

Ask the Experts

In this and future issues of *MPM*, we ask a panel of experts to comment on a pressing issue of the day. Let us know if you have suggestions regarding experts you would like to hear from or questions you would like to see addressed.

What would it take to push a significant number of providers out of the Medicare program?



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A continued, protracted drop in the Medicare fee schedule would lead to a constant erosion of physician support for the Medicare program. At some point, the worsening economics for physicians would reach the tipping point, and the Medicare program would experience large-scale resignations from participating physicians. For ancillary providers, such as DME/HME (durable medical equipment, home medical equipment) suppliers, competitive bidding would logically lead to a concentration of these Medicare services in the hands of a smaller number of contractors. Presuming that the competition is based on quality, service, and cultural competency—rather than simply on price—the net result may not be harmful to the Medicare program nor to Medicare beneficiaries. The effect of such a scenario would be, nonetheless, to push significant numbers of DME/HME providers out of the Medicare program.

Causes that would push large numbers of facilities such as hospitals and skilled nursing facilities (SNFs) out of Medicare are much harder to predict. These providers often enjoy an advanta-

geous payer mix and other sources of revenue that can adjust for the effects of Medicare payments.

Aside from (or in combination with) the economic/reimbursement causes I outline above, onerous reporting requirements and excessive—albeit well intentioned—fraud, waste, and abuse interventions that have the effect of “criminalizing” the practice of medicine would, in my view, push significant numbers of many types of providers out of the Medicare program.



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Frankly, I believe that it would take relatively little for many providers to opt to either limit services to new Medicare beneficiaries or to leave the program entirely. The basis for that decision is ultimately linked to reimbursement. When it costs more to provide a service to a group of patients than a provider can receive in payment, the business decision is rather clear. The decision point is different, depending on the type of provider, but the common trigger is when a provider can no longer either subsidize reimbursement from other payer sources or does not have an income stream to support the ability to deliver the service. Clearly the most pressing concern for most primary care physicians is a resolution to the sustained growth rate (SGR) formula and the yearly battle with Congress to halt impending reductions in physician payments.

A related issue is the movement of the Centers for Medicare and Medicaid (CMS) to link payment reform with pay-for-performance (P4P) strategies. While most physicians agree that the concept is both desirable and appropriate, it is the design and implementation of such that creates the potential discord. What would likely serve as a trigger for providers (physicians and others) to jump the Medicare ship would be if P4P measures:

- Are not based on sound science
- Are subject to variation in use and calculation

- and therefore meaningless
- Reward the wrong set of activities
- Are so complex that the operational requirements for providers overwhelm their ability to see any reward

Clearly, merely moving more money into the Medicare system cannot be the answer. However, how physicians and other providers are reimbursed for the service and care delivered is at the crux of where reform solutions must lie. Several intriguing models are being presented by a number of provider organizations and policy researchers. Concepts that define the core elements of the “advanced medical home” or that look at aggregate or comprehensive payment for comprehensive care are directions that I believe are pivotal to the sustainability of the Medicare program. These ideas have the potential to help create a payment system that supports the needed care for patients with chronic and complex needs, and supports those who are seeking to deliver that necessary care. Trying to accomplish this within our current payment model and ongoing battles over payment reductions will only drive more providers away from the population of Medicare beneficiaries who so clearly needs their services.



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As with many things in life, there is not a single, clear-cut answer. The scenario for pushing a significant number of providers out of Medicare is multifactorial. As we have seen over the last few years, one single factor may not be enough to cause providers to leave unless the intensity of that factor is great. There are two factors that may be key drivers in moving providers out of Medicare. The first, and probably the most important, is reimbursement. Medicare reimbursement has recently become a concern for physicians, their practices, and other providers.

If reimbursement levels were to remain somewhat constant, physicians possibly would be able to adapt for a time. But if reimbursement does not at least keep up with the increased costs of care delivery, then the reimbursement levels become a disincentive.

The second factor is the increased complexity of the

Medicare system with the changing requirements for providers. If there were either a simpler system or better training, this factor would not be such a strong driver.

The complexity driver is very dependent on reimbursement. If reimbursement for services does not cover the complex requirements that the Medicare system requires, then providers may not want to continue caring for Medicare patients. The balance between these two factors may be different for various providers depending on the environment—for example, a small group practice may be less able to manage than a large group practice.

If the perception of balance between reimbursement and Medicare program requirements is maintained, then providers will stay. However, if the balance is not maintained—that is, reimbursements don't cover the level and complexity of Medicare requirements, then a significant number of providers may be pushed out of the Medicare program.



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America's health plans, especially those with significant involvement in Medicare Advantage (MA), are actually more concerned that Congressional actions could push seniors out of current Medicare programs. They are also deeply concerned about the problem of physician fee-schedule updates but see a real threat that Congress will try to solve the fee-for-service reimbursement problem by reducing programs and benefits that are proven to improve clinical outcomes. Physicians are also concerned about this threat, and in a recent Ayres McHenry & Associates poll, 74% of physicians stated that they believe cuts to the MA program would harm seniors.¹ Cuts would disproportionately hurt minority and low-income Medicare beneficiaries, and 62% of low-income enrollees say they would skip some current treatments if they lost their MA plan.² Recent data show very high satisfaction with these plans, and substantially higher rates of delivery of key preventive services like colorectal screening and mammography, compared to the Medicare fee-for-service system.



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Multiple factors influence my remaining as a provider within the Medicare program. It is not just about the money and the recent reduction in overall reimbursement for 2007. More important is having the necessary resources to care for and truly meet the needs of my aging patient population. During the past 15 to 20, my practice patient population has aged. As the practice became known, there was a convergence of older and more complex patients within our care delivery model.

We serve a frail and vulnerable patient: they have much more than medical conditions. The average age of our patients is greater than 85 years, and they have associated psychological, social, and functional needs that are not often met under traditional fee-for-service Medicare. If they are eligible for Medicaid as well, then we can often tap into those resources to meet some of their needs, although in Nevada Medicaid re-

sources are less than ideal, and fragmentation always exists between Medicare and Medicaid.

So where does that leave me as a geriatrician who only serves the Medicare population, and a complex one at that? Often frustrated over the disparity in what is required versus what can actually be provided for my patients. Not a day goes by in which the available care options are less than ideal, much less appropriate.

My objective for committing my professional life to the care of the elderly patient population was not about the money to be made, but rather about doing something positive and meaningful for older Americans. The current Medicare and Medicaid systems significantly impede my ability to carry out that commitment, which will eventually cause me to leave this career path. MPM

References

1. Ayers McHenry & Associates. National survey of physicians regarding medical issues. October 6–November 2, 2006. Available at: www.ayresmchenry.com/docs/Docs_Toplines.pdf. Accessed March 28, 2007.
2. America's Health Insurance Plans. Most doctors say Medicare Advantage cuts would harm seniors; satisfaction with Medicare health plans rises. March 20, 2007. Available at: www.ahip.org/content/pressrelease.aspx?docid=19240. Accessed March 28, 2007.

MedPac's March '07 Report to Congress

Our analysis finds that most indicators of payment adequacy for physicians are stable. Beneficiary access to physicians is generally good. The number of physicians providing services to Medicare beneficiaries has more than kept pace with growth in the beneficiary population, and per-beneficiary service volume grew 5.5% in 2005. Our claims analysis shows small improvements in the quality of ambulatory care. The ratio of Medicare payment rates to private payment rates was essentially unchanged.

The Commission recommends that the Congress update payments in 2008 for physician services by the projected change in input prices less the Commission's expectation for productivity growth.

Although the recently passed Tax Relief and Health Care Act directs additional funds to physicians in 2008, the sustainable growth rate (SGR) formula continues to call for substantial negative updates through 2015. The Commission is concerned that consecutive annual cuts would threaten beneficiary access to physician services over time, particularly those provided by primary care physicians. As a mechanism for volume control, the current national SGR has several problems, which the Commission examines in its mandated report to the Congress (see: www.medpac.gov/publications/congressional_testimony/030107_Testimony_Mar07_report.pdf).

Fee-schedule mispricing may be one factor contributing to disparities in volume growth among services. The Secretary could play a lead role in identifying mispriced services by measuring volume growth for specific services, while taking into account changes in the number of physicians performing the service and other factors. CMS could use the results to flag services for closer examination of relative work values. Alternatively, the Secretary could automatically correct such mispriced services.

Source: Hackbarth GM. Medicare payment policy. Report to Committee on Ways and Means, US House of Representatives. March 1, 2007.