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## why 2014 may be the year for physician payment reform

The last quarter of 2013 has one thing in common with the last quarters of every year over the past decade: It started with physicians facing significant reductions in unit fees in Medicare at the beginning of the following year—in this case, 24.4 percent. And like most other years, Congress intervened late in the year to forestall the fee reduction—this time providing a three-month reprieve.

What is different is that bipartisan, bicameral interest has been focused on developing an alternative payment system for physicians that would reward physicians who improve quality and value in place of the resource-based relative-value system (RBRVS) that encourages volume. It would also mean not just kicking the sustainable growth rate (SGR) can down the road, but also eliminating the need for a spending limit by encouraging a focus on value and efficiency and rewarding those who accomplish those goals.

For more than 20 years, Medicare has been paying physicians using the RBRVS along with a spending limit—initially the "volume performance standard," which was replaced with the SGR, thereby tying growth of Medicare physician spending to the growth of the economy. The use of a fee schedule that has physicians bill Medicare according to the thousands of codes in the CPT system and that adjusts how much each code is worth by aggregating physician spending has produced a "disconnect" between the behavior of individual physicians or their practices and the effect of all physicians on the SGR. The SGR is

driven by the aggregate behavior of all physicians, and no one physician or physician's practice is big enough to influence aggregate spending. As a result, there is no reward for "good" behavior and no consequence for "bad" behavior.

Also, because of all the congressional overrides, the SGR hasn't even been effective in limiting physician spending.

Legislative proposals made during the past decade primarily focused on using separate SGRs for different physician groups. Examples include the Children's Health and Medicare Protection of 2007 and the Medicare Physician Payment Reform Act of 2009—both of which were passed by the House but not the Senate.

### Current Efforts and Challenges

The recent efforts differ markedly from the previous legislation, but they have clear similarities to each other. A bipartisan bill developed by the Energy and Commerce Committee was passed unanimously last summer, and a bipartisan legislative framework developed by the Senate Finance Committee and the House Ways and Means Committee was released in October. Both of these proposals provide some certainty and stability for physicians, with zero to small updates for several years, higher adjustments for physicians who participate in alternative delivery systems or who show that they are improving quality or value, and ultimately, reduced payments for physicians who cannot demonstrate that they improve value.

Although the similarities between these two efforts are encouraging, clear challenges remain. The most obvious is for Congress to agree on a set of changes that will pay for repeal of the SGR and the introduction of a new payment system. The “cost” of the repeal itself (that is, the amount of revenue that would otherwise have been generated by the SGR, even though it has actually only been used once) was estimated by the Congressional Budget Office (CBO) to be just under \$140 billion over 10 years. Meanwhile, CBO has estimated the cost of the Energy and Commerce legislation to be \$175 billion—that is, the \$140 billion repeal cost plus the cost of other changes introduced in the legislation. CBO has not yet estimated the cost of the Finance/Ways and Means framework.

### Other Key Questions

Almost as important as funding the cost of the RBRVS/SGR replacement is deciding which performance measures should determine payment increases or decreases and which advanced payment models should warrant increased payment. The best approach for making these decisions may be to look at the many pilot projects and demonstration models that are currently under way—including those sponsored by the Center for Medicare and Medicaid Innovation (CMMI) and those sponsored by private payers. These pilots and demonstrations include the many models of patient-centered medical homes (PCMHs) currently being tested, as well as some of the advance payment model medical homes that are just being started. Thus far, the early results appear to be producing modest savings at best, but few independent evaluations have been reported, and these efforts are only in their preliminary stages.

Also early are the results coming in from ACOs, which remain a relatively new phenomenon—especially the Medicare ACOs. Recently, the Centers for Medicare & Medicaid Services (CMS) reported savings from its ACOs, although results from the Pioneer ACOs reported last summer indicated a mixed finding among these more experienced groups. As with the PCMHs, few

independent evaluations are available to date. Models that combine medical homes with other strategies are also being tried. In Michigan, for example, Blue Cross Blue Shield of Michigan is partnering with physician organizations to provide resources for infrastructure development and rewards performance improvement that occurs for the entire population rather than just for its enrolled population.

Relatively few strategies are being tried that assess alternative ways to pay physicians other than by bundling the services they provide with institutional services, as in the CMMI bundled payment projects. That situation is unfortunate. Efforts to develop the details of potential alternative physician payment models could benefit greatly from a better understanding of the effects of bundling payments for entire groups of physicians who treat specific medical conditions, and from the construction of episode-based payments for physicians using different timeframes. The American Medical Association has been working with its specialty groups on developing a condition-based payment but does not seem to be moving forward very quickly in this effort.

Caution will be needed in applying the findings from pilot projects or demonstrations to legislation, in part because one-time subsidies that had been available early are unlikely to be repeated in the future. Also, it bears repeating not only that the projects and demonstrations are still early in their implementations or evaluations, but also that they all are voluntary and that some of the early savings may not be sustainable.

Still, the level of interest in fixing the SGR we have seen in this past year is more promising than what we have seen at any other time in the past two decades. So there is reason to be encouraged. But as with so much of health care, the devil will be in the details—and these have yet to be spelled out. ●

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