Sing for Your Supper and You’ll Get Breakfast

Dear Dr. Jeff:

Whenever I hear about “pay for performance,” I feel like a trained seal. Once I was a professional. Then I became a health care provider. Now it seems that I am to become a health care performer. Am I missing the bright side here?

Dr. Jeff responds:

Nearly everyone agrees that medical practitioners should be adequately reimbursed for the services they provide. Despite years of malpractice advertise-
ments and endless changes in delivery systems, medicine and nursing remain at the top of popularly admired professions. When there are glitches in the reimbursement system, such as the annual crisis over the Sustainable Growth Rate that threatens physician payments, both parties in Congress desperately search for a “fix.” Obviously, there is no universal agreement as to how fair and adequate payment can be determined. Certainly, the portion of national medical expenses allocated to practitioners could be divided equally. However, if every practitioner is not paid the same, what characteristics should be rewarded? Number of patients seen or procedures performed? Time spent caring for patients? Severity of illnesses treated? Choice of specialty? Regional cost of living? Board certification? Service to underserved populations? Experience or years of training? Judgment? Patient satisfaction? Outcomes? Use of electronic health records? Availability? Currently, the system has chosen to reward by specialty and service volume, with modifications by region and use of computers. Some limited reimbursement may be earned for specified time spent in direct patient care or care coordination.

Historically, Western physicians have seen themselves as independent practitioners, charging fees to their patients based on services performed and patients’ ability to pay. This fee-for-service model is so deeply entrenched in American medicine that many physicians take for granted that it is the “right” way for physicians to be reimbursed. Even as practitioners have increasingly moved to salaried positions, their salaries are usually generated by revenues from patient billing using the fee-for-service model. Current procedural terminology codes are created by the American Medical Association to define an enormous list of services that could be provided. Because the health insurance model has largely eliminated the notion of individual patients paying for services, the concept of adjusting fees based on ability to pay has largely disappeared. Some clinics, usually nonprofit or government-funded, do maintain sliding scale fees, but insurance companies—including Medicare and Medicaid—have forced physicians to strictly limit charity care by threatening to cut fees if the “usual” fee is not routinely charged.

Medicare has instructed the 29-member AMA/Specialty Society Relative Value Scale Update Committee, commonly known as the RUC, to assign relative values to each of literally thousands of different procedures. These assigned values, multiplied by an arbitrary number set by the Centers for Medicare & Medicaid Services, generates the assigned Medicare charge for each procedure. These calculations are then modified by geographic practice expense and malpractice insurance costs. Theoretically, CMS could reject or modify RUC recommendations, but in practice, it hasn’t. Charles Creedell, MD, PhD, CMD, and Dennis Stone, MD, CMD, both past AMA presidents, deserve tremendous appreciation for the amazing work they have done to advance reimbursement for services delivered in long-term care through this bizarre and cumbersome system, which is overwhelmingly dominated by the surgical specialty societies.

Almost all pay-for-performance (P4P) proposals start with the current payment systems and introduce modifications. Just as rewards and penalties were added to Medicare reimbursement based on meaningful use of electronic health records, some proposals suggest that various measures of the quality of physician services should also be linked to incentive payments or take-backs. These notions come from the overwhelming desire to introduce business management concepts into what has become the trillion-dollar business of medical care. The express intention of these proposals is to change physician behavior through financial incentives.

This initiative parallels “merit pay” in education—in which penalties are assessed, or teachers whose pupils have poor test results are fired—and presents many of the same problems. Is the physician whose patients don’t achieve target blood pressure or glycoshemoglobin levels a “poor performer” who should be punished (financially at first, but if parallel to education hold true, ultimately by firing)? CMS and provider organizations are considering proposals to modify hospital performance measures based on the socioeconomic status of the patient population. These issues become even more complex when reduced to the level of the individual practitioner.

Outcome Measures

Initially, the concept of financial reward for performance might seem reasonable. (Of course, we all practice in Lake Wobegon, where all the physicians are above average.) Unfortunately, attempts to measure quality performance are fraught with difficulty. Simple outcome measures inevitably undervalue work in long-term care, where so many of our patients already have very advanced disease and irreversible conditions. Even if outcome measures, such as diabetic control, are adjusted for ideal geriatric values, outcomes for patients with very advanced disease trail those of a healthier cohort. Risk adjustment can make the process more equitable, but risk factors for negative outcomes are extremely complicated, only partially understood, and would need to be weighted. The Minimum Data Set divides residents into “high-risk” and “low-risk” for various outcomes in its quality measures, but these categories are crude at best. CMS, in its zeal for transparency, publishes Medicare mortality statistics. In the first year of publication, the worst statistics in Washington, DC, were attributed to a nationally famous palliative care specialist who was medical director of the District’s largest hospice. If death, which is obviously easily measured and usually regarded as a negative outcome, can’t be used to measure quality of care, then what can? Outcome measures discourage treatment of frail and complex patients, who need treatment most. Patients with multiple comorbidities or limited ability to follow instructions require more time and attention, but will ultimately have poorer outcomes. Practitioners should not be penalized for providing care for them.

Process Measures

Many P4P proposals are based on process measures, which are easily calculated and have determined parameters. Just as facility quality measures reward or punish the administration of the influenza vaccine, rather than the occurrence of a flu outbreak, process measures evaluate performance based on what was done rather than what was accomplished. For example, was the patient screened for tobacco use? Check the box. Were they referred for a smoking cessation program? Check another box. There is no third box that asks what the practitioner did about the refused referral, or how effectively and sensitively the referral was made, or whether the refusal was ignored or, more commonly, whether this was the sixth time this week that the patient was screened for tobacco use and “referred.” Because every consultation in a nursing home is reimbursed using the same examination codes, every consultant needs to ask all the same questions to qualify for a comprehensive evaluation, leading either to endless repetition or duplication of other practitioner notes. Obviously, screening for tobacco is in some way linked to improved quality of care, but checking boxes should not be the sole measure of performance.

This does not mean that checklists and structured systems don’t improve care. From central line insertion in the intensive care units to computerized screens for drug interactions, systematization of care can reduce medical errors and improve patient outcomes. Medical directors have been trained to improve care systems within nursing homes. Checklist reminders help us all to perform complex tasks and thus improve everyone’s performance. This result occurs without financial incentives.

Penalties and Rewards

As discussions of P4P have progressed, the vocabulary has morphed into value-based purchasing. This is a key component of the CMS P4P program for hospitals, which started with process measures, but it has gradually transitioned to a complex set of penalties for negative outcomes that increase costs. PA/LTC professionals are certainly familiar with hospital readmission penalties, but these are only a portion of the current existing potential payment reductions and more are planned for the future. Some large practitioner group practices may already receive reports from CMS regarding their group data, including not only quality measures on self-reported data but also efficiency measures and quality resource use reports that evaluate overall costs of care. By 2016, some practices could receive rewards for identified high-quality/low-cost care. This is cost-based, not evidence-based, medical care.

Unfortunately, there is abundant evidence that simple fee-for-service reimbursement can and has encouraged excessive utilization without necessarily producing excellent outcomes. Hospitals have lacked incentives to do the careful patient education, discharge planning, and information transfer to PA care providers that might keep discharged patients healthy and out of the hospital. Even with the new P4P penalties, many hospitals have calculated that the cost of improving these processes

By Jeffrey Nichols, MD

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Medicare at 50: Hassles Lead to Doctor Opt-Outs

By Alicia Gallegos

A fter suffering through reduced reimbursement year after year and encountering government rules that caused her to restrict the way she practiced, Atlanta otolaryngologist Elaina George, MD, was fed up with Medicare and what seemed its endless red tape.

“We found that the time it took to be reimbursed was much longer than the average commercial payer,” Dr. George said in an interview. Because of global period payment rules, “several times, we got paid nothing. [Medicare] stopped me from doing the things I was trained to do. I stopped doing head and neck surgeries because it wasn’t cost effective.”

Instead of complaining or appealing payment decisions, Dr. George made a more drastic move. She dropped Medicare altogether. Nearly a decade later, the solo practitioner continues to opt out of Medicare, obtaining payment through some commercial insurers and direct pay contracts with patients.

“Direct pay is going to be the future, and anybody who can figure out how to work around the (traditional) insurance model is going to save money,” said Dr. George, an advisory council member of Project 21 black leadership organization, an initiative of the National Center for Public Policy Research, a conservative think tank and policy institute.

Dr. George is far from alone. She is part of a growing vocal minority that says dropping Medicare is the only way to cope with ongoing payment reductions, extended wait times for reimbursements, audits, and growing regulations, such as meaningful use. The feasibility of leaving the program, however, depends on specialty, geographic location, and patient base, physician leaders noted.

Measuring the number of doctors who opt out of Medicare isn’t easy. The U.S. Department of Health & Human Services’ Office of Inspector General said in a 2012 letter to the Centers for Medicare & Medicaid Services that CMS does not maintain sufficient data regarding physicians who opt out of Medicare, and therefore the OIG could not complete an analysis into reasons doctors choose not to participate.

However, federal data released to the Wall Street Journal in 2013 show that 9,539 physicians who previously accepted Medicare opted out of the program in 2012, up from 3,700 in 2009. The CMS had never before released annual opt-out figures, and the data can be found on CMS’s website. A CMS spokeswoman declined comment for this story.

Despite the drop-out figures, government statistics paint a picture of growing physician participation in Medicare. A 2014 CMS report shows that a total of 1,226,728 health providers of all specialties participated in Medicare in 2013, up from 1,089,306 in 2009, according to federal data. (The report noted physicians may have been counted in more than one specialty.) There were 219,536 primary care physicians/providers who treated Medicare patients in 2013, up from 215,919 in 2012.

But the stats on physician participation do not tell the whole story, said Austin King, MD, president of the Texas Society of Otolaryngology, an otolaryngologist. Although many physicians have Medicare patients, he noted that a large portion do not accept new Medicare patients. In Abilene, for example, Dr. King said he knows of no internists who accept new Medicare patients. In Aiken, he said, only 9% of the population does not accept new Medicare patients. In Aiken, he said, 9% of the population does not accept new Medicare patients.

The dilemma means as more of the population reaches Medicare age, there could be fewer doctors to treat them.

“It seems like the government is almost making it more difficult for physicians to participate in Medicare,” said Dr. King, who limits the number of Medicare patients he treats. “It’s difficult for many reasons, but what I hear most are complaints about the enormous amount of red tape and bureaucracy associated with Medicare payment.”

For family physician Andrew Merritt, MD, of Marcellus, NY, the decision not to accept new Medicare patients made sense 15 years ago and still does today. Medicare is one of the lowest payers in the Marcellus area, he said, second only to Medicaid. “The regulations have gotten worse.”

The government disputes that most doctors are rejecting new Medicare patients. The percentage of all office-based physicians who report accepting new Medicare patients has not changed significantly between 2005 and 2012, with 87.9% of physicians accepting new Medicare patients in 2005 and 90.7% accepting new patients in 2012, according to a 2013 issue brief from the HHS Office of the Assistant Secretary for Planning and Evaluation. The percentage of doctors accepting new Medicare patients in 2011-2012 is slightly higher than the percentage accepting new private insurance — about 86% of physicians in 2012 accepted new privately insured patients, according to the brief.

To the extent that there may have been a very small increase in the number of providers ‘opting out,’ that increase has been mitigated by an increase in the share of other physicians who accept new Medicare patients, according to the issue brief. “Further, the total number of providers participating in and billing Medicare has steadily increased since 2007,” said Dr. Merritt.

Dr. Merritt noted that although opting out of Medicare might work for some physicians, it’s not practical for all. For instance, in his area, most psychiatrists have opted out of Medicare. “In primary care, it becomes difficult,” he said. “You have to see a lot of people, and it depends on the level of competition.”

Similarly, where a doctor practices depends on the level of competition. “Further, the total number of providers participating in and billing Medicare has steadily increased since 2007,” said Dr. Merritt.

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Editor’s Note

This controversy as to whether doctors are leaving Medicare in droves is esting. Our nursing homes consider Medicare patients to be cash cows that historians have allowed to thrive and cow the costs of providing care to less fortunate people, like Medicaid recipients whose per diem is below their break-even point for a bed day. But I haven’t encountered too many docs who have stopped accepting Medicare assignment, even though I am sure there are plenty out there.

What is more concerning to me is the incontrovertible trend that doctors are dropping Medicaid. Now that the Medicare-Medicaid pay parity that we enjoyed in 2011-14 has expired, many of us are being reimbursed at about one-third of the rate we were getting just a few months ago on our Medicare patients. With the implementation of the Affordable Care Act, it’s estimated in California (as an example) that over 25% of our state’s population will be covered by Medicaid (or as we call it, Medi-Cal) this year. Even before the pay drop, I was having trouble getting certain kinds of specialty referrals (urology, for instance) for my Medi-Cal patients. I have serious fears that access problems are going to increase and become huge, and that is in a major metropolitan area with 10,000 licensed physicians. I can only imagine what this will be like elsewhere. We will see how it all shakes out.

In the meantime, and understanding that we all need to be able to make ends meet, it’s worth reflecting on why we went into medicine in the first place. To me, even if seeing Medi-Cal patients borders on charity care (with some visits compensated at $17, probably not worth the time and effort to try to bill), it feels like the right thing to do. Concierge practices certainly have their appeal, and I understand why someone would choose that route. But for me, I chose to do what I do based on caring for the frail, vulnerable, needy – and that includes the indigent. If everyone goes to a cash-only system, a lot of people will slip through the cracks, and we can only hope there will be enough advanced practice nurses, physician assistants, etc., to take up the slack. I hope that will not be necessary, considering the workforce shortage issues we are already facing.