

Ending ‘Doc Fix’ Won’t Be Painless

By Emily Ethridge, CQ Staff

For years, doctors have pushed lawmakers to do away with Medicare’s outdated physician payment formula and move to a more stable system that would reward quality work, not just volume. Congress is now closer than ever to repealing the sustainable growth rate formula, which has resulted in repeated short-term “doc fixes” to avert drastic cuts in Medicare reimbursements.

But after 16 years under that detested but familiar approach, are doctors really ready for a new world of Medicare payments?

The question yet to be answered is whether the new approach that various congressional committees have agreed upon — incorporated into a House bill that may come to the floor this week, and a companion Senate measure — will build new payment models that fit all kinds of practices, from the solo primary-care provider to the large multispecialty network. Any payment system also must avoid the faults of its predecessor, which, after all, was enacted with the best of cost-saving intentions.



PHYSICIANS IN TRANSITION: Specialists and smaller practices and may face the most trouble adjusting to a new Medicare payment system. (Patrick Fallon/Bloomberg News)

Doctors’ groups acknowledge that some of their members may have trouble adjusting. But they say that ending the SGR formula will be worth it. “We will do just about anything to get rid of the SGR. Whatever it takes — within reason,” says Alex Valadka, a neurosurgeon and spokesman for the Alliance of Specialty Medicine. “Whatever we haven’t figured out yet, we will figure out.”

Lawmakers passed the first doc fix in 2003, and since then the government has spent \$153.7 billion on 16 of the patches, according to the American Medical Association. That is more than the \$138.4 billion cost over 11 years estimated for bipartisan, bicameral legislation that would repeal the SGR and replace it with new payment systems.

Physicians’ groups of all types support the legislation, which represents a policy agreement among three committees — Senate Finance, House Energy and Commerce and House Ways and Means. The groups

see it as their best shot at doing away with the recurring doc fix nuisance. Yet they also know that some medical practices will transition much more easily than others to the new payment systems created in the bill.

Smaller practices and those in rural areas will have a harder time participating in group-oriented alternative payment models created in the bill. And specialists are concerned about how they will work within those models and whether they will have a chance to be judged by quality metrics that suit their practices.

For lawmakers who crafted the replacement legislation, a one-size-fits-all model like the SGR was out of the question. The bill instead attempts to extend some flexibility to providers, giving them the choice of staying in a program that rewards doctors for meeting performance thresholds within the traditional fee-for-service system or opting into an approved alternative payment model.

Standardization Ahead

The wide variety of practices across the country means that provider readiness varies greatly. Jay Crosson of the American Medical Association says physicians vary widely in terms of practice design, technology and, particularly, marketplace. “If you’ve seen one practice, you’ve seen one practice, as the saying goes,” says Crosson, the AMA’s group vice president for physician satisfaction and care delivery payment.

A post-SGR world will throw all of these Medicare providers into a payment scheme that everyone will be trying for the first time — and not everyone is guaranteed to do well.

“Under the current system, the people who do well tend to be those who have a higher volume of procedures that are highly reimbursed,” says Bob Doherty, senior vice president for government affairs and public policy at the American College of Physicians. “Whenever you create incentives, you’re going to create new categories of people who do well and people who don’t do well.”

Lawmakers who support the bill say it would enable providers to find a payment model that works for them. After a five-year period of payment stability, doctors’ payments would be adjusted based on whether they participate in a new Merit-Based Incentive Payment system in traditional fee-for-service Medicare or in one of the new models that try to measure how well doctors do in keeping patients healthy.

Provider-group representatives acknowledged that most large multispecialty group practices are well-positioned to move away from fee-for-service but that smaller independent practices and specialties may have a harder time.

“The little bitty ones, I think it’s fair to say, are the most worried,” said Len Nichols, director of the Center for Health Policy Research and Ethics at George Mason University. “It’s kind of like, you only jump in the river if it’s burning behind you. Well, it’s kind of burning behind them — because fee-for-service is coming down because we can’t afford it.”

Crosson said the merit-based system will be the more attractive avenue for smaller practices because it will

have stable payments without the risk of an alternative payment model. “Generally speaking, the small practices have neither the expertise nor the financial resources to be able to do this on their own,” he said of alternative payment models.

The bill makes an effort to help smaller practices move into the new world. It would provide \$40 million annually for the next four fiscal years to help providers in small practices, particularly those in rural or medically underserved areas, make a transition.

Doherty said that many small providers are still in the early stages of converting to electronic records, and “it’s hard to imagine doing a successful, merit-based reporting system that is not supported by electronic health records.” He added that many small groups lack other infrastructure and technology needed to participate in some alternative payment models.

In contrast, American Academy of Family Physicians President Reid Blackwelder says family physicians “are probably in a better place than many” to move to the new models. He says two-thirds of family physicians use electronic medical records — “far and away more than any other specialty.” One-third are already in patient-centered medical-home demonstration projects, which qualify under the bill as an alternative payment model. A medical-home practice agrees to monitor and coordinate the overall care of beneficiaries.

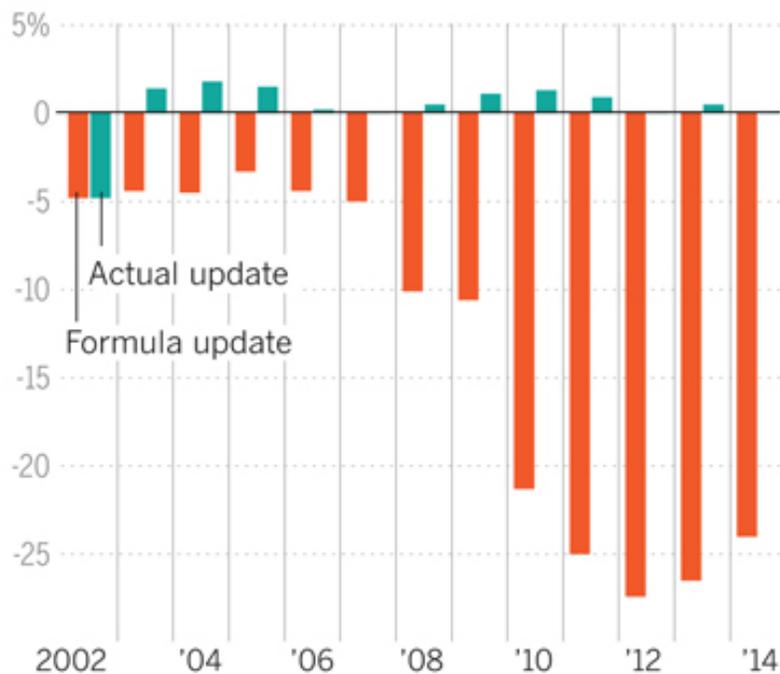
Specialty providers also are expected to have a more difficult time with the payment transition. Anything in the bill meant to encourage better and more primary care, Nichols says, is likely to result in less specialty care.

“They see almost all of these initiatives as designed to reduce their income,” Nichols says of specialists. “Well, you know what — you can’t reduce spending unless you reduce spending.”

An Unpopular Routine

The Medicare physician payment system known as the sustainable growth rate formula forces deep reductions in doctors’ payment rates. Congress has regularly jumped in with a temporary “doc fix” to avert the cuts.

Physician payment rate updates



SOURCES: Congressional Research Service; Centers for Medicare and Medicaid Services

Valadka, of the Alliance of Specialty Medicine, says his group is working to ensure that specialists will have appropriate metrics for quality measurement as well as the right incentives to participate in alternative payment models. “Although we certainly support the legislation ... there’s still a lot of work that needs to be done to make sure that all the incentives aren’t pointing exclusively to primary-care practitioners,” he said.

Physicians also say they will keep a close watch on the MIPS, which would combine and modify Medicare’s current quality performance incentive programs. Under the program, providers would receive a score from 0 to 100 for their performance in four categories, and payments would be based on where the score falls relative to a performance threshold.

Providers praise language that would allow professional groups and stakeholders to weigh in annually on which quality measures should be used in the next performance period and that would give providers credit for improving.

But for the MIPS to succeed, many physicians will have to change the culture and structures of their practices to meet those quality metrics, said Doherty. He emphasized that the Centers for Medicare and Medicaid Services would need to give feedback to providers quickly so they could improve before the next reporting period.

One aspect of the bill that all of the provider groups praised is a period, through 2018, with 0.5 percent annual payment updates. Groups say the interval would provide much-needed constancy after years of watching to see whether Congress would avert scheduled cuts.

Doherty says the transition time would give providers a chance to evaluate which payment model they should participate in later and prepare accordingly.

“One of the most important benefits if this bill goes through, and pretty much in this fashion, will be a five-year period of stability with payment for Medicare,” Blackwelder says. “We haven’t had that in ... I can’t even remember.”

FOR FURTHER READING: *House bill is HR 4015; Senate bill is S 2000. Legislative summary, CQ Weekly, p. 56; bicameral agreement, 2013 CQ Weekly, p. 2092.*

Source: **CQ Weekly**

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