



Rescuing Medicare



By Joanne Berkowitz, MD

Unless something is done, physician payment rates will be reduced about 31 percent in the next seven years.

EVERYONE AGREES THAT HEALTH CARE costs are rising, but beyond that, there is little else that we can readily agree to. While some physicians have complained about inadequate Medicare reimbursement for years, others tell me Medicare is one of their best payers! For most physicians, the Medicare Sustainable Growth Rate formula (SGR) will affect our incomes greatly.

The SGR formula was enacted by Congress as a loose expenditure target in 1989, to address increasing costs of care. Physician payments under the SGR are currently tied to the US Gross Domestic Product and growth in the volume of services.

Under this program, if actual growth in physician spending exceeds a target amount, further updates to physician fees are reduced by that amount. This allowed annual Medicare expenditures to decrease from an average 13.9 percent in the 1980s to 6.7 percent in the early 1990s. At the same time, it created or perpetuated inequities among specialties and regions - and did little to decrease overall spending because it applied only to physician fees and not to hospital, pharmaceutical and other types of care.

In the Medicare Modernization Act (MMA), Congress intervened to prevent the negative payment updates for 2004 and 2005 that would have occurred under the formula. However, by not raising the spending targets, the subsequent fee reductions mandated in the SGR were worsened by the need to offset the MMA increase.

As it now stands, Medicare rates will be reduced by about 5 percent annually for the next seven years or, overall, about 31 percent. At the same time, physician costs are expected to rise by at least 19 percent over the same seven years! If nothing is done, patient access to physicians under Medicare would likely be limited at a time when the aging population is expanding because of retiring baby boomers.

The SGR approach has many flaws. Among them, it disconnects the cost of producing services from the payment for those services. Because the target is national, there is no incentive for individual physicians to control costs. It affects physician office fees only, and there are those who think it will push physicians to perform in hospitals what they would previously do in their offices, thus raising the costs for the Medicare system as a whole. Or, when office-based physicians are unavailable, Medicare patients will resort to vastly more expensive emergency care.

Fixing the SGR problem is a high priority for the AMA and the CMA. Medicare should not penalize physicians for growth of patients' use of services at the same time that the government is promoting greater use of physician services. The new Part D drug benefit is one of many new programs that will bring more Medicare patients into doctors' practices. Payments must be adequate to insure access to high quality care.

The two broad approaches to fix the SGR problem are:

- Eliminating the prescription drug expenditures in Part B coverage (which is estimated to reduce the years of negative updates from 7 to 4),
- Resetting the targets; and not requiring the system to recoup previous excess spending.

There are current bills on the topic pending in Congress.

H.R. 2356 would replace the SGR system with a payment update for 2006 of 2.7 percent and, beginning in 2007, would replace the SGR system with an update system based on physician practice costs.

S. 1081 is a short-term, two-year fix that would provide for a 2.7 percent increase in 2006 and an update in 2007 that reflects practice cost inflation, expected to be about 2.6 percent.

Congress is resolved to move Medicare to a "value-based" purchasing model, paying physicians on their services' quality and efficiency. This may include payments for reporting and tracking services, payments for using evidence based clinical measures and pay for performance.

There are marked differences in provision of services among different regions of the country with little or no difference in outcome. This data fuels requests that additional funds be tied to quality of care initiatives. It is important that any pay for performance funds and programs be available to solo and small group doctors as well as to large groups. The CMA's Pay for Performance TAC has developed policy that the CMA, working with the Department of Health and Human Services Region 9 task force as well as the AMA, is trying to adopt.

S. 1081 is estimated to cost \$6 billion and H.R. 2356 \$50-100 billion. Both will need to be heavily lobbied and physicians will need to begin lobbying soon. When you are contacted by the CMA or AMA on these bills, please help by contacting your legislators and letting them know what a 31 percent decrease in Medicare reimbursement would do to your ability to continue to care for Medicare insured patients.

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