Medicare accelerates plan linking US doctor pay to costs

Kate Randall
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Medicare is moving to accelerate plans to link payments to doctors to the cost and supposed quality of their patient care. The changes—a result of the health care legislation signed into law by Barack Obama in 2010—will affect nearly 500,000 doctors working in group practices.

Under provisions of the Patient Protection and Affordable Care Act (ACA), the Centers for Medicare & Medicare Services (CMS) began mailing "resource use" reports to doctors in four Midwestern states in the spring of 2012. These reports are designed to show the amount an individual doctor's Medicare patients cost on average as well as the quality of the care they have received.

The ACA's Physician Value-Based Payment Modifier Program, or VBP, initially targeted 20,000 doctors working in large doctor groups—those with 100 or more doctors, nurses or other health professionals. It had already been determined that these doctors would gain or lose as much as 1 percent of their pay starting in 2015, based on the resource use reports.

As part of the health care overhaul, the Obama administration aims to slash $700 billion from the Medicare program for seniors and the disabled over a decade. CMS officials are now moving more aggressively to implement the VBP in order to drive down Medicare costs, directly tying physicians' compensation to a rationing of medical care.

The ACA requires Medicare to factor quality and performance—i.e., rationing—into payments for all Medicare physicians, hospitals, nursing homes and other providers. Key to achieving these cost-cutting goals is pressuring providers to abandon the current fee-for-service system—in which providers are paid for individual services—to a system based on overall payments per patient.

Under the accelerated plan, all doctors working in large group practices will, beginning in 2015, receive bonuses or penalties based on their performance. These incentives will double in 2016.

Under the draft regulations released this month, midsize physician groups (10 to 99 health professionals) serving Medicare will be phased into the program in 2016, instead of 2017 as originally planned. All doctors who take Medicare patients, including about 350,000 in physician groups with nine or fewer providers, will be brought in by 2017. All told, the plan will eventually encompass about 500,000 doctors nationwide.

The process for evaluating physicians is both punitive and arbitrary. Bonuses and penalties will be calculated on quality measures varying by specialty. The resource reports take into account not only the services doctors provide, but the services of any other doctor who provides treatment to patients under their care.

For example, older patients often have multiple doctors to treat various health conditions, meaning that some of the criteria on which doctors are rated will be out of their control. There will be a financial incentive to ration medical care, limit testing and other procedures, and avoid hospitalizations. Smaller practices that may potentially find it more difficult to adjust to the system may face disproportionate penalties for "underperformance."

Doctors judged to be high-cost providers will miss out on incentives and face penalties. It is also likely that doctors with the lowest levels of reimbursement will dump Medicare patients or stop serving them altogether. Many seniors already have difficulty finding doctors to treat them.

The American Medical Association has been lobbying Congress to eliminate the program, writing in

a letter to the House Ways and Means Committee in April, “To impose a program that takes money off the top of payments that have not kept up with inflation for more than 10 years will increase the migration of physicians into hospital settings.” Such a shift will penalize rural and poor communities served by smaller clinics.

Taking aim first at Medicare, the Physician Value-Based Payment Modifier Program ultimately serves as a model for the US health care system as a whole, through trimming costs and targeting fee-for-service payments. Private insurers, eager to trim costs and do away with fee-for-service, undoubtedly view the new Medicaid rating formulas as a mechanism they can utilize to reduce outlays for patient care.

The Obama administration has cynically maintained that hundreds of billions of dollars can be cut from Medicare and that patient services will actually improve as a result. In reality, the draconian cuts being implemented as part of the health care overhaul will result in a rationing of care and reduction in life-saving tests and procedures—all in the guise of streamlining the system and cutting “wasteful spending.”

In reality, the top driver of spiraling health care costs is the profit-gouging of the private insurers, drug companies and giant health care providers, which will continue to haul in huge profits under the Affordable Care Act.