So how will we pay the doctors?

A look at physician payment reform

By

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Health Care Costs

• In the United States, three trillion dollars a year are spent on health care
• This spending is more than any other developed country
• It is argued that outcomes are no better in the US despite this spending
Medical spending is out of control

• By 2020, health care spending will consume 18% of US gross domestic product.
• This would be equivalent to $8,000 per person per year in the US.
• By 2020, Medicare will be 17% of the federal budget. This is a huge investment and it is argued to be unjustified based on the lack of improvement to care.
How to cut costs?

• Very difficult question to answer in part due to the uncertainty of the future health care environment

• Future challenges include uncertain health care reform, aging populations of patients and physicians, maldistribution of physicians, loss of interest in the health care professions, loss of research dollars (to name a few)
Uncertainty

• The discovery of H. pylori as a cause of ulcers affected one of the mainstays of general surgery.

• Laparoscopic cholecystectomy replaced the open procedure that usually required a 10 day hospital stay.

• Unsure how cancer services will be affected once treatment becomes based on underlying mutations.
Factors driving high costs

• Fee-for-service reimbursement. Physicians are paid for each service they provide. Pay is **not** linked to outcomes.

• High technology and expensive care is paid at higher rates than services geared to evaluation and management of chronic conditions.
Factors driving health care costs

• Specialists are paid at a higher rate than primary care providers. Again, high cost procedures are reimbursed at levels not commensurate with time spent for evaluation or management of care.

• Procedures done in a hospital setting are paid at higher rates as opposed to the same procedures done in an outpatient setting.
Physician pay is a significant factor in health care spending

- Physician salary and related expenses are estimated to be about 20% of health care spending.
- Physician decisions affect another 60% of spending. (Kaiser Family Foundation. *Health Care Costs: A Primer*; May 2012)
Must decrease physician pay

• Several strategies are already in play to help decrease physician pay.
• Nothing mentioned about CEO’s, lawyers, actor’s, sports figures, medicines, medical devices...do you get my point?
Primary Care

• Primary care providers are scheduled to lose Enhanced Medicaid Payments starting in 2015. This will lead to a 40% drop in Medicare reimbursements for these physicians.
ICD 10

• Much more complex coding system.
• Complex systems may fail in which case physician will be paid late or not at all.
Accountable Care Organizations

- ACA’s are supposed to lead to increased savings; if they fail, costs may be born by the physicians that joined the organization.
- If there are no shared savings, the physicians will lose their potential bonus which could be substantial.
Telemedicine

• Non-physician health care providers will take some of the payment of the patients.

• Up front costs of a telemedicine system will be substantial for those who want to participate. The physicians will not be able to directly examine these patients. Liability issues are not yet defined.
Telemedicine

• Already being used in specialty clinics (derm), remote intensive care units where there is no in-house physician, the frail elderly, and for those being treated for mental illness in clinics not served by psychiatrists in-house.

• These interventions will need to be reimbursed appropriately if they are to succeed.
Retail Clinics

• These will most likely be staffed by non-physicians e.g., Nurse Practitioners who will be following protocols.

• Will likely skim the patients who are easy to treat.
High Deductibles

- The Affordable Care Act requires everyone to have insurance.
- Higher deductibles means smaller premiums.
- Physicians may have to go after the deductibles or require payment up front.
- Patients may need to shop around for the cheapest physician; this will result in a decrease in physician pay.
Electronic Health Records (EHR)

• In 2016, Medicare bonuses will stop if you don’t use an EHR.
• EHR’s are very expensive; driving private practitioners out of business and into the employment of hospitals and large clinics.
• Penalties will increase each year that you don’t use an EHR.
• IT people are making a bundle.
Websites

• Websites easily accessed by patients will allow them to see what physicians are being paid.
• Local media can have a field day with this information.
• This information can be misleading and embarrassing and may lead to a loss in patients which could lead to a reduction in payments.
Chronic care payments

• Chronic care outreach may actually be a good thing as Medicare starts to pay for chronic care management even if contact is over the phone or telemedicine. This could keep patients out of the hospital with its associated higher costs.

• Payment will be in a lump sum and dependent on the condition. It would pay to care for the patient before he got seriously ill.
National Commission on Physician Payment Reform, March 2012

• Calls for changing the current pay-for-service model.
• Recommends a new system that rewards **quality** and **value based** care; not a good track record so far, but it is being pushed.
Recommendations (12)

• (1) Payers should eliminate the fee-for-service payment to practices as it leads to unjustified financial incentives to drive up costs.
Recommendations

• (2) Transition to payments based on quality and value. Test models of care over 5 years and incorporate the best models into practices. Practices will need to incorporate the recommended models if they are to be paid.
Recommendations

• While shifting away from the fee-for-service model to a fixed payment system, encourage behavior that improves quality and cuts costs. At the same time, penalize behavior that misuses or overuses expensive care.
Diagnosis Codes need updating

• Evaluation and Management codes need updating to reflect their value—these are considered to be undervalued.

• Procedural diagnosis codes need to be frozen for an extended period (three years?) as they are considered to be overvalued.
Facility based pay

• Higher payments for hospital based services which can be safely done in an outpatient setting must be eliminated.
Quality Metrics

• Any fee-for-service contracts need to incorporate quality metrics which will be used in deciding reimbursement rates.

• Not sure what these “quality” metrics will be; in the past, they have been things that could be measured and thought to reflect “quality” although data was lacking e.g., perioperative antibiotics, B-blockers, strict glucose control
Small practices

- Small practices should form “virtual” relationships with other small practices to share resources and achieve higher quality care; not sure how this will be done or how higher quality care will be realized.
Fixed payments

- Patients with chronic conditions can be handled with fixed payments to their providers; this would encourage preventative care and, hopefully, prevent deterioration which would lead to higher acute care costs.
Fixed payment models

• Risk adjustment indicators need to be used and improved.
• Measures to assure access to high quality care must be developed.
• Physicians must be monitored as to their commitment to patients; don’t want them to cherry-pick the healthiest patients and avoid the sickest patients.
Sustainable Growth Rate (SGR)

- Sets an expenditure rate every year
- Has always been ignored
- Never addressed the underlying issues of why the costs have been rising e.g., volume and price of services and health outcomes
Sustainable growth rate (SGR)

- Must be eliminated. There is no incentive for physicians to hold down costs, and if they do, they are penalized.
- Short term extensions have been done in the past.
- Repeal of the SGR can be paid with cost savings from the Medicare program.
- However, if no extension or repeal, physicians will take a significant pay cut.
Sustainable Growth Rate

- Congress has a history of pushing cuts in the SGR into the future.
- Congress has finally passed the “doctor fix” so we are no longer at risk of the 21% decrease in pay.
- Of course, a different decrease in pay can happen at any time.
Relative Value Scale Update Committee (RUC)

• Will decide how physicians will be paid and how much.
• Relative values will be reevaluated on a yearly basis to improve on their accuracy.
• E&M codes will probably get increases in pay while procedural services will see a decrease in pay.
RVU

• As of March 2015, the conversion factor is $35.75 (this is what the RVU’s are multiplied by to determine payment)

• RVU value of a cabg at the VA

• RVU value of a cholecystectomy at the VA
RUC

- Managed by the AMA; makes recommendations to CMS regarding the relative value scale on which physician payment is made.
- Composition skewed to specialties and this is likely to change in favor of the “cognitive” specialties.
- Critical need to validate data to justify relative values.
There are many things of value for which RUC has not designated any RVU’s e.g., taking call, doing research, teaching residents and students, working on committees. These things are important and clearly have “value.”

Who will want to do these things if it cuts down on the ability to generate clinical income which only comes from seeing patients?
RUC

• Unfortunately, there is no transparency for this committee.
• Meetings are closed to the public and minutes are not published
• RUC members sign confidentiality agreements
• Member voting records are secret
• Since CMS takes the RUC recommendations (90%) shouldn’t they be subject to the Federal Advisory Committee Act?
Federal Advisory Committee Act

• This law provides the legal foundations on how federal advisory committees operate
• The law emphasizes open meetings, public involvement and reporting
• Shouldn’t RUC fall under this law?
• What gives?
Where the service is performed

• Higher payments for services done in the hospital when lower cost settings can be used will be eliminated.

• Hospitals will only be used for complex care and procedures; “value added facilities,” whereas most care will be done on an out-patient setting or thru the use of self-monitoring and telemedicine. NP’s and PA’s will have a more important role in health care.
End of life care is very expensive

- The Affordable Care Act requires a committee to evaluate care and make recommendations as to costs and appropriateness.
- What if the committee decides that the “right to die” is equivalent to a “duty to die?” WSJ January 23, 2015. Under these circumstances, palliative care may become the recommendation of the committee.
Private practice model is dead

- Overhead costs are becoming prohibitive; EHR are becoming mandatory and they cost a lot.
- Hospitals are limiting their physicians and some are requiring their physicians to become employees of the hospital. Good initial contracts will probably decrease as the physicians cannot win in the RUC model.
Physician contracts

• Beware the Restrictive Covenant
• Beware the Intellectual Property Clause

--These may affect your future income and may even affect your ability to practice elsewhere in the community

--You may lose your right to royalties
Contracts for physicians

- Will be for a definite time period
- Likely to have restrictive covenants and intellectual property clauses
- If the physician costs are not met, may have penalties; if no penalties, the new contract likely to be for a lesser salary (or a non-renewal)
No matter how you look at it

• The politicians believe the cost of health care is too high.
• Physicians make too much money; and they are being singled out.
• With the above premise, the best and brightest may decide that giving up their youth to become a physician is just not worth the effort.
• What a shame!
Why not just retire?

• With the Affordable Care Act, there is a Public Health Service Clause that has not received much press.
• Will allow drafting of any physician where there is a perceived need; no war is required.
• Not only can they draft you, they can even tell you where you need to go practice.
• Ouch!
Who will want to be a physician?

- Foreign medical graduates; not sure what their training will be; Somalia med students are volunteering to help ISIS—will they be practicing here?
- Home grown medical graduates; but not from our “post Flexner” educational bodies
- Hospitals may start to train their own; different standard for graduation and accreditation.
- Those who fail to study history may be forced to relive it.
Are you depressed yet?

Stop it.
Stop being sad.
Right now. stop.
Questions