

Cumulative Changes in Payment Updates, in the Medicare Economic Index, and in Spending per Medicare Beneficiary (2000–2012).).

The fee-for-service system, under which doctors are paid for each service provided, is very different from the way Medicare reimburses for other services. For hospital services, home care, and nursing home care, Medicare has moved to the use of bundled payments — a single payment that covers all services provided in a particular setting or during a specified event. Although bundled payments present their own challenges, since they encourage either the provision of more bundles of services or unbundling (i.e., billing separately for parts of the service bundle), they do, on the whole, reward the efficient delivery of services within the bundle, something that the relative-value scale does not do.

The use of a relative-value scale with fees adjusted according to the SGR is inconsistent with the renewed interest in value creation in health care. A fee schedule that reimburses physicians on the basis of billing for approximately 8000 discrete service codes makes it very difficult to hold physicians responsible or accountable for the health outcomes of their patients or for the costs of treating them. Furthermore, the incentives that the SGR presents to the individual physician are incompatible with the formula's objective of controlling aggregate physician spending. The SGR is driven by the aggregate spending of all physicians. Since no one physician or physician group is large enough to affect aggregate spending, good behavior can't be rewarded and bad behavior can't be penalized at the level of the physician or the group associated with the good or bad behavior.

Past legislative efforts to reform the SGR relied primarily on applying the formula to different subgroups of physicians, as in both the Children's Health and Medicare Protection Act of 2007 and the Medicare Physician Payment Reform Act of 2009. Both of these bills were passed by the House of Representatives but not by the Senate. Each one allowed for evaluation-and-management codes associated with primary care to receive higher payment updates than other services.

Very different types of legislative bills are now under consideration. Last summer, a bipartisan bill was passed unanimously by the House Energy and Commerce Committee, and in October, a bipartisan legislative framework was released by the Senate Finance Committee and the House Ways and Means Committee. In a rare display of congressional agreement, the strategies underlying these two legislative efforts have many elements in common. These include a short period of stability for physician reimbursement, during which zero-to-small updates would be provided; larger updates made available to physicians who participate in alternative delivery systems that can demonstrate improved value; and ultimately, reductions in payments made to physicians who do not demonstrate success in improving value or efficiency.[2.3](#)

It has been estimated that the bill passed by the Energy and Commerce Committee would cost \$175 billion over a period of 10 years.⁴ The draft strategy from the Finance and Ways and Means Committees has not yet been given a cost estimate by the Congressional Budget Office, but the cost of simply eliminating the SGR is estimated at just under \$140 billion over 10 years.⁵

Because the legislative draft from the two congressional committees contains many elements similar to those in the Energy and Commerce bill, there appears to be more unity in thinking about how best to reform physician reimbursement than has existed since the relative-value scale was passed in 1989. But as promising as these efforts are, there are still many difficult issues that will need to be resolved. The most obvious immediate challenge is agreeing on how to pay for the cost of removing the existing SGR. When it comes to any fiscal matter, agreement between the rather conservative Republican House and the relatively moderate Democratic Senate seems to have become more difficult. The Senate's recent removal of the filibuster option for presidential and judicial nominees is likely to further complicate any near-term deal making.

A second challenge is to determine which alternative payment or care-delivery models warrant increased reimbursement. The hope is that some of the pilot projects currently under way sponsored by the Center for Medicare and Medicaid Innovation (Innovation Center) or by private payers will provide insights to answer this question. For example, can the various models for medical homes and accountable care organizations (ACOs) or other strategies being tested consistently produce savings, and are any early savings that are produced by voluntary participants likely to be generalizable and sustainable? This is clearly a stretch goal, at least in the near term, since most evaluations are still in a relatively early stage, and some of the more advanced models of medical homes are only now beginning to be implemented.

Unfortunately, there are some important strategies that are not being piloted — most notably, projects that assess alternative ways to pay for physician services other than bundling them with institutional services (e.g., those of hospitals or nursing homes) or strategies involving alternative ways to pay for specialty care (e.g., episode-based payments).

There are a few efforts under development that will begin to focus more systematic attention on changing incentives for specialists. Blue Cross Blue Shield of Michigan, for example, is planning to extend its “fee for value” incentive program to specialists in 2014, and the American Medical Association is in the early stages of developing a condition-based payment system for specialists. Obviously, the results for these activities are years off. Specialists may need to consider whether they will be able and willing to accept more financial risk than they have in the past. The success of physician-led ACOs may clarify their ability to do this successfully.

This year's interest in fixing the SGR is more promising than it has been in the decade during which Congress has engaged in this year-end ritual. But as in so much of health care, the devil is in the details, and those have yet to be spelled out.

Audio Interview



Interview with Dr. Gail Wilensky on proposed legislation to replace Medicare's physician-payment formula. (11:52)

[Download: http://www.nejm.org/doi/media/10.1056/NEJMp1313927/NEJMp1313927_interview.mp3?area=](http://www.nejm.org/doi/media/10.1056/NEJMp1313927/NEJMp1313927_interview.mp3?area=)

[Disclosure forms](#) provided by the author are available with the full text of this article at NEJM.org. This article was published on December 11, 2013, at NEJM.org.

SOURCE INFORMATION

From Project HOPE, Bethesda, MD.

<http://www.nejm.org/doi/full/10.1056/NEJMp1313927#t=article>