Doctors Disagree on Medicare Payment Reform

BY JANE ANDERSON

FROM ARCHIVES OF INTERNAL MEDICINE

VITALS

Major Findings: More than three-quarters of physicians believe that Medicare reimbursements are inequitable; however, there is little agreement on how to reform the system.

Data Source: A national survey of physician attitudes on Medicare payment. Physicians were randomly sampled from the American Medical Association Physician Masterfile.

Disclosures: The survey was supported by grants from the Robert Wood Johnson Foundation; the National Institute on Aging; the National Heart, Lung, and Blood Institute; and the Veterans Administration Health Services Research and Development Service.

Physicians are dissatisfied with the current Medicare reimbursement system and want reform, yet they disagree on what type of reform they would be willing to accept.

"Most physicians believe that Medicare reimbursements are inequitable, and yet there is little consensus among them regarding major proposals to reform reimbursement," Dr. Alex D. Federman and his colleagues from Mount Sinai School of Medicine, New York, said regarding their national survey of physicians' opinions on reform, published Oct. 25 in Archives of Internal Medicine.

"Overall, physicians seem to be opposed to reforms that risk lowering their incomes. Thus, finding common ground among different specialties to reform physician reimbursement, reduce health care spending, and improve health care quality will be difficult," the investigators noted.

The investigators surveyed physicians between June and October 2009 – at the height of the congressional debate on health reform. Of 2,518 physicians who received a version of the survey addressing reimbursement reform, 1,222 (49%) responded.

In all, 78% of respondents agreed that under Medicare some procedures are compensated too highly while others aren't compensated enough. However, when asked about specific methods to reform Medicare payment, the physicians surveyed showed little agreement.

More than two-thirds of physicians said they opposed bundled payments, with surgeons – who have the most experience with bundling – expressing the lowest levels of support for this strategy (Arch. Intern. Med. 2010;170:1735-42). "Because bundled payments are likely to be implemented in one form or another, this mechanism ought to be carefully explained to physicians to promote broad acceptance and smooth implementation," Dr. Federman and colleagues wrote.

Half of the responding physicians said they supported financial incentives to improve quality, and "support for incentives was more common and more consistent across all specialties compared with shifting and bundling payments," the investigators wrote. "Actual experience with financial incentives to improve quality could have directly informed physicians' generally more positive views of these types of reimbursement mechanisms."

Physicians disagreed on whether to shift some portion of payments from procedures to management and counseling, with those who conduct procedures saying they were against it and those who do more management and counseling coming out in favor of it.

The investigators reported no relevant conflicts of interest. ■

VIEW ON THE NEWS

Failure to Reform Could Lead to Cuts in All Fees

"Despite physician concerns about payment reform, failure to change payment systems may be worse for providers," Michael E. Chernew, Ph.D., wrote in an accompanying commentary. "If we retain the current fee-for-service system, there will likely be significant downward pressure on payment rates for all providers … hoping that payment reform (or fee cuts) will not materialize seems overly optimistic."

It's likely that any payment reform will have significant effects on the basic business model of many physician practices, but providers can find ways to save costs within most of the reforms by reducing redundant and unnecessary care, according to Dr. Chernew (Arch. Intern. Med. 2010;170:1742-4).

"Payment reform will surely generate some provider backlash, and surely bundled payments will create tension between physicians and other types of providers, among different specialties, and between primary care and specialist physicians," he wrote.

"Moreover, the transition to new payment systems may not be easy, requiring considerable investment and organizational change." But failing to act could lead to worse consequences for physicians, he wrote.

DR. MICHAEL E. CHERNEW *is a professor of health care policy at Harvard Medical School. He reported no relevant financial conflicts of interest.*

IMPLEMENTING HEALTH REFORM

The Ban on Physician-Owned Specialty Hospitals

Criticse of physician-owned specialty hospitals say they receive the same tax breaks and insurance payments as do traditional hospitals, but don't provide the same breadth of care, and that they are rife with conflicts of interest. Periodically, the federal government has imposed moratoriums on physician ownership. Even so, the number of facilities has grown. Now, a provision of the Affordable Care Act bans the construction of new physician-owned hospitals that do not receive Medicare certification before Dec. 31; the existing facilities have been prohibited from expanding since the law was enacted on March 23. Dr. Jack Lewin, CEO of the American College of Cardiology, talks about the ban.

In many instances, physician investors are limited to less than 1% of overall ownership.

DR. LEWIN

CLINICAL ENDOCRINOLOGY NEWS: What finally moved Congress to approve permanent restrictions on physician ownership?
DR. LEWIN: Strong opposition from hospitals was very effective. There are legitimate concerns related to specialty hospitals in some communities – for example, where services for low-income patients may be jeopardized by the shifting of high-revenue patients from public and community hospitals to specialty hospitals. But this is not a phenomenon everywhere specialty hospitals exist. The contrary position is that specialty hospitals provide services at a higher quality and a competitive cost. If legitimate problems were caused by the introduction of a hospital into a community, it would be better to address the concern in approving the new facility rather than to create an outright ban, which is all too often simply an anticompetitive effort of the existing traditional hospital.

CEN: Critics claim improper referrals and higher procedure rates among reasons to ban physician-owned hospitals. The ACC is against a ban. What is the argument for physician ownership?
DR. LEWIN: The ACC supports a policy that promotes better medical and clinical quality outcomes and patient satisfaction. There are many ways to protect against physician self-interest, self-referral, and overuse of services. The use of ACC registries could readily identify such problems. In many instances, physician investors in these facilities are limited to less than 1% of overall ownership. It is hard to argue that this in itself is an unfair self-interest, in particular when there is no source of funding available to improve the situation in communities where ORs are overbooked, understaffed, and ill equipped. The ACC supports assurances that physician self-interest is not the key factor behind a specialty hospital, but rather that the central issues are the best interests of the patient and community, and the quality of care.

CEN: How can physicians ensure that appropriate and high-quality care is being delivered at specialty hospitals?
DR. LEWIN: More than 2,400 hospitals participate in the ACC's NCDR (National Cardiovascular Data Registry), but by using just a few specialty-hospital registries, we could provide objective feedback and comparisons based on clinical data, rather than on claims data that insurance companies and the government use. Our registries provide most of the U.S. hospitals that offer cardiac care access to data and feedback on quality outcomes, system problems, and rates of complications. If specialty hospitals were required to participate in these registries, most of the concerns could be mediated.

CEN: Does the ACC support legal challenges to the coming ban?
DR. LEWIN: The ACC believes that the ban should be lifted and replaced with thoughtful policies that allow for specialty hospitals to improve access, quality, patient satisfaction, and efficiency. These policies could address concerns about self-referral, self-interest, or adverse impacts on other needed community-based hospital services.

CEN: Does the ACC have an alternative?
DR. LEWIN: Community hospitals will still need to provide emergency surgeries, general intensive care, and other services as provided in the traditional model, but the ACC believes that the best care and services will evolve into specialty units that focus on increased volume and increased quality. If we are serious about promoting the best outcomes, then this is where we are headed, regardless of the politically inspired ban. ■