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Gail R. Wilensky

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Medicare continues to struggle with physician payment

The challenge of Medicare physician spending continues to be a thorny issue.

A year and a half ago, I wrote a column about the subject. The challenge then—and now—is to develop a strategy for reimbursing physicians that promotes the delivery of the appropriate mix and volume of services, provides good access, and moderates physician spending. Most of the more recent attention has focused on strategies that redefine the sustainable growth rate (SGR) or eliminate it altogether.

As is well known, physicians are reimbursed through the use of the resource-based relative value scale (RBRVS) combined with the SGR. The RBRVS sets relative prices, based on work value, practice expenses, and geographic adjusters, but it is the SGR, through its impact on the conversion factor, that converts relative weights to absolute dollars and, thereby, sets the dollar reimbursement rate.

By linking the growth in Medicare spending for physician services to the growth in the economy and then adjusting changes in physician fees to reflect any excess growth in physician spending that exceeds the growth in the economy, Medicare enforces a rigid relationship between the growth in physician spending, which has mostly been driven by changes in the volume and intensity of selected services, and subsequent changes in fees.

The Medicare Payment Advisory Commission (MedPAC) and many others have questioned the wisdom of holding one part of Medicare spending to this tight relationship while other sectors of Medicare are not required to maintain such a relationship. As a result, it's been suggested that if expenditure targets are to be used for physician services, it would be better to use expenditure targets across all Medicare services—a strategy proposed by the Republican leadership in the mid-1990s.

Yet freezing shares of Medicare spending across sectors of Medicare to those that exist at a moment in time provides no assurance that the relative shares represent the best distribution of spending in Medicare. Expenditure targets across all of Medicare could indeed keep Medicare spending within specified growth rates—if the targets were actually enforced. But as the use of the SGR for physician fees has shown, expenditure targets per se do nothing to improve quality, ensure clinical appropriateness, or meet any of the other goals that have been set for Medicare—and they frequently are not implemented anyway.

Fundamental Problem with the SGR

The problem with the SGR is that although it can control total spending by physicians, it neither affects nor is driven by the volume and intensity of spending of any individual physician. In fact, there is some concern that the SGR expenditure targets actually give individual physicians even greater incentives to increase the volume and intensity of the services they provide because physicians know that nothing they do as individuals can affect overall physician spending and, as a result, their fees.

Alternative Ways to Define the SGR

Various alternatives to the use of a single spending target have been suggested. Although none of them compensate for the lack of a direct

relationship between what individual physicians do and what happens to their fees, some of the alternatives attempt to protect those groups of physicians that have been less associated with changes in the volume and intensity of services provided.

For example, it has been suggested that evaluation and management services used mostly by primary care physicians could have targets distinct from those for all other services, just as separate targets were used for primary care, surgery, and other services when the RBRVS was first implemented. Kaiser Permanente's Jay Crosson, MD, executive director of the Permanente Foundation, and others have suggested that groups that are more accountable as systems, such as multispecialty group practices, could be allowed to have their own targets so as to reward and give incentives to their membership.

Robert Berenson, MD, senior fellow at the Urban Institute, has been advocating that the SGR be used differentially according to the "value of the services" provided to beneficiaries or to Medicare and having Medicare become more of a value-based purchaser. This approach recognizes that increases in the quantity of services provided have been limited to certain areas of services, such as advanced imaging and niche services, rather than having occurred with major surgical procedures or E&M services.

The Children's Health and Medicare Protection Act, passed by the House last August, although never enacted into law, provided for six expenditure targets—not only distinguishing between various types of services, but also allowing spending targets for primary care and preventive services to be substantially greater than spending target increases for other categories of services.

Next Steps

The most important next step is for Congress to decide on the basic outline and direction of a future reimbursement system for physicians. Only then can or should Congress decide what to do in the short term while work begins on the next generation of physician payments.

My personal belief is that only by developing a more aggregated payment strategy will it be possible to resolve the frustrations and perverse incentives that have been associated with the current system without risking high rates of physician spending. And although we are clearly not yet ready to implement such a payment system, the decisions about the direction of the next evolution of payment strategies need to occur now so that work can begin on its development. Otherwise, we are going to be in the same position a decade from now, bemoaning the perverse incentives of the current system without an alternative available to introduce in its place.

Aggregating across chronic care treatments so that physicians can receive a bundled payment for single or multiple chronic diseases; combining Part A and B payments for high-cost, high-volume procedures, particularly those that show substantial variation in expenditures; and instituting partial or full capitation payments—all of these are ideas that have been raised periodically and that represent a far superior reimbursement system to the RBRVS combined with the SGR.

Ultimately, we need to have physicians be better associated with the full spectrum of professionals and institutions that deliver care for an individual during an episode of illness or treatment of a chronic disease. But even if that goal remains substantially in our future, figuring out how to bundle payments for physicians need not be. For those of us who believe that having the right incentives in place is crucial to building a better Medicare program, multiple SGRs with a disaggregated RBRVS is not the right answer. ●

Gail R. Wilensky, PhD, is a senior fellow at Project HOPE and a commissioner on the World Health Organization's Commission on the Social Determinants of Health. She was the HCFA administrator from 1990 to 1992 (gwilensky@projecthope.org).