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SGR: Data, Measures and Models; Building a Future Medicare Physician Payment System

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Chairman Pitts, Representative Pallone, and members of the Committee:

I very much appreciate the opportunity to provide testimony to the Committee as it attempts to identify how to achieve higher value for physician services for Medicare beneficiaries and taxpayers. It is a subject that I have been deeply involved with through most of my professional career. I have had a diversified career as a general internist, practicing just a few blocks from here, a medical director of a preferred provider organization and two independent practice associations, a senior official at CMS in the Clinton Administration, and Vice-Chair of MedPAC until this past May. As an Institute Fellow at the Urban Institute, I have been studying the effects of the Medicare Physician Fee Schedule and am involved now with colleagues from UI and two other policy research organizations in trying to develop improved methods for improving the valuation of services in the fee schedule.

I understand and support the Committee's interest in moving from volume-based to value-based payment. However, I think in some ways the value-based payment concept has gotten off track. I want to focus my testimony on some misconceptions inherent in current policy discussions and also offer some specific recommendations in this area that in my opinion have not received enough attention by policymakers.

The challenges of performance measurement and pay-for-performance

The current approach to value-based payment basically attempts to measure what all physicians do and provide financial rewards or penalties physicians based on their performance on a few particular clinical activities. The approach assumes we have robust quality measures that are a fair representation of a physician's clinical activities and that providing financial incentives to the physicians based on these measures will improve the quality of their professional activities to benefit their patients. I would point to a number of concerns with this formulation.

First, the available process measures that CMS has adopted in the Physician Quality Reporting System (PQRS) program for most physicians capture very little of their professional activities. To illustrate, MedPAC data show that family physicians, general practitioners, and general internists treat nearly 400 different diagnostic categories in a year, with about 70 categories making up 80 percent of their clinical episodes.[1] Basing a payment modifier on performance on as few as three PQRS measures, the current plan, will therefore not provide a meaningful assessment of the quality of a clinician's care.

[1] Medicare Payment Advisory Commission, "Outlier Alternative," Report to Congress: Assessing Alternatives to Sustainable Growth Rate System (Washington, DC: MedPAC, March 2007).

Further, there are major gaps in available performance measures, some of which are unlikely to be filled, even with information from electronic health records. For example, the core of what we want to measure for many specialties—making correct diagnoses—is not measured now nor easily measurable, even from medical records. Nor, for the most part, can we measure from administrative claims data whether a particular intervention was appropriate based on the patient's clinical circumstances and preferences. Yet, overuse of services remains a major problem in the provision of physician services. Given the inherent lack of face validity for physicians of this particular measurement exercise and the reporting burden created for practices, it is not surprising that participation in the PQRS has attracted fewer than 30 percent of physicians who have billed Medicare since the program was launched in 2007.[2]

The technical issues in assigning a cost measure to physicians are similarly difficult. Physicians not only provide services for which they are paid directly, they are also responsible for ordering services across the continuum of care—care provided by other physicians, hospitals, clinical labs, post-acute care facilities, and so on. Yet, the problems inherent in attributing costs generated by many clinicians and institutional providers to a single physician are daunting in the full freedom-of-provider-choice, traditional Medicare program. In short, while I give CMS great credit for trying to accomplish what Congress has mandated, the mission of creating a physician-specific, value-based payment modifier is too ambitious; the numerator of the value equation—quality—captures too little of any physician's performance on quality, while the denominator—cost—cannot be accurately attributed to an individual physician. CMS has correctly started with valuing the performance of large groups, a more promising approach than focusing on individual physicians.

Rather than attempting to provide a "value-index" for each physician, CMS should focus it use of measures derived from quality and cost data on outlier physicians—those who are overtly abusing the fee-for-service system for personal reward or simply not practicing acceptable quality or reasonably prudent care. Performance against available measures would not be sufficient to make a correct assessment of any physician's performance, but would point the way to those for whom more targeted evaluation, including clinical records review, should be conducted.

Second, recent research studies are finding that pay-for-performance as adopted in Medicare has not been particularly successful. The major demonstration—the Premier Hospital Quality Incentive Demonstration Project—did not actually produce better results than other hospitals, which with a short lag demonstrated comparably improved scores on what were mostly

[2] Iglehart, J.K., and Robert Baron. "Ensuring Physicians' Competence—Is Maintenance of Certification the Answer?," *New England Journal of Medicine* 367:26, 2012.

process measures of quality.[3,4,5] Perhaps most troubling, the evaluations have found little evidence that improving the mostly process measures used in CMS's core measure set actually produce better patient outcomes, which after all is the objective. In responding to incentives to improve their measured performance on a relatively few quality process measures, clinicians and hospital staff may well be diverting their attention from other activities to improve quality, much of which would involve developing detailed work process routines to increase the reliability of service delivery. An example would be adoption and deployment of evidence-based checklists providing straightforward activities that doctors, nurses, and other hospital personnel need to consistently follow to achieve good clinical outcomes. Work process improvements have led to major reductions in hospital infections, yet are activities carried out by quality improvement teams within hospitals and not readily amenable to performance measurement using process measures. Stimulating such quality improvement to actually improve outcomes is best supported by a move from measuring and publicly reporting a relatively few processes of care to reporting important outcomes. In the context of hospital value-based payment, CMS indicates that it needs to strengthen its portfolio of hospital measures, especially outcome measures, such as by emphasizing measures of 30-day mortality, hospital-acquired infections, cost, and patients' experiences with care.

For physicians, we know even less about whether reporting and performing well on a handful of process measures makes much difference to patients. Even in the United Kingdom, which in its Quality and Outcomes Framework provided bonuses of as much as 25 percent to general practitioners based on performance on more than a hundred primary care measures, the evidence is mixed on whether patient outcomes have improved meaningfully despite major improvements on the reported measures.[6,7]

I am not questioning the importance of the goal of improving physician performance on process activities that are clearly associated in clinical research studies with better outcomes. Clearly, control of blood pressure in diabetics would reduce disabling complications, such as renal failure and heart attacks. We know that having patients with cardiovascular disease take a small aspirin tablet daily would decrease subsequent cardiac events. What I am questioning is the

[3] Werner, R.M. and Dudley Adams, "Medicare's New Hospital Value-Based Purchasing Program Is Likely to Have Only a Small Impact on Hospital Payments," *Health Affairs* 31:1932–40, 2012.
[4] Andrew M. Ryan, "Effects of the Premier Hospital Quality Incentive Demonstration on Medicare Patient Mortality and Cost," *Health Services Research* 44(3):821–42, 2009.
[5] Jha A.K., K.E. Joynt, E.J. Orav, et al., "The Long-Term Effect of Premier Pay for Performance on Patient Outcomes," *New England Journal of Medicine* 366(17):1606–15, 2012.
[6] Sutton M., S. Nikolova, R. Baoden, et al., "Reduced Mortality with Hospital Pay for Performance in England," *New England Journal of Medicine* 367 (19): 1821:28, 2012.
[7] Campbell, S.M., D. Reeves, E. Kontopantelis, et al., "Effects of Pay for Performance on the Quality of Primary Care in England," *New England Journal of Medicine* 361(14): 368–73, 2009.

strategy of burdensome and error-prone reporting and pay-for-performance as the dominant approaches to achieving greater success on fostering evidence-based medicine.

Behavioral economics offers insights into why, despite intuitive appeal, pay-for-performance may have a limited—or even adverse—impact on improving quality of care. Economic incentives seek to change behavior through extrinsic motivation, yet most clinicians want the best outcomes for their patients based on an intrinsic motivation to act in their patient's best interests. And even when motivation is lacking, money may not be the solution, since the behavioral economics literature shows that performance bonuses often backfire, particularly for cognitively challenging activities performed by highly skilled persons needing to muster their skills to manage complexity and creatively solve problems.[8,9] Experimental data demonstrate that financial incentives often "crowd out" intrinsic motivation. If intrinsic motivation is high and crowding out is strong, payment incentives may actually worsen performance.

Value-based payment has been too narrowly conceived

What has been lost in equating value-based payment with pay-for-reporting and pay-for-performance is the recognition that value can be improved not only by improving how well particular services are provided but also by improving the kind and mix of services that beneficiaries are receiving. The Medicare Fee Schedule for physicians and other health professionals produces too many technically oriented services, including imaging, tests, and procedures, and not enough patient-clinician interaction to diagnose and develop treatment approaches consistent with a patient's values and preferences, and continuing engagement to assure implementation of mutually agreed upon treatment plans. Similarly, the fee schedule does not encourage care coordination and other patient-centered activities that would actually improve patient outcomes, including their own sense of well-being.

In urging more attention to modifying payments and payment methods to obtain a better mix of clinician services, I want to emphasize that while I agree with the conventional policy wisdom that fee-for-service as a payment method has substantial, inherent flaws and over time needs to be replaced—mostly—fee-for-service gets an undeservedly bad reputation because of its flawed implementation in Medicare and by private payers, which largely rely on the Medicare Fee Schedule in setting their own fee schedules.

The resource-based relative value schedule that was implemented beginning 20 years ago was a definite improvement over the prior system but has not achieved its intended purpose of reorienting payment—and care—away from technical services toward primary care and what

[8] Cassel, C.K., and J. Jain Sachin, "Assessing Individual Physician Performance: Does Measurement Suppress Motivation?" *Journal of the American Medical Association* 307(24):2595–96, 2012.
[9] Daniel H. Pink, *Drive: The Surprising Truth about What Motivates Us*. New York: Riverhead Books, 2011.

are called evaluation and management services, such as office visits. That objective has not been achieved for a few reasons. Current estimates of the relative resource costs associated with each of the 7,000+ individual services that Medicare pays for are flawed. The resultant payment distortions lead physician practices to emphasize services with remarkably high profit margins, leading to the proliferation of a raft of tests and procedures, while skimping on activities that might actually help patients more, including longer office visits, more frequent communication with patients outside office visits, and better care coordination.

Although fee-for-service payment often is criticized for providing incentives for excessive volume of services, regardless of need, in fact, fee-for-service does not reward all volume equally. It does not reward provision of services that are not on the fee schedule at all nor does it promote volume for services that are not particularly profitable. The policy wisdom that physicians respond to a reduction of fee schedule prices by increasing their volume does not hold for many services, as recent research and natural experiments demonstrate. In short, a "smarter" fee schedule can increase the volume of desired physician activities and depress overproduction of profitable services being provided to excess.

Indeed, one the positive attributes of fee-for-service is that payers and clinicians can identify clinical activities that need financial support, develop the necessary payment codes that describe the activity, and then pay enough so that physicians will perform the services, especially if their intrinsic motivation to help patients is supported. Yet, until very recently, there has been little interest in identifying and paying for activities needed for an aging Medicare population, many of whom now live longer but with multiple chronic conditions and, in many cases, serious functional limitations.

The changing demographics call for much more attention to evaluation and management broadly conceived; it includes attention to shared patient-clinician decisionmaking, teaching patient self-management skills, greater attention to medication management, counseling, care coordination, and other activities that currently do not receive explicit attention in fee schedules. The result is that physicians continue to perform lucrative, but often unneeded, tests and procedures while skimping on various activities that are not able to be done in an occasional 15 or 20 minute office visit. Here, fee-for-service is a problem in that it is hard to pay for some of these desired evaluation and management activities *a la carte*. However, a fee schedule can accommodate monthly care management fees for high-risk patients and can develop and recognize for payment other codes that would alter the current mix of services beneficiaries receive. The result would be more value-based payment in a volume-based payment system.

Price distortions are not inevitable

Or at least they can be reduced significantly. A clear example is the natural experiment that resulted from Congress's reduction in overpriced advanced imaging services in the Deficit Reduction Act of 2005. The policy to pay physician practices no more for advanced imaging services, like CT and MRI, than what is being paid for the same services when provided by a hospital outpatient department produced significant program savings directly from the price reduction. In addition, the rate of increase in the performance of these imaging services declined, although still positive.[10] Now years later, the volume of advanced imaging services are pretty flat, in marked contrast to the double-digit rates of increase that occurred through the first part of the last decade. It is not clear that the significant reductions in prices for many advanced imaging tests led to the moderation in volume growth—volume growth has decreased as well for imaging services whose prices were not reduced. However, the price reductions did not generate volume increases to make up for the price reductions.

Anecdotally, at least some of the decline in the growth of advanced imaging services resulted from mid-sized medical practices no longer finding it fiscally prudent to purchase these scanners as highly profitable ancillary services, given the reduction in fees. What the experience suggests it is that physicians do not necessarily respond to fee reductions by increasing the volume and intensity of the services receiving the cuts. Their behavior is more nuanced and varies by their circumstances and the nature of the particular services under consideration. The clear policy implication is that Medicare can buy a better mix of services by altering the prices paid for services, balancing considerations of assuring good beneficiary access to care and reducing overuse of services produced partly from inordinately high payments.

Fee-for-service: end it or mend it?

I share the broad policy community sentiment for moving away from fee-for-service to new payment models involving some amount of physician risk-taking. Even if the current distortions in the Medicare Fee Schedule were reduced substantially, not an easy achievement, fee-for-service nevertheless retains inherent incentives for raising the volume and intensity of services. Further, separate fee-for-service revenue streams reinforce siloed clinical practice at a time when the current challenges of health care delivery demand much greater cooperation and coordination across the numerous sites of health care services provision and community resources. Nevertheless, there are several reasons to improve the Medicare Fee Schedule over the short to medium term, even if the ultimate goal is to reduce its importance or eliminate it altogether.

[10] Government Accountability Office, *Trends in Fees, Utilization, and Expenditures for Imaging Services before and after Implementation of the Deficit Reduction Act of 2005* (Washington, DC: Government Accountability Office, 2006) GAO-08-1102R.

In fact, I believe it is necessary, if seemingly paradoxical, to take firm steps to improve the fee schedule in order to implement new and improved payment reform models for a number of reasons. First, the migration to new payment models that better reward prudent care will not be easy or quick. Despite hopes for a fast track to new payment approaches, it will take years for the Medicare payment pilots to be tested, refined, and then scaled up to be implemented on a widespread basis. Second, fee schedule prices are building blocks for virtually all of the payment reform approaches being tested, most notably bundled episodes, but also shared savings and global payments for accountable care organizations (ACOs). Errors in individual fees in the Medicare Fee Schedule would therefore be carried over into the bundled episodes and shared savings calculations.

Third, entities like ACOs will work best when formed around multispecialty group practices and independent practice associations, which would be well positioned to accept care responsibility for a population and to organize needed services across the spectrum of providers. But specialties that continue to be generously rewarded from distorted prices under current public and private fee schedules, such as cardiology and radiology, prefer to continue in large single specialty practices or to cash out and accept hospital employment rather than join with primary care physicians to form and maintain the medical group. Perpetuating the current, nearly 3:1 compensation differences between important specialists and primary care will frustrate the transition to ACO-like delivery systems, even if they are supported by new payment approaches. Narrowing the compensation differentials that the Medicare Fee Schedule produces now would help create the environment in which ACOs can become established and do well.

For better or worse, organizations we consider as prototypical ACOs often use Medicare-determined relative value units as the basis for determining their internal compensation approaches. It is informative that many of these groups take advantage of one of the positive attributes of fee-for-service payment—to reward industriousness. Even if the groups themselves receive global payments, they may turn around and reward physicians for productivity, as measured by “work RVUs” (work relative value units) generated. But again, if the RVU valuations are off, the organization’s assessment of productivity will be off as well—and an ACOs may find it unwittingly is perpetuating the income disparities that plague current fee-for-service payment.

Finally, some better functioning payment approaches actually retain an element of fee-for-service because, as I have emphasized, fee-for-service does have certain positive attributes. My personal choice for payment reform would be moving toward global payment approaches to support ACOs, but using risk-sharing with Medicare rather than full risk for many ACOs. One way to moderate risk and protect against stinting on services is through what is called partial

capitation—a combination of fee-for-service and per member per month payment for a population. Mixed payment approaches also work well for supporting individual physicians as well. A few European countries use an approach of mixing fee-for-service for visits with a monthly fee to support primary care physicians, one of the approaches that is being tested in CMS's advanced primary care demonstrations. In short, there are many good reasons to continue and improve the Medicare Fee Schedule as we test improved payment models for future adoption.

Moving to new payment approaches: the role of demonstrations

An important way to obtain higher value for beneficiaries is to adopt new payment approaches with better incentives for prudent use of resources, even if we back off the commitment to measuring and publicly reporting individual physician performance, as I am suggesting. Rather than assuming that a limited and intrusive portfolio of measures will improve value, the new payment methods are promising because they embed the incentives for better care into the payment model itself; then targeted quality measures can complement the new payment method by focusing on particular activities, some of which might be adversely affected by the altered payment incentives. That is the approach CMS is taking under the Shared Savings Program for ACOs. Incentives for more prudent use of resources derive from the fully implemented shared savings payment approach. And the quality of certain activities that might be compromised in the zeal to contain costs are being measured to help guard against stinting on care.

A range of payment methods and new organizational delivery structures are being tested, from Independence at Home practices providing "house calls" for frail seniors and disabled to bundled payments for acute care events around a hospitalization to ACOs responsible for populations' health care. I have my own views on which of these and other approaches offer the greatest potential, but here I want to make some general points about the purpose and nature of demonstrations, based partly on my experience as responsible for many of the demonstrations CMS was running when I was there 10+ years ago.

First, it is important not to draw early—often premature—conclusions from demonstrations, sometimes based on partial information or claims of success by self-interested parties. For example, the declared, early success of the Premier Hospital Demonstration of pay-for-performance was not corroborated in subsequent, careful external evaluations, yet the early claims contributed to Congress's formation of Medicare value-based purchasing program for hospitals.

Currently, some are claiming success for the ACEs (Acute Care Events) demo testing bundled episode payment for joint replacements and cardiac procedures. In this demo, Medicare

obtains a small payment discount off the top, while in early findings the "bundled" hospitals and physicians apparently have saved money by agreeing to combine their bargaining power to obtain substantial discounts on equipment and supplies related to these particular procedures.[11] Further, the bundled payment for a discrete episode of care provides the hospital-physician collaboration a concrete, financial reason to get together to improve quality and efficiency, offering the possibility of savings beyond obtaining lower prices for joint appliances and coronary artery stents.

However, it is also plausible that the new financial alignment could stimulate efforts for the physician-hospital collaboration to brand, market, and otherwise attempt to induce demand for these services, which already are examples of services that research shows are significantly overused.[12] After all, bundled episodes remain a form of volume-based payment, even if the approach varies from traditional fee-for-service. Only a comprehensive, external evaluation of the ACEs demo will reveal whether the likely per case savings attained will be offset by an increase in service volume.

The second caution is that the behavior that is seen in a demonstration may not be the same as what would occur if the payment or organizational innovation is adopted broadly in Medicare. Demonstrations sites usually are not typical providers. They may be "early adopters" of a particular approach that is being tested—with an interest in demonstrating success. Further, in a demonstration the sites are under a spotlight, and their behavior is not necessarily reflective of what would take place once the spotlight is turned off.

I am not raising this concern about generalizability from demonstrations to dismiss the desirability of doing demonstrations to inform policy. Rather, I would emphasize that a major purpose of demonstrations is to test operational feasibility of a new approach to payment or delivery for CMS, its contractors, providers, and beneficiaries. There may be important lessons learned that inform how policy might proceed, even if the overall impact of the demonstration cannot be characterized as a "success" or "failure." For example, the Physicians Group Practice Demonstration was not a success overall,[13,14] yet the operational lessons and observations about medical group behavior importantly led to the Affordable Care Act's adoption of the Shared Savings Program and what has become the Pioneer ACO Demonstration.

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[11] Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System* (Washington, DC: MedPAC, June 2011).
[12] Berenson, R.A., and Elizabeth Docteur, *Doing Better by Doing Less: Approaches to Tackle Overuse of Services* (Washington, DC: Urban Institute, January 2013).
[13] Gail Wilensky. "Physician Group Practice Demonstration—A Sobering Reflection," *New England Journal of Medicine* 10(1056): 1–3, October 2011.
[14] Robert A. Berenson, "Sharing Savings Program for Accountable Care Organizations: A Bridge to Nowhere?" *American Journal of Managed Care* 16 (10): 721–26, October 2010.

At some point, the decision on whether to adopt a new payment approach broadly into the Medicare program is a judgment call about which the demonstrations can be informative but not decisive. I believe we are a number of years away from being able to make good policy decisions about which new payment methods to adopt and whether to make them available as options for practices along with a legacy fee schedule available for those who opt to not play or to make them mandatory as an no-choice substitute for fee-for-service.

Fortunately, the remarkable recent moderation in service volume and intensity growth in Medicare generally and for physicians in particular offers the opportunity to take the necessary time to learn from the many demonstrations being tested in Medicare, from the experience with other payers' similar initiatives, and experience from other countries, about how best to proceed to replace or complement a physician fee schedule. My estimate is that five or more years will be needed to achieve some consensus on a major reformulation of payment for physicians. In the meantime, many physicians already have the opportunity to opt into ACOs, which is the most important and far-reaching approach being tested or to participate in some of the other promising demonstrations.

Improving value in the short term

For the short term, I would offer the following list of immediate steps Congress should consider to support an improved physician payment system.

1. With the CBO score for repeal of the Sustainable Growth Rate (SGR) now down to $138 billion, it is time to eliminate it once and for all. MedPAC proposed elimination when the score was $300 billion and produced a balanced portfolio of payment reductions to physicians and other Medicare providers and suppliers to offset the cost. Given the new circumstances, I believe a balanced approach would still be the best way to proceed, with a much smaller, but real, reduction in payments for non-primary care services in the Medicare Fee Schedule. CMS has started more actively to correct misvalued services, as MedPAC has recommended for a few years and as the Affordable Care Act mandated. This activity would redistribute relative value units and dollars to produce a different mix of services, which among other things would help address the current and growing shortage of primary care workforce. I understand that in difficult budget times, it is difficult to find new money for the substantial administrative work to accomplish the needed, major recalibration of the Medicare Fee Schedule. Yet, attention to misvalued codes now would more than pay for itself in reduced health spending in the future.

2. For now, I would not replace the SGR mechanism with a different volume control mechanism to automatically reduce fees for volume growth that exceeds a target amount. Rather, I would aggressively work to improve the accuracy of the fees—that is, payment in relation to the

resource costs of production—to alter the incentives for volume growth rising primarily as a source of windfall profits for certain specialties.

3. I would specifically target services that are provided in accordance with the In-office Ancillary Services (IOAS) Exception to the Stark self-referral regulations to target these for specific fee cuts if analysis shows, as I expect, that many are overvalued. In addition, consideration should be given to narrowing or eliminating the IOAS exception for those services that are rarely performed during the same visit it is ordered. Imaging, pathology, and physical therapy are among the services that have grown inappropriately from self-referral abuse.[15,16] The more general policy guidance is to rely on discrete policy interventions to reduce volume growth for particular services rather than rely on across-the-board fee cuts, as under the SGR.

4. As part of a thorough review of the Medicare Fee Schedule, it is time to redefine the core evaluation and management, visit codes that in aggregate represent almost 45 percent of spending under the fee schedule. Among other problems with the current codes and their definitions, recent research shows there is an epidemic of office visit up-coding—physicians and hospitals providing outpatient services.[17,18] While I argued earlier that there is relative underpayment of evaluation and management services in comparison to tests, imaging, and procedures, that unfortunate reality does not provide an excuse for physicians to abuse the payment system by up-coding to make up for what they consider insufficient payment rates.

Still, the code definitions need to change so that there is less ambiguity about how physician practices should correctly code. We need to explore whether the decision made two decades ago to have a single set of visit codes for all specialties and for all patients needs to be revisited, given growing patient heterogeneity. Further, the current evaluation and management definitions and accompanying documentation guidelines have a highly negative impact on the potential use of electronic health records, which have been developed and implemented more to permit easy compliance with CMS documentation requirements than to promote decision support to physicians to improve their care. Clearly, the current documentation requirements are having a detrimental effect on the value of care beneficiaries receive.

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[15] Government Accountability Office, "Higher Use of Advanced Imagine Services by Providers Who Self-Refer Costing Medicare Millions" (Washington, DC: Government Accountability Office, September 2012) GAO-12-966.
[16] Medicare Payment Advisory Commission, Report to Congress: Aligning Incentives In Medicare, "Chapter 8: Addressing the Growth of Ancillary Services in Physicians' Offices" (Washington, DC: MedPAC, June 2011).
[17] Abelson, R., J. Creswell, and Griff Palmer, "Medicare Bills Rise as Records Turn Electronic." *New York Times,* September 21, 2012.
[18] Shulte, F., and David Donald. "How Doctors and Hospital Have Collected Billions In Questionable Medicare Fees" (Washington, DC: Center for Public Integrity, September 2012), http://www.publicintegrity.org/2012/09/15/10810/how-doctors-and-hospitals-have-collected-billions-questionable-medicare-fees

5. Any overdue correction of misvalued services will be counterproductive unless the current site-of-service differential is corrected. In accordance with that differential, “provider-based payment” pays as much as two times more for physician services when provided in an outpatient department than in an independent physician’s practice. There was a reasonable rationale for the site-of-service differential when outpatient departments were appendages of the main hospital, which, in contrast to physician practices, have obligations to have “stand-by capacity” and offer 24/7 access to emergency departments, accompanied by some amount of uncompensated care. However, in recent years, provider-based payment has become a primary reason for hospital employment of physicians. But now, the newly employed physicians usually do not move their practices to the main hospital campus and participate in the broad mission of the hospital related to access to care. Rather, they maintain their established practice locations and rarely change the payer mixes of their patients. Yet, the combined hospital facility fee and physician’s professional fee adds up to a doubling of the payment—and a commensurate doubling of the patient’s co-insurance obligation.

A few years ago, CMS reasonably reduced the overpayment for cardiac imaging tests performed in physician offices; yet, the correction initiated a hospital employment frenzy of cardiologists to take advantage of the higher outpatient payment rates. The result is that Medicare perversely wound up paying more for the same services to the same patients. Hospitals do have costs that independent practices do not face, but these costs should not be reflected in services that do not reflect hospitals’ unique obligations. The site-of-service differential for physician services should be significantly reduced or eliminated, while the costs that hospitals do bear for their unique obligations should be paid for but through other means, possibly through increases in inpatient, emergency department and other unique hospital services.