More is not Better in American Healthcare

--By Senator Bill Frist and Dr. Steven Schroeder

This spring we saw some encouraging bipartisan cooperation in both the House and the Senate to finally do away with that pesky issue plaguing Congress every year – the Sustainable Growth Rate (SGR) and its threatened 24 percent reduction in physician reimbursement. Other than in 2002 when the SGR pay cut to physicians was actually applied, each year we have seen Congress struggle with how to avoid cutting physician reimbursement year after year, while facing the burgeoning Medicare costs the SGR was designed to curtail.

But this spring was different. While the end result was with another SGR "fix" thru March 2015, the negotiations this year were around a real solution. The proposed bill passed by the House would repeal the SGR *and* institute value-based reimbursement options with opportunities for pilot programs for innovative models.

But alas, there is the problem of how to pay for it. While SGR repeal is basically on sale with its Congressional Budget Office rating as low as it has ever been, the Bill could not pass for want of its cost. So we have another delay and another deadline – March 2015.

The "doc fix" has become the legislative equivalent of the boy who cried wolf. But we fear the wolf is actually coming. The result? Physicians will stop taking Medicare patients for want of job security and adequate reimbursement leaving our ballooning population of Medicare beneficiaries without a provider.

But the SGR is not the only thing to blame. There is a systemic misalignment resulting in a country where almost 20 percent of the Gross Domestic Product (GDP) cannot buy us more than the 37th best health in the world. We are on track to have 34 percent of the GDP devoted to healthcare by 2040. More dollars do not equal better health, but as the adage goes – you get what you pay for. So what are we paying for?

Under the current Medicare system: doctors are reimbursed for each service provided, regardless of outcome. Due to the current Relative Value Unit (RVU) system by which we value the cost of care, high-cost, technology-intensive services such as surgery garner higher reimbursement while long term management of patients with chronic illnesses pay relatively little. While reimbursing high-cost specialty care more than primary care is reasonable to a point, the current disparity in pricing is extreme. Additionally it results in over utilization of expensive services and under utilization of much needed primary care services. And even more nonsensical is that the exact same service has two different prices depending on whether it is provided in a hospital setting or office owned by a hospital versus a doctor's office not owned by a hospital.

So we are paying for more procedures, more surgery, and more high tech specialty care. We are not paying for the extra thirty minutes a patient really needs to understand how to take their insulin properly or adjust their diet to avoid yet another hospitalization for heart failure. This is not to say, if you need incredible medical care, the U.S. is the place to get it. But most of our citizens just need basic medical care. You get what you pay for and we are paying for healthcare "services" instead of paying for health.

We had the pleasure of co-chairing the National Commission on Physician Payment Reform, which was convened by the Society of General Internal Medicine - and has been endorsed by other provider groups and payers. The Commission set out to assess how physicians are reimbursed and how pay incentives are linked to patient outcomes. Over months of deliberations, the Commission developed a series of recommendations which, we believe in time, would transform the healthcare system into one where we are actually paying for quality and outcomes and not just the number of patients that pass through a doctor's office each day. You can read a summary and the entire report at http://physicianpaymentcommission.org/report/.

The Commissions recommendations were several, but among them is a call for repeal of the SGR, which we know Congress is working towards. We also recommend a transition away from fee-for-service medicine as much as possible and doing so by testing new potential models that link payment to quality and value.

While we are encouraged by the efforts of Congress this year, we recommend taking reform even further. Disparities in reimbursement based on location of service should be eliminated or mitigated. And we must change the focus of reimbursement towards the outcome we desire, and find a way to reimburse for that. This means reimbursement for the time it takes the manage illness over time and provide the needed support and counseling that is so integral to the delivery of good primary care.

We hope the work Congress has done this year on the physician payment reform has laid the groundwork for a more long-term solution. We urge our policy makers to take a look at the Commission's recommendations as a helpful starting point. We want there to continue to be progress, and not just towards repealing the SGR, but also addressing the true disparity in American healthcare – that more is not better because we are simply paying for the wrong thing.