Medicare begins linking doctor pay to costs

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Under provisions of the health care legislation signed into law by Barack Obama in 2010, the Centers for Medicare & Medicaid Services (CMS) began mailing "resource use" reports to doctors last month. Some 20,000 physicians in four Midwestern states—Kansas, Iowa, Missouri and Nebraska—received reports designed to show the amount their patients cost on average for Medicare as well as the quality of care they received.

These initial reports are part of a wider plan of the Patient Protection and Affordable Care Act (PPACA) to tie doctors' pay under the Medicare program for the elderly and disabled to performance and cost. The mechanism—which the Obama administration ultimately aims to expand to the US health care system as a whole—ties physicians' compensation directly to a rationing of medical care, providing a financial incentive to doctors to cut costs and limit care.

Doctors receiving the reports will be judged against their peers in the other states, and eventually will be rewarded and penalized accordingly. Doctors are discovering that the reports' calculations take into account not only the services they provide, but the services of any other doctor that provided treatment to the patients under their care. As older patients often have multiple doctors to treat various health conditions, some of the criteria on which the doctors will be rated are out of their control.

Dr. Michael Kitchell, a chairman of the board at the McFarland Clinic in Ames, Iowa, told the *Washington Post*, "You're a victim or a beneficiary of your medical neighborhood. If the primary-care doctors are doing the preventative screening tests, you'll get credit for that, but if you're in a community where the community doctors are doing a poor job, you're going to look bad."

The "resource use" reports will be used as the yardstick for phasing in a new payment system under the health care legislation called the Physician Value-Based Payment Modifier Program. While it is beginning now with the 20,000 doctors, CMS eventually aims to rate all doctors who treat Medicare patients on a fee-for-service basis.

Despite the fact that the program is still being developed, beginning next January data gathered on doctors' patient care and costs in 2013 will be used as the basis for financial penalties and bonuses awarded to these doctors in 2015. In effect, Medicare will be shifting funds from doctors judged to be high-cost providers to those who show they are able to rein in costs. It is also likely that doctors receiving the lowest rates of reimbursement will dump Medicare patients.

Private insurers will undoubtedly view the new rating formula under Medicare as a mechanism they could also utilize to trim costs and boost profits. As with other areas of the health care overhaul, aim is first being taken at Medicare, with an eye to cutting costs and services for the vast majority of Americans either privately insured or on other government health care programs.

Throughout the health care debate in Congress, President Obama consistently maintained that hundreds of billions of dollars could be cut from Medicare without impacting care. In fact, he maintained that less could be more, and that medical care would actually improve as a result of the massive cuts and slashing of "wasteful spending."

Most patients participating in Medicare—or who receive their health coverage under another government program or a private insurer—would agree that bureaucracy and mismanagement exist throughout the health care system. However, the top driver of spiraling costs is the profit-gouging of the private insurance companies, pharmaceuticals and giant health care providers who continue to rake in billions while working families see their health care costs rise as

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services deteriorate.

The CMS web site describes the Physician Value-Based Payment Modifier Program as "one part of Medicare's efforts to improve the quality and efficiency of medical care." This will supposedly be achieved by "providing meaningful and actionable information to physicians so they can improve the care they furnish, and by moving toward physician reimbursement that rewards *value* rather than volume."

In reality, the program seeks to co-opt physicians into a form of self-policing, where the quality of the health care they deliver to their patients is based not on their patients' best interest, but on its cost-cutting value for government. Ultimately, the government, employers and private insurers hope this reduction in spending will become the standard throughout the health care system.

In another development related to doctors' role in cutting health care costs, on April 4 the American Board of Internal Medicine Foundation in partnership with Consumer Reports announced an initiative called Choosing Wisely. A group of nine medical specialty boards are recommending that doctors perform 45 common medical tests and procedures less often, while urging patients to question these services if they are offered.

The specialty boards include the American Academy of Family Physicians, American College of Cardiology, American Gastroenterological Association, along with six others. Included among the dozens of recommendations are reduced use of electrocardiograms (EKGs) in asymptomatic and low-risk patients, colorectal cancer screening only every 10 years after a negative colonoscopy, and reduced use of CT scans or MRIs for severe headaches in people with a normal medical history and neurological exam.

There are obviously numerous factors governing when and if patients should receive these and other treatments, including the health of the patient, and the potential side effects and risks. (How patients are medically qualified to determine whether or not they should undergo a particular procedure is another question.) But it cannot be a coincidence that these recommendations come now, in the midst of a concerted drive by the government and the health care industry to cut costs.

As the *World Socialist Web Site* has explained from the start, the Obama administration's overhaul of the health care system has nothing to do with providing universal and quality health care for all—let alone even marginally improving the services received by ordinary Americans. The plan has been designed to ration health care along class lines in the interest of corporate profit. Beginning first with Medicare, the government and big business are targeting the medical care and benefits relied upon by millions of working people.

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