Whatever Happened to Medicare Reimbursement Reform?

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The 1980s may well be remembered as a decade of missed opportunity, both for the medical profession and for the nation's health care delivery system, to bring meaningful reform to Medicare physician reimbursement policies. It was the staggering national budget deficit that finally forced policymakers to focus attention on Medicare reimbursement policies as a major factor in a health care delivery system that had become too costly and unwieldy. By the late 1980s, the health care system had gone out of control. It is beyond the purpose and scope of this editorial to comment on why this happened, but most practicing family physicians would agree that the Medicare bureaucracy had a lot to do with that state of affairs.

The reimbursement system based on the "customary, prevailing, and reasonable" (CPR) payment method became too inflationary, complex beyond reason, unpredictable, and inequitable. There is little argument that it had incorporated inappropriate incentives into what was initially sound public policy. Perhaps even more devastating to the primary care specialties, the Medicare reimbursement system created strong disincentives for medical students to seek careers in family medicine or general internal medicine, especially in rural areas.

The late 1980s was a perfect time for reform of the Medicare reimbursement policy. The resource-based relative-value scale (RBRVS) developed by William Hsiao and his colleagues at Harvard University offered tremendous potential for meaningful physician reimbursement reform. Some of us involved in this new method of determining the value of physician services were almost delirious with joy and excitement when the congressionally appointed Physician Payment Review Commission (PPRC) recommended to Congress that Medicare adopt a new policy of physician payment based on the RBRVS. With the adoption of the Omnibus Budget Reconciliation Act of 1989, Congress gave the Health Care Financing Administration (HCFA) the legislative empowerment to institute the long-awaited reform. The dream of Medicare reimbursement reform appeared certain.

In the months that followed, we watched with horror as the regulators at the HCFA nullified many of the benefits family physicians would have realized under the original RBRVS payment method. The HCFA proposals essentially killed reform through reductions in the conversion factor, the behavioral offset, and geographic adjustments. This prompted Robert Graham, MD, executive vice president of the American Academy of Family Physicians (AAFP), to declare that "instead of a budget-neutral redistribution of Medicare dollars from overpriced procedures to underpriced services, primary care payments will remain low; payments for other services will be reduced far more than anticipated, and much of the savings will be reserved for deficit reductions. AAFP finds it unconscionable that budget-neutral payment reform could be parlayed into the largest Medicare budget cut in history."[1]

Against this background of unkept promises by policymakers to bring reform to the Medicare payment system, it is not surprising that physicians in general, and primary care physicians in particular, have formed negative opinions about Medicare policies. As the Geiger and Krol study in this issue demonstrates, Ohio primary care physicians strongly believe that Medicare reimbursement policies are negatively affecting both their elderly patients and their practices.[2] These authors found that 50% of the respondents to their survey had limited the number of Medicare patients allowed in their practices.

Although there is concern for the low response rate (48%) on which the findings in this study were based, the authors do point to some trends that should concern us all. Only 6% of respondents agreed that Medicare policies allowed adequate access to medical care for the elderly. Most of the respondents (63%) believed that Medicare policies had resulted in a decrease in their practice incomes.

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Based on the study by Geiger and Krol, it is not at all clear that the current plans for Medicare physician payment reform will result in a meaningful improvement in the attitudes of family physicians and general internists toward Medicare. Although the new fee schedule will standardize and clarify many of Medicare's payment regulations, it will not greatly modify the policies that the survey's respondents found so objectionable. For example, the new limits on balance billing simplify the convoluted methods currently employed to calculate the Medicare Maximum Actual Allowable Charges (MAAC), but it is not clear that the limits will increase sufficiently to improve physicians' attitudes regarding the program.

Many aspects of the Medicare program were not addressed by the survey, the most notable of which was payment rates. It would have been interesting to know the extent to which nominal prevailing fees and fees relative to other specialist physicians influence attitudes about Medicare. Do Medicare fees in Ohio differ for family physicians and internists, and to what extent do these differences influence physician attitudes?

Table 1. Is Your Practice Accepting New Medicare Patients?

	Yes (%)	No (%)	Missing (%)
All Regions			
Urban	77.0	19.2	3.8
Rural	81.3	16.3	2.4
New England			
Urban	75.2	20.4	4.4
Rural	84.0	11.7	4.3
Mid-Atlantic			
Urban	83.7	13.5	2.8
Rural	77.1	22.9	
South Atlantic			
Urban	75.2	20.5	4.3
Rural	68.0	30.7	1.3
East South Central			
Urban	78.2	17.7	4.0
Rural	87.9	10.3	1.9
West South Central			
Urban	69.3	26.1	4.6
Rural	86.4	9.1	4.5
Mountain			
Urban	74.6	23.9	1.4
Rural	82.6	16.5	0.8
Pacific			
Urban	75.5	19.4	5.1
Rural	76.1	19.6	4.3

From the American Academy of Family Physicians, Office Practice Characteristics Survey, May 1990.[3]

Table 2. Reasons for Not Accepting New Medicare Patients (percentages)

Reason	Urban	Rural
Inadequate reimbursement	27.7	21.0
Excess paperwork	18.5	24.4
Practice full	29.3	45.4
Nongeriatric practice	5.6	0.5
Other	19.0	8.6

From the American Academy of Family Physicians, Office Practice Characteristics Survey, May 1990.[3]

Unless they are significantly revised, the proposed Medicare fee schedule regulations will halve the anticipated gains for family physicians and virtually eliminate any gains for internists. If nominal payment rates influence primary care physicians' attitudes toward Medicare, then payment reform is not likely to have much impact. However, if the issue for family physicians is payment rates relative to other specialists, then the payment reform currently envisioned by the HCFA may result in an improvement in attitudes.

The 1990 AAFP practice profile survey shows a significant proportion of family physicians not accepting new Medicare patients (Table 1). The primary reason for closing a family practice to new Medicare patients is that the practice is full (Table 2). Inadequate reimbursement and excess paperwork are often cited as reasons for these practice decisions.[3]

The framers of the legislation that created the Medicare policies in the 1960s envisioned a system that would ensure the health care of elderly Americans. Events that have followed, especially in recent years, bring to question whether that dream will become reality or another failed government promise. As the providers of most of this care, primary care physicians have a tremendous stake in how this program is administered. Our views of Medicare policies have great potential for affecting the health of a major portion of our society. It is time for primary care physicians and policymakers to work together for the good of our elderly citizens.

References

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2. Geiger WJ, Krol RA. Primary care physicians' attitudes and behavior in response to changes in medicare reimbursement policies. J Fam Pract 1991; 33:244–248.
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