REFORMING REIMBURSEMENT

Many provisions in the Affordable Care Act make minor tweaks to the payment strategy for physicians accepting Medicare. A survey of doctors predicts which options are most likely to be successful.

National health expenditures amounted to $2.3 trillion dollars in 2008 divided among many different areas. The most costly segments of the health care economy were hospital care (31 percent), physician/clinical services (21 percent), and prescription drugs (10 percent) according to data analysis from the Kaiser Family Foundation.

Currently, hospital care is paid for by many purchasers on a prospective basis determined by the diagnosis of the individual patient. Thus, hospitals are compensated for the average costs of care for a patient with pneumonia or heart attack or emphysema. By way of this style of prospective payment, hospital care does not provide an incentive to increase the intensity of services.

On the contrary, physician services, which account for 21 percent of national health care costs, are currently paid by many purchasers (including Medicare) on a retrospective basis. Specifically, in this review, physician payment reform will refer only to the Medicare physician-fee-schedule (MPFS).

Beginning in 2015, the Affordable Care Act (Section 3007) directs the Secretary of HHS to develop a value-based payment modifier for physicians. This does not, however, shift the strategy of payment from retrospective - which has perverse incentives to increase the frequency and intensity of care - with a prospective system of payment.

The Affordable Care Act also expands the Physician Quality Reporting Initiative (PQRI) and attaches financial penalties for failure to report (Section 3002). This program can be thought of as a type of pay-for-performance program in Medicare.

A national survey conducted last fall examined the opinions of physicians with regard to reforming reimbursement. Physicians surveyed were randomly selected from the AMA Physician Masterfile. 2518 physicians were sent surveys and only 1222 responded; this is a typical response rate for...
Commentary

Although touched upon in the Affordable Care Act, physician payment reform is not substantially altered as a result of the health reform law. Policy makers are beginning to assert the leverage of the Medicare program to pay physicians for quality (not quantity) of service. New payment structures which attempt to provide a lump sum payment for a patient’s care (such as bundled payments) should be explored. However, based on the above data physician buy-in appears unlikely. A more palatable methodology might be lump sum payments to an accountable care organization (ACO) as opposed to physicians individually.

At a recent breakfast with friends, one of them inquired about how effective this model (popularized by the Cleveland Clinic) might be. Formulating a group mentality out of independently minded physicians will be a huge challenge. However, if real or pseudo networks can be structured with physicians and nearby hospitals, the ACO model which compensates physicians in a salaried (not fee-for-service) manner may thrive.

Highlights

- Bundled payments mean that an insurer would pay a lump sum for all care delivered for a patient - hospitals, physicians, consultants, and possible post-hospital care providers would have to decide how to divide the funds
- Accountable Care Organizations could take multiple shapes and look like: Kaiser Permanente, Community Care of North Carolina, or Cleveland Clinic
- Beginning January 2012, Medicare can contract with ACOs to delivery health care


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