,000 hospitals. Hospitals typically receive a fixed amount for each Medicare patient, regardless of how long the person stays in the hospital. Each patient is classified in one of 526 categories, known as diagnosis-related groups.

Federal officials had proposed sweeping changes in the classification system, to account for the severity of each patient’s illness. They wanted to replace the 526 categories with 861. They settled for more modest changes in 2007, creating 20 diagnostic groups and altering 32 others.

The severity of a patient’s illness can have a significant effect on the costs of care. In trying to account for those costs, the proposed rule relied heavily on a patient-classification system devised by 3M, the technology company based in Minnesota.

Hospitals said Medicare should not rely on a proprietary system controlled by a single company.

The Bush administration agreed to consider alternatives, to ensure that no company would have a monopoly over the software needed to manage billing and payment