The Twin Policy Challenges Of Medicare Physician Payment And Medicaid

For each challenge well met, another one remains.

by Gail R. Wilensky

The two most important challenges during my tenure as Health Care Financing Administration (HCFA) administrator (1990–92) were implementing physician payment reform and thwarting the "creative" financing schemes being adopted by states to finance a portion of their Medicaid programs. "Fixing" physician payment and reforming Medicaid continue to be two of the most serious challenges facing the Centers for Medicare and Medicaid Services (CMS) today.

■ **Physician payment reform.** In 1990–91, the challenge regarding physician payment was to implement the first phase of the resource-based relative value scale (RBRVS) and the volume performance standards (VPS). Making sure that the agency was able to implement the administrative changes and issuing the necessary rules in a timely way were major challenges to the agency, although probably far less difficult to meet than the challenges posed by the Balanced Budget Act (BBA) of 1997 or implementation of the new Part D drug benefit. Although most policy analysts and policymakers believed that the RBRVS represented an improvement over the traditional fee schedule and that the VPS would limit spending, concerns were already being raised about the "perverse" incentives associated with the system Medicare was adopting. Those incentives continue to plague Medicare. None of the reimbursements used by Medicare currently reward quality or good clinical outcomes, but the bundled payment systems like diagnosis-related groups (DRGs) at least reward the more efficient institutions. The RBRVS, because it is so disaggregated, used along with the VPS penalizes rather than rewards efficient physicians. Congress and the administration recognize that Medicare needs to find a way to reward physicians who achieve good clinical outcomes, follow practice guidelines, and practice in an efficient way, and Congress has been pressing the CMS to begin implementing pay-for-performance measures.

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The CMS has a demonstration under way that rewards excellence for physicians who practice in large group practices. However, most physicians practice in small groups or in solo practices; therefore, reforming physician payment in ways that would improve their incentives will be more difficult. Supposedly, a starter set of performance-related ambulatory care measures is in the final stages of development so that some changes may be able to be implemented sooner than had been expected. However, changes that move away from the current payment system will be expensive and thus present another type of challenge in this period of tight budgets.

■ **Medicaid financing.** The most pressing fiscal problem for Medicaid in 1991 was the burgeoning growth of provider taxes and voluntary donations, strategies the states were using to bring in additional federal dollars without adding their own state share. Because the legislative session was nearing an end, introducing legislation that would prohibit these strategies required an agreement of unanimous consent in the Senate. Obtaining that required a "full-court press" by Tom Scully, then at the Office of Management and Budget (OMB), and me, meeting with each of the senators and with representatives from each of the governors. To the surprise of many, we did obtain unanimous consent, and the legislation passed. But not surprisingly, the problem really was not solved. Other financing mechanisms that accomplish a similar purpose have since been put in place, and attempts to limit these strategies have been only marginally successful.

As much as Medicaid has become a challenge for the federal government, it has become even more troublesome to state governments. The past several years have been particularly challenging to the states because they have coincided with unprecedented declines in state revenue. Because these declines occurred at the same time that states have experienced substantial increases in Medicaid spending, states have found themselves desperate to reduce spending, particularly on Medicaid. Unlike the federal government, almost all states have to balance their budgets each year.

Medicaid's financing problems are just part of the reason that it is time for the nation to rethink the type of program for low-income Americans that makes sense for the twenty-first century. Medicaid does not cover many very low-income people, whereas it covers some who are well above poverty. It spends large amounts of funds but provides little coordination of benefits and care for people who are covered by both Medicaid and Medicare (dual eligibles). Medicaid started as a narrow, focused program but has become a major funder for "moms and kids," acute care and long-term care for the elderly and disabled, and a supplemental insurance program for the poor elderly. Finally, for all of the money Medicaid has spent, little is known about its impact on the health status of the low-income population it serves.