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Don't Just Blame Doctors: Physician Payment Reform Report

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Introduction

Most suggestions for reducing the nation's healthcare costs focus on physician payment. Those that recently came from the *Report of the National Commission on Physician Payment Reform, March 2013* will probably arouse strong emotion.

What About Patient Engagement?

What is missing from the recommendations regarding payment reform is the role that patients play in driving up healthcare costs. In fact, this lack has been notable among many of the past year's proposals for cutting the costs of healthcare in the United States.

One of the critical ingredients for a reduction in healthcare costs is patient engagement and activation in his or her own health. The health status of the US population is also a function of the patient, the patient's health choices, and our "just fix it" mentality.

Physicians and medical practice executives are keenly aware of a key mechanism that has already reduced the volume of elective procedures in many markets: high-deductible health plans that require patient financial engagement in healthcare costs.

It is concerning that the use of such health plan products are not mentioned in the report as a mechanism to reduce the cost of care. Some specialty practices have seen double-digit percentage reductions in elective procedure volume when these health plans are introduced in a market.

Without adequate engagement and activation on the part of the patient-- to include financial and other incentives to follow medical advice, make appropriate care access decisions (eg, don't go to the emergency department for nonurgent conditions), engage in self-care, and participate in shared medical decision-making for preference-sensitive conditions -- true cost savings will necessarily be limited.

Several of the suggestions and recommendations by the council in their report make sense and certainly seem worth pursuing. Others will be subject to considerable debate.

Encouragement for Small Practices?

One of the recommendations outlined in the Commission's report is that fee-for-service reimbursement should encourage small practices (those with fewer than 5 providers) to form virtual relationships and thereby share resources to achieve higher quality of care.

The Commission appears to be actively encouraging clinically integrated networks of small private practices, such as the model embraced by Advocate Physician Partners in Chicago. When structured to be legally compliant, these arrangements permit joint negotiation of fee-for-service reimbursement for quality measures. This begins the process of aligning medical practices and their physicians on quality, providing the technology and other infrastructure to let practices measure and monitor data.

It should be noted that clinically integrated networks have not yet been found to reduce the overall cost of care. They

still depend on fee-for-service reimbursement and do not focus on limiting unnecessary care. But they begin to develop the required infrastructure and measurement to show quality and to evaluate value-based care -- defined as high quality at low cost.

The Commission's recommendation to form virtual structures will probably be welcomed by small physician practices that are concerned about whether they can remain independent from health systems, hospital, and payers. This will require small practices to look toward potential integrating arrangements, such as independent practice associations or a local healthcare system, to help with the infrastructure and development of the clinically integrated or clinically networked model of care.

The Robin Hood Effect: Shifting Reimbursement

Another recommendation from the Commission report is that for both Medicare and private insurers, annual updates should be increased for evaluation and management codes, which are currently undervalued. Updates for procedural diagnosis codes should be frozen for 3 years, except for those that are shown to be currently undervalued.

This recommendation has 2 purposes: to transfer reimbursement dollars from specialists to primary care doctors, and within a specialty, to transfer reimbursement from interventional care to patient visits and medical management of the patient. For example, the reimbursement differential between an interventional cardiologist and his or her noninvasive cardiologist colleague will begin to shift.

Specialists will probably perceive that money has been taken away from them to subsidize their primary care colleagues. This is nothing new. These debates have been ongoing within multispecialty groups as they work to translate payer reimbursement to physician compensation within the group.

This recommendation may promote heightened medical management of the patient. Conceivably, a reduction in elective procedure volume -- or a delay in elective procedures until less costly medical interventions are tried -- may occur.

Each specialty needs to address the clinical appropriateness and outcomes of such models. Patients too will need to be taught to recognize the value of medical intervention rather than a "just fix it" approach. This could also lead to expansion of requirements that a patient be "medically cleared" for procedures. For example, a morbidly obese patient may be denied knee replacement surgery until weight management is under control. Some may decry this as "rationing" care; others will see it as effective management of scarce healthcare resources.

Conversely, this recommendation could create an unintended consequence. If there is no oversight, the decrease in reimbursement could be made up through an increase in procedure volumes.

Fixed Fee at Any Site of Service

The Commission has also recommended that higher payment for facility-based services that can be performed in a lower-cost setting should be eliminated: for example, an echocardiogram done in the hospital for $450 and in the physician's office for $180.

When reimbursement levels changed relative to hospital-based services and provider-based clinics, there were unintended consequences. The most glaring example -- and one that should have been an early warning sign -- was that cardiologists flocked to hospitals for employment. The financial reimbursement model simply did not allow them to continue to provide interventional care in their offices.

So if the difference in reimbursement based on location of service is eliminated overnight, and assuming reduced reimbursement for the hospital and a potential increase in reimbursement for the physician practice setting:

1. Hospitals will lose significant revenue to support their newly acquired specialty physicians. Physicians have already become employed or are closely affiliated with hospitals. It will not be easy to dissolve the mergers and acquisitions that have occurred to date.

2. If hospitals decide to divest physicians, doctors may find themselves highly dependent on the termination language of their contracts as they unravel complicated financial, equipment lease, and other terms. Many may need to reestablish their practices in the community -- essentially starting their practices from scratch or joining with other physicians or systems.

3. Reduced hospital revenue could lead to hospital closures in markets where there is strong competition for patients. This will help to consolidate healthcare in a region and probably lead to reductions in the overall cost of care. It is very difficult to voluntarily close a hospital in a community; this may provide the impetus in markets that have too many hospitals.

4. Physicians who have not already changed their structural care models are likely to get higher reimbursement for certain services conducted in their office as parity reimbursement becomes a reality. This will be a welcome step for practices providing these services and could potentially lead to an expansion of service volumes and associated ancillary services in the physician practice. This would swing the pendulum from hospitals to physician practices and potentially increase the overall cost of care.

5. This particular recommendation will also support what many believe to be the end-state model of healthcare: the integration of financing and delivery of care. Regardless of place of service, care is paid at a fixed rate.

6. Geographic differences in reimbursement may be wiped out in reimbursement currently hard-coded in the relative value unit formula. It is hard to argue that an echocardiogram performed in Utah should be reimbursed differently than one performed in Mississippi or Massachusetts. The physician's work and effort is the same.

Other Ways to Achieve Major Savings

Beyond any of the recommendations made by the Commission, there are many ways to realize some major savings. Some of these are as follows.

Eliminate any payer payment for serious reportable events. The National Quality Foundation has developed a list of reportable events. In this instance, payment would be withheld not just for repairing the event, but also for the initial intervention. This will affect all providers -- hospitals and physicians -- and will encourage and foster collaborative care. For example, it is hard to argue that surgery conducted on the incorrect body part should be reimbursed -- either the initial surgery or the subsequent surgery to repair the error.

Require warranties. Expand services included in the global period, such as Geisinger Health System's ProvenCare warranty model. Define the global services and create a warranty program, thereby creating a mini-bundle of services for the contract-allowable rate.

Reimburse virtual medicine -- telephone visits and secure email messaging -- now! This will allow physicians to practice care in the most appropriate setting for the patient and the patient's condition. However, given physician shortages in many markets, it will serve to expand access to care for patients who cannot find a physician willing to take new patients. By managing 2 to 3 chronic care patients via telephone, a practice can open access to an additional 2 to 3 new patients in the office, thus extending a limited physician supply.

Cite this article: Don't Just Blame Doctors: Physician Payment Reform Report. *Medscape*. Mar 08, 2013.