Op-Ed

Medicare Physician Payment Reform in 2014 Is Looking Unlikely

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AFTER MORE THAN TWO DECADES OF PAYING PHYSICIANS USING a resource-based relative value scale (RBRVS) in combination with a spending limit, there has been a growing convergence of views in Congress about the next steps needed to reform how physicians are reimbursed by Medicare. Despite this and a decade of frustration over the threats of significant reductions in fee payments that have been a part of the last quarter of each year since 2004, the likelihood of getting legislation through Congress is less promising than it looked at year-end. The reason for this shift in mood is an important reminder of how hard it can be to get a reformed payment system through Congress.

The Relative Value Scale with a Spending Limit

The physician payment reform that began in 1992 combines a spending limit with (1) the use of a fee schedule that sets a relative value based on the amount of work associated with providing the service, (2) the average practice expense associated with providing the service, and (3) a geographic adjustment factor. The relative prices are converted to dollar amounts based on a conversion factor that is set by statute. A spending limit has always been a part of this relative value system. Initially called a “volume performance standard,” the current spending limit—the sustainable growth rate (SGR)—was established by the Balanced Budget Act in 1997 and ties the growth in physician spending to the growth in the economy.

The slowdown in economic growth that started in 2003, along with an increase in the volume of physician services provided, has resulted in a series of “negative updates” (ie, fee reductions). Although Congress has chosen to override this spending limit each year since 2003, it generally has paid the cost of the override for only the year in question, which has

meant that the cost of eliminating the spending limit has grown over time.

The use of a fee schedule that has physicians bill Medicare on the basis of thousands of CPT (current procedural terminology) codes in combination with a spending limit is very different from the way that Medicare reimburses for other services. Since the early 1980s, Medicare has been moving to the use of “bundled payments” for most other services, with a single payment covering most or all of the services provided during a health care event such as a hospital stay or an episode of home care. But bundled payments have been challenged because they may encourage a proliferation of “bundles” to be provided, such as hospital readmissions, or a skimping of services, since by definition, the amount of revenue received is fixed prospectively. Unlike the RBRVS, however, the use of a bundled payment that does not vary with the amount of resources used actually encourages the efficient delivery of services.

By contrast, the RBRVS rewards neither efficiency nor value. A fee schedule with thousands of CPT codes effectively makes it impossible to hold physicians accountable or responsible for the clinical outcomes of their patients. The use of an RBRVS in conjunction with a spending limit also produces a “disconnect” between the behavior of an individual physician and the aggregate behavior of all physicians. The SGR is driven by the aggregate behavior of all physicians, and no one physician’s practice is big enough to influence aggregate spending. This means that there can be no reward for “good” (efficient, high-value) behavior and no consequence for “bad” (costly, low-value) behavior. The yearly overrides of the spending reductions implied by the SGR also have limited its effectiveness for physician spending.

The SGR Repeal and Replacement Bill

In a rare example of bipartisan and bicameral activity, the House Ways and Means Committee and the Senate Finance Committee first collaborated on a legislative framework, which was released last October, and then they produced a bill to permanently repeal the SGR and put in its place a reimbursement system that moved physician payments to a more value-oriented reimbursement system. This combined effort was similar to a bill passed by the House Energy and Commerce Committee last July.

The most recent legislation increases physician payments by 0.5% per year for 5 years but also offers the possibility of a 5% increase for physicians who provide a significant amount of care in alternative delivery systems. In addition, it consolidates 3 existing Medicare quality payment programs and provides incentives for physicians to coordinate care for their patients with chronic diseases. It calls for the development of physician-developed clinical guidelines and a technical advisory committee that would develop metrics for transparency and quality and recommend which alternative delivery payment models should be used to justify higher payments.

The Challenges

The most obvious challenge is for Congress to agree on a set of spending reductions that would pay for the repeal of the SGR and any costs associated with the new payment system. The “cost” of the repeal itself represents the amount of revenue that would otherwise be generated by having the SGR in place. Current budget rules require Congress to come up with an equivalent amount of revenue, even though the SGR has been used only once. Congress estimates that this amount will be \$138 billion over 11 years (1 year longer than the traditional score). Other payments would be required as well, such as the additional \$10 billion to pay for the 0.5% increase per year.

Senator Ron Wyden (D-OR), the new chairman of the Finance Committee since the departure of Senator Max Baucus (D-MT) to become ambassador to China, has already said that the funding for a permanent repeal of the SGR will be very challenging. He also has indicated that the funding for new health care spending will need to come from cuts in health care, which is important, since some of his Democratic colleagues were trying to use “savings” from winding down the war in Afghanistan as the source of funding for repealing the SGR.

Policy analysts from both the left and the right of the political spectrum have begun complaining about the legislation. The left has complained that the proposed legislation partially represents a backsliding from certain provisions rewarding value-based practice that are scheduled to go into effect under current law and that it also would increase cost because of the way it is structured. For example, by consolidating the 3 quality payment programs, the amount of payment that would be at risk in 2018 would be half of what it would be under current law

and would be only marginally stronger in 2021. In addition, the ability of physicians to pick and choose which quality measures would be used to assess them and requiring only those metrics that physicians have submitted have raised concerns about whether the resulting evaluations would be biased. Increasing payments for physicians who use alternative payment methods rather than penalizing those who remain in fee for service has added about \$5.5 billion to the legislation.

The concern from the right is that the government is substituting one dysfunctional, government-designed payment system with another government-led payment system, one that would have the government decide what constitutes quality physician care and which metrics should form the universe of metrics used for measuring physician quality.

The interest in moving away from what has been seen as a frustrating and unsatisfactory physician payment system remains strong, however, especially among physicians. Whether that and the tiresome nature of the end-of-year SGR fixes will be enough to push the legislation across the proverbial goal line has yet to be determined. If not, Congress has to put in at least enough money to get the existing legislation through the end of the year, which it has now done.

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