Medicare Pay Fix Won't Come Cheap or Easy

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WASHINGTON — It won't be cheap to fix Medicare's problematic physician pay formula, but lawmakers aren't saving any money by waiting to replace it either, experts testified at a hearing of the Senate Finance Committee.

"We have been kicking this can down the road for the past 5 years. This committee, and certainly Congress, understands it's not going to get any easier," said Dr. Cecil Wilson, board of trustees chairman for the American Medical Association.

The rising cost of health care is one of the biggest problems facing the government. At the current rate of growth, federal spending on Medicare and Medicaid will eventually consume 20% of the U.S. economy, according to Peter Orszag, Ph.D., director of the Congressional Budget Office (CBO).

"In health care, we get what we provide incentives for. We currently provide lots of incentives for advanced technologies and high-end treatment, and we get a lot of that. We provide very little incentive for preventive medicine and get very little of that," testified Dr. Orszag.

Early in 2006, lawmakers asked the Medicare Physician Advisory Commission (MedPAC) to examine ways to shift those incentives. Their findings were presented to the committee a few days before MedPAC members presented the commission's annual report to Congress.

While the report represents the consensus of the commission, commissioners were unable to forge a consensus on what should be done to replace the Sustainable Growth Rate (SGR) system, MedPAC Chairman Glenn Hackbarth testified.

Instead, the commission offered lawmakers two alternative approaches—one that doesn't include an SGR-like spending target and one that does.

Eliminating spending targets altogether would require Congress to create a whole new system with incentives to physicians to provide high-quality and low-cost care, Mr. Hackbarth said. Choosing to keep spending targets would simplify payment reform but still would require changes to make the system more equitable.

In opposition to spending targets, Dr. Wilson said, "No amount of tinkering can fix what is broken beyond repair." While doctors account for a small portion of increasing premiums, they are the only group that has spending targets imposed on them, he added.

"The AMA asks that Congress ensure that physicians are treated like hospitals and other providers by repealing the SGR and enacting a payment system that provides updates that keep pace with increases in medical practice costs. We, in turn, are committed to helping assure appropriate use of services," he said.

In cooperation with several other physician groups, the AMA brought to the hearing a list of recommendations to achieve those goals. In addition to repealing the SGR, the recommendations included having Medicare reimburse physicians for care coordination services that occur outside of a face-to-face visit, and re-examining Medicare's pay-for-performance program.

Dr. Richard Hellman, president of the American Association of Clinical Endocrinologists (AACE), said in an interview that AACE was in agreement with many of the AMA's recommendations. "We think [the pending payment cuts] will decrease access to care," he said. "Many in Congress seem to be making the calculation that physicians will not leave Medicare, that they will stay in it regardless of what changes in payment policy are made. I think that's a cynical calculation. And the evidence strongly suggests that when physicians are under stress—when they can't earn a living unless they see people more quickly— patient quality of care and safety are put at risk."

Speaking for himself, Dr. Hellman suggested that Congress needs to reconsider the whole way it looks at Medicare payments. "Currently, if a physician uses his or her skill to prevent a hospitalization or to reduce the number of complications, the rewards go to someone else," said Dr. Hellman, clinical professor of medicine at the University of Missouri, in Kansas City. "All the government sees is that the physician saw the patient more often or prescribed more medication; it doesn't consider the favorable effect that has on the rest of the system in terms of less nursing home care and less hospital care.

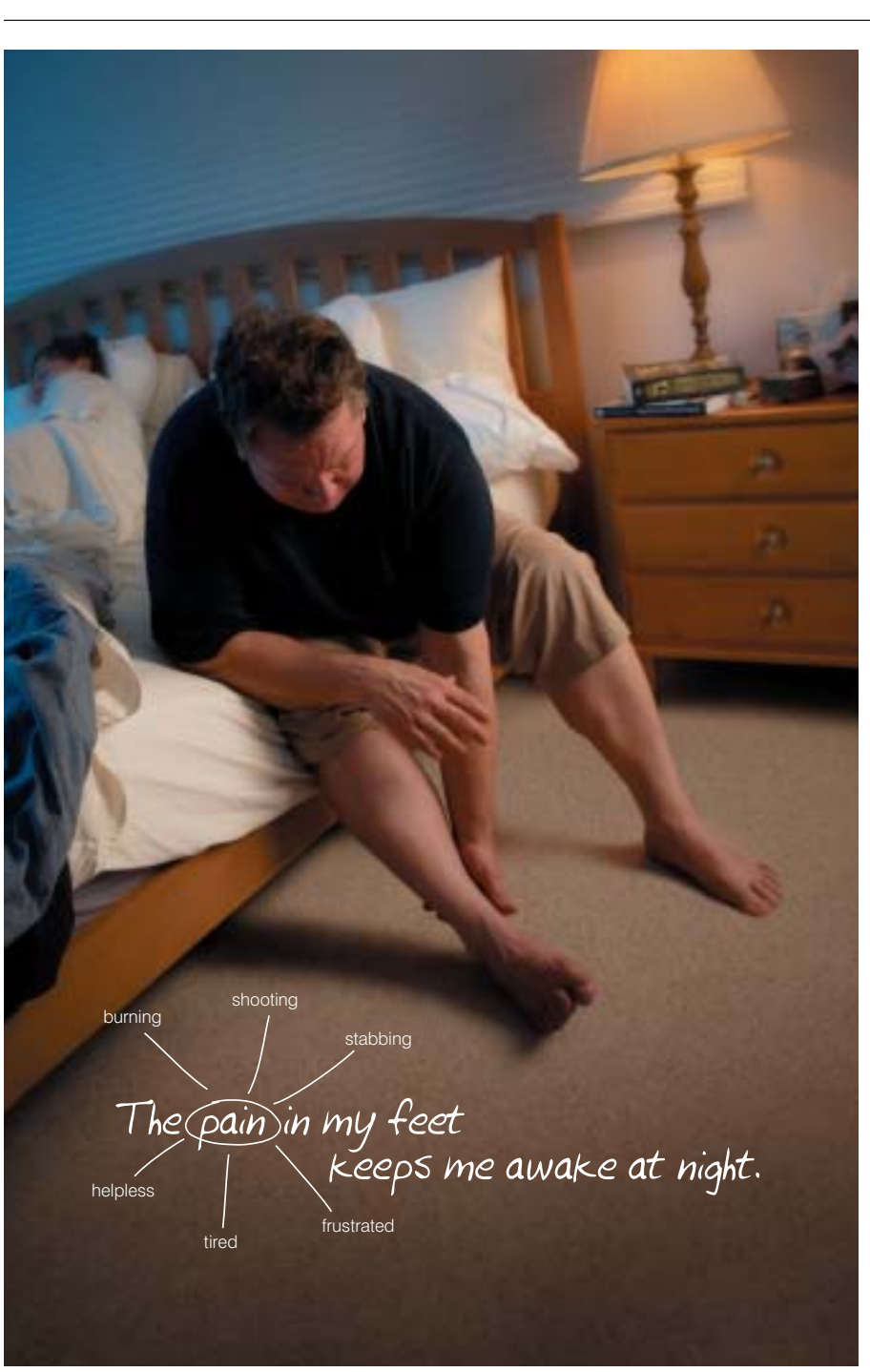
"As long as Congress is paying for hospital care and physician care out of separate buckets, it can never understand that interrelationship and will vainly try to save costs by restricting physician payments," he continued. "That will only increase quality and safety problems and drive up costs on the other side."

No matter whose plan is embraced, fixing the SGR system is unlikely to come cheap. The CBO has estimated that current proposals will cost anywhere between $22 billion and $330 billion over 10 years.

"There are lots of steps, including [health information technology] and comparative effectiveness, that offer at least the potential to bend that curve over the long term, but the cost savings may not show up in the next 10 years. That is just the way it is," testified Dr. Orszag, adding that it will take time and resources to build a system in which Medicare pays for high-value instead of high-cost services.

"Given the scale of the problems that we face, we need to be trying lots of different things and recalibrating all the time," he said.

Asked by senators what to focus on first, Dr. Wilson responded, "It would be nice if we had the luxury of just having one thing on our plate and one magic bullet, but we don't." ■



MedPAC Offers Two Paths: One With Expenditure Targets, One Without

In testimony to the health subcommittee of the House Ways and Means Committee, Mr. Hackbarth explained that the MedPAC commissioners struggled with their task of choosing an alternative to the current sustainable growth rate (SGR) system. He reported that there were many tough debates, and that commissioners couldn't agree on just one solution. So instead they offered two proposals—ones they've deemed "Path 1" and "Path 2."

Path 1 calls for repealing SGR and eliminating the system of expenditure targets. The MedPAC report suggests that Congress should implement new ways to improve incentives for physicians and other providers to offer quality care to their patients at lower costs. This could be done in the following ways:

► Giving the Centers for Medicaid and Medicare Services the authority to pay providers differently based on performance measures;
► Ensuring accurate prices by identifying and correcting mispriced services;
► Encouraging coordination of care and use of care management, especially for patients with chronic conditions.

Path 1 also calls for collecting information on physicians' practice styles and sharing the results with other physicians across the country. The commission proposes that Medicare could then use the results to adjust payments to physicians and base rewards on both quality and efficiency.

Path 2 calls for pursuing the approaches in Path 1 but also including a new system of geographically adjusted expenditure targets. The MedPAC report states that expenditure targets are necessary because they put "financial pressure on providers to change." Path 2, however, does goes on to propose that expenditure targets should not fall solely on physicians but rather be applied to all providers in an effort to encourage different providers to work together at keeping costs as low as possible.

—Glenda Fauntleroy