

Physician Payment Reform in Medicare

“Physician Payment: Current System and Opportunities for Reform,” a research report from AARP’s Public Policy Institute, discusses the need to change physician payment approaches to realize broader goals of health system reform and identifies promising payment approaches now being tested to improve physician payment.

Changing the way physicians are paid is a critical piece of health care reform. Physician payment policies should align with—and reinforce—the goals of a health care system that works for patients. Physician payment policies should create incentives so that payers and patients receive value for money spent.

Critics of the current system say that Medicare’s fee-for-service physician payment method fails to promote the delivery of efficient or effective care. They argue that the system does not reflect the value or effectiveness of services provided to patients; the system values new high-technology services over office visits and results in lower payments to primary care physicians; and paying for services separately leads to growth in volume and spending.

Improving Physician Payment: Innovations Being Tested

What follow are the most prominent payment options being offered to improve physicians’ performance. Most are still in the development and testing phase, and it is difficult to say how successful they will be. Nonetheless, these payment changes might encourage physicians to deliver more effective, efficient care and to improve the value patients and payers receive.

- **Pay-for-Performance (P4P)** pays physicians based on their performance on defined measures. Providing financial incentives for improved outcomes is an approach reflected in most reform proposals. However, in practice to date, P4P programs typically assess only discrete conditions and do not necessarily yield a coherent or comprehensive picture of a physician’s practice. Depending on its structure, a performance program can add a bonus when clinicians meet or exceed a benchmark for quality or efficiency or impose a penalty when they fail to meet the target. **Challenges:** There are several challenges, including a lack of comprehensive measures, risk judgment is inadequate, determining the level of financial rewards is difficult.
- **Episode-Based Payments** are based on a fixed payment for a bundle of related services or an episode of care. This approach looks at the outcomes and cost of care over an extended but predetermined period. It requires careful use of resources because the physician gets one payment for a package of services, and it also encourages cooperation among providers who care for a patient during the defined period.

Challenges: Defining the duration of an episode is difficult. For instance, does the episode begin before a particular event occurs, and how long after the event does it last? Also, when care involves numerous providers, it is difficult to determine who should be accountable for conducting specific processes of care or for a particular outcome.

- **Accountable Care Organizations** are groups of hospital and physicians that share savings that may arise from reduced Medicare spending. Physicians can earn bonuses if they keep the rate of growth in total spending for Medicare below a defined target.

Challenges: To qualify for bonuses, physicians may shed their sickest **patients** to reduce costs. They might also cut back on needed care in order to reduce spending.

- **Medical Home** continues fee-for-service payments but adds a monthly fee to cover time spent on care coordination and investment in health information technology. Some view the medical home as an extension of chronic care programs that focus on improving care for people with chronic conditions, while others see it as having the goal of improving care coordination for all patients.

Challenges: The medical home addresses only a piece of broader reform because it focuses chiefly on primary care practices. In addition, the concept remains largely untested. Finally, consumers may be unwilling to participate in medical homes.

Lessons from Abroad

Other countries' experiences with alternative payment methods offer important lessons about how payment affects physician behavior and patient outcomes. Fee-for-service payments and a lack of integrated delivery systems or

multispecialty group practice are quite common internationally, just as they are in the United States. At the same time, we see interesting approaches abroad, including pay for performance in the United Kingdom, budget targets with all-payer systems in Germany and Japan, physician feedback and medical homes in France, and combined payments to specialists and hospitals in many countries. However, we observe that system context (e.g., government role in financing and organization of care delivery) may drive more of the differences among countries than the features of the payment system.

Which Approaches Are Likely to Work in the United States?

The ideas under development for physician payment all hold promise for aligning incentives toward better quality and efficiency of care. The key questions for discussion include whether we should try them all, whether they are compatible with each other, what unintended consequences might result if and when they are adopted on a large scale, where to commit the most political and administrative capital, and what other ideas for improving physician payment await examination.

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