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Physician and Hospital Reimbursement: From "Lodge Medicine" to MIPS

Introduction

When seeking to understand the priorities and behaviors of various professionals or organizations it is instructive to understand how they are reimbursed for the goods and services they provide. As is commonly observed in business, "you get the behaviors that you reward," and this has historically been true in healthcare. Both physician and hospital priorities and practices have been shaped by shifting methods of reimbursement, and reimbursement patterns and models remain the key to understanding why healthcare is delivered the way that it is.

In this white paper, Merritt Hawkins traces how compensation for physician and hospital services has evolved through the years, and we examine the profound ways in which new reimbursement models are transforming the healthcare delivery system in today's era of healthcare reform. The white paper begins with a look at early, direct compensation methods and includes an examination of emerging compensation models such as the Merit-Based Incentive Payment System (MIPS) mandated by the 2015 Medicare Access and CHIP Authorization Act (MAPRA). It concludes with a discussion of how changing reimbursement methods may affect physician practice patterns and physician staffing.

Meat, Milk, and Mashed Potatoes

Until the early part of the 20th Century, hospitals in the United States were almost exclusively charitable institutions that catered to the needs of indigent patients too poor to afford a physician to care for them in their homes. Hospitals had little to offer patients other than bed rest and three square meals a day. Often, these meals would be a repetitive helping of meat, milk and mashed potatoes, thought to be a nutritional and sustaining diet at the time. As private institutions, early hospitals could admit or deny care to anyone, and those with chronic diseases such as cancer often were unwelcome, as were those not thought to be "morally worthy," such as alcoholics or prostitutes (*When Hospitals Were Places Only the Poor Could Afford to Enter*, Wall Street Journal, March 3, 2004).

In the late 19th Century, hospitals became a more prevalent site of service for an increasingly urbanized population. In 1873, there were only 178 hospitals with a total of 35,064 beds in the entire United States. Only thirty-six years later, in 1909, the number had grown to 4,359 hospitals with 421,065 beds, and by 1929 to 6,665 hospitals with 907,133 beds (*Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, Vernellia R. Randall, University of Dayton, 1993).

The cost to maintain hospitals and provide a basic level of services was minimal by today's standards. In 1880, the average daily cost for keeping a patient in New York's St. John's Hospital was 80 cents, or $14 in today's money. The total budget for St. John's in that year was $4,689 (*Wall Street Journal*, March 3, 2004). As Lister and other scientists and physicians discovered the importance of germs and bacteria in causing or exacerbating disease, hospitals were obliged to incur the considerable expense of maintaining sterile conditions. Medical innovations increased the sophistication of equipment used in hospitals, incurring further costs. Hospitals then found it necessary to charge for inpatient stays and other services, as they could no longer operate strictly on a charitable basis.

The financial burden on patients of hospital stays rose accordingly. Hospital costs rose from 7.6% of family medical bills in 1918 to 13% in 1929, and by 1934 hospital and physician inpatient bills rose to 40% of family medical costs (*The History of Health Care Costs and Health Insurance*, Linda Gorman, 2006).

The Flexner Report

Physicians also had comparatively little to offer patients in an era before the great majority of vaccines, antibiotics, effective drugs, and diagnostic equipment were developed. In addition, the expertise and education of physicians varied widely, as many medical schools were essentially diploma mills that did not offer scientific training or employ dissection as a teaching method. Patients paid physicians directly and their fees were nominal by today's standards. Physician incomes generally were on par with those of tradespeople or artisans. At St. John's hospital, for example, the annual salary of a house physician in 1880 was $300 (Wall Street Journal, March 3, 2004).

The professional status of physicians changed rapidly, however, with publication of the Flexner report in 1910. Abraham Flexner, a prominent educator, was contracted by the Carnegie Foundation to inspect all U.S. medical schools. His damning report about their quality and methods led to a reformation of medical education, and the number of medical schools declined from 162 in 1906 to 85 in 1919. Physician to population ratios also declined, from 157 per 100,000 population in 1900 to 125 per 100,000 in 1930 (Gorman).

With less competition to drive down prices and a higher standard of physician education and training, physician fees increased. Prominent medical groups such as the Cleveland Clinic, Mayo, Marshfield and Lahey were established, enhancing physician overhead and prestige and increasing costs. Like rising hospital costs, rising physician costs were felt by consumers.

As both hospital and physician costs rose, the discussion of health insurance coverage was born.

The Loyal Order of the Moose

While there was no formal health insurance industry in the late 19th Century or the early part of the 20th, fraternal societies such as the Loyal Order of the Moose and many others contracted with physicians to care for dues paying members for as little as $1 to $2 per year in what was known as “lodge medicine.” (Gorman) This was an era in which many more adults belonged to fraternal organizations than do so today. In 1910, one-third of male adults belonged to fraternal organizations, which provided many of the social services currently provided or supported by the government, including orphanages, hospitals, job exchanges, homes for the elderly and scholarships.

Nevertheless, for the most part, patients still paid directly for medical care. In 1919, medical expenses in the U.S. as estimated by the American Medical Association (AMA) were $3.6 billion, or 4% of GDP (today they are about $3 trillion, an 83,000% increase). Of this, patients paid 80.6%.

U.S. Healthcare Expenditures - 1929

Total	$3.6 billion
Paid by consumers	$2.9 billion
Paid by public sources	$485 million
Paid by philanthropy	$217 million

Source: The History of Health Care Costs and Health Insurance, Linda Gorman, 2006

In a “back to the future” moment, national health insurance was part of the Progressive Party presidential platform in 1912 and continues to be a hot button political issue today. In 1927, “the inability to pay the cost of modern scientific medicine” was the first item on the agenda at the AMA convention (Gorman).

We Get the Blues

Despite early calls for reform, direct pay for hospital and physician services remained the prevailing paradigm throughout the United States. The Great Depression, however, altered the status quo. Due to declining employment and incomes, patients were increasingly unable to pay for healthcare, and hospital utilization declined. Average hospital receipts fell 75% per patient after 1929, from $236 to $59.26, and bed occupancy dropped 10% (Randall). Subsequently, hospital deficits increased substantially. In response to the loss in revenues, the American Hospital Association developed a plan to bring patients back to hospitals by making it more affordable. They called the pre-paid hospital care plan Blue Cross.

Blue Cross was one of the first health insurance programs available in the United States. With Blue Cross, the American Hospital Association (AHA) provided a way to guarantee payment of hospital costs. The program was modeled after a predecessor developed by Baylor University's health care facilities in Dallas, Texas in 1929. The Baylor model also was designed to address the problems of access to healthcare and guaranteed local Dallas teachers 21 days of hospital care for $6 per person a year. Due to the success of the program at Baylor Hospital, the AHA formed Blue Cross and expanded upon the pilot program by including hospital networks rather than individual hospitals.

Blue Shield was later established by the AMA to provide reimbursement for physician services. Today, Blue Cross/Blue Shield no longer is affiliated with the AHA or the AMA and has affiliated insurance plans in 36 states.

Reimbursement's "Original Sin"

While the Blues expanded access to health insurance, they also instituted the "pay as you go" model of reimbursement for individual policy holders, which, from a cost perspective, can be viewed as the healthcare system's original sin. Unlike home insurance, where home owners are paid a lump sum by insurance companies in the event of a disaster and then pay contractors to rebuild their homes, the Blues paid the physician or the hospital directly, not the insured patient. All services were paid for, even routine, easily affordable services. There were no deductibles and no co-pays.

Predictably, the effect of this fee-for-service model has been to increase utilization and hence costs, as neither the patient nor the provider has a stake in limiting services or expenses. If home insurance paid for routine upgrades such as new curtains to replace faded ones, or new appliances to replace old ones, the effect on utilization and costs would no doubt be similar.

Insurance Becomes Employer-Based

Due to the success of the inaugural health insurance programs, President Franklin D. Roosevelt explored the notion of creating a national health insurance program. He abandoned the idea because the American Medical Association (AMA) fiercely opposed it. The AMA sought to keep coverage limited for fear of third-party payers gaining too much influence on medical decisions.

While a national health insurance program did not come to fruition, private health insurance programs flourished. As the healthcare market grew, government encouragement led to the next step in healthcare payments: employee-based benefit plans.

World War II put employers in a bind. Shortages in both goods and workers forced employers to be creative in order to meet demand. Many had the idea of increasing wages to attract employees, but the federal government quickly eliminated that option. In order to avoid inflation, the government instituted wage and price controls. Employers did find a key recruiting and retention tool, however, when the War Labor Board exempted employer-paid health benefits from wage controls and income taxation.

Health benefits paid by employers and received by employees were exempt from individual federal, state, and city taxation, creating an enormous tax advantage for employer-sponsored group health benefits, and this exemption currently costs the federal government an estimated $250 billion a year (*'Cadillac' tax repeal gains momentum*, Modern Healthcare, October 12, 2015). As more and more employers used this tactic to entice workers, demand for health insurance as a standard benefit of employment became commonplace.

Kaiser Permanente, one of the nation's largest not-for-profit health plans, developed as a result of employee-based benefit plans. In 1933, Henry J. Kaiser needed to provide health care to 6,500 workers and their families at the construction site of the Grand Coulee Dam. In conjunction with Dr. Sidney Garfield, Kaiser agreed to pay $1.50 per worker per month, to cover work-related injuries, while the workers would each contribute five cents per day to cover non-work-related injuries. Dr. Garfield was paid in advance for the services he would provide (*Our History*, Kaiser Permanente).

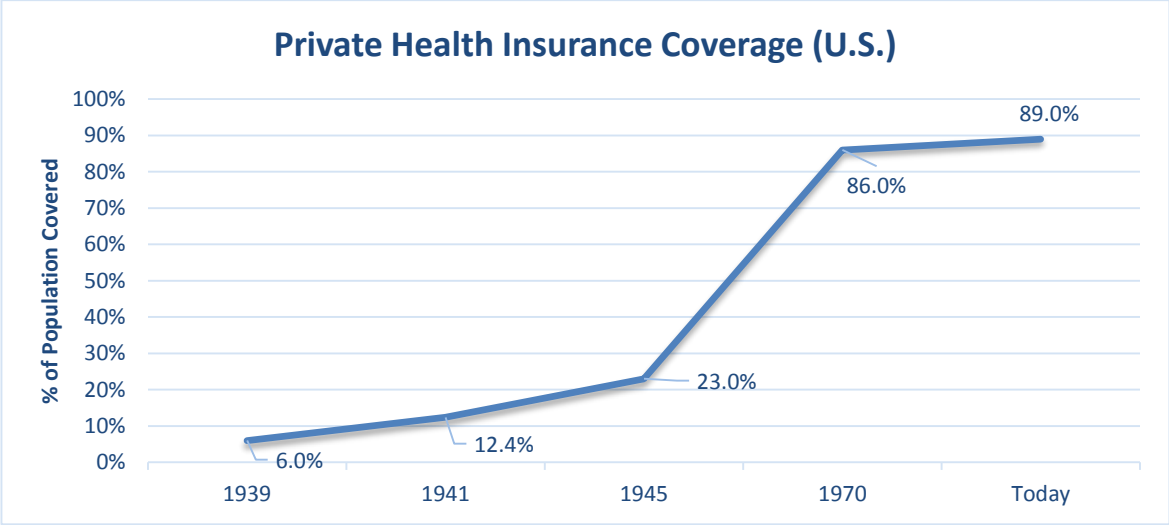
The partnership between Kaiser and Garfield was so successful that Kaiser called upon Garfield again when he needed to provide health care to 30,000 workers constructing Liberty Ships and aircraft carriers for the United States during World War II.

After losing the majority of their employees upon culmination of the war, Kaiser and Garfield decided to continue with their new form of health care delivery. On July 21, 1945, the Permanente Health Plan officially opened to the public. In 10 years, enrollment surpassed 300,000 members in Northern California. In 1953, the name of the health plan was changed to its current name, Kaiser Permanente, to increase name recognition.

Kaiser and Garfield marketed Kaiser Permanente to other businesses and municipal governments in California and Oregon. Kaiser Permanente became one of the early adopters of "cooperative health plans"

or group healthcare plans. Kaiser played a key role in the growth of group healthcare plans in California.

The practice of using healthcare benefits to attract the best employees expanded the healthcare system immensely. According to the Economic History Association, between 1940 and 1960, the total number of people enrolled in health insurance plans grew 589%, and by 1958, 75% of Americans had some form of health coverage.



Source: The History of Health Care Costs and Health Insurance, Linda Gorman, 2006

A shift was emerging where physicians were no longer paid in advance for their services, but rather, their payment was determined by charges for items and services provided to patients at the conclusion of their visit.

While providing health insurance as a part of the compensation package offered health coverage to those with a job, people without work were left in the cold. Private healthcare insurance remained a distant goal to the poor, the elderly, and the unemployed. Moreover, corporations and unions were beginning to take a major hit as health insurance became a significant portion of company budgets. A change was needed.

Medicare (A&B) and Medicaid

In 1965, Congress passed legislation to provide public health insurance for those who did not have the means to enter the private market. President Lyndon B. Johnson signed the Medicare and Medicaid programs into law, spawning the next shift in the healthcare payment model in which the government was to play an increasingly large role.

Physicians were reimbursed for services provided to Medicare patients on the basis of customary, prevailing, and reasonable charges, extending the pay-as-you go, fee-for-service model. State governments determined physician payments for Medicaid, which also were fee-for-service.

Reimbursement was "cost-based," assuring that providers could bill at least as much as services cost them to provide and typically above that level. Billing was "retrospective" and was submitted after services were provided.

Medicare was designed to cover inpatient hospital visits (Part A) and outpatient services and products often provided by physicians (Part B). Part A helped pay for most aspects of inpatient hospital stays from food and room to tests and procedures conducted. Part A also covered brief stays in a skilled nursing facility. Part B included outpatient medical treatments administered in a doctor's office including physician and nursing services, x-rays, laboratory and diagnostic tests, and other such services. Part C later was added to create Medicare Advantage (see below) while part D was introduced in the administration of George W. Bush to provide a drug benefit to seniors.

At the time Medicare was adopted, the life expectancy for men was 66 years and for women, 71.7 years. It was not expected that seniors would use their Medicare for long, but expanding life spans have made the program considerably more expensive than was originally anticipated.

Since that time, changing reimbursement methods in healthcare have been part of an ongoing quest to rein in the fee-for-service model, modifying it in ways policy makers hoped would reduce costs.

For example, Congress added an amendment to the Social Security Act that required a Medicare fixed fee schedule and created fee limits when calculating "reasonable" charges, as they believed prices were rising too quickly. The fixed fee schedule became known as the Medicare Economic Index (MEI). The index set a benchmark to limit payment rates and the costs of physician services. The MEI was modified annually to adjust for inflation and account for other professional expenses.

In 1973, in a further attempt to limit the increases in the Medicare budget, Congress passed the Health Maintenance Organization Act, which required businesses with more than twenty-five employees to offer at least one federally qualified health maintenance organization (HMO) as an alternative to conventional insurance.

HMOs presented an alternative to the traditional fee-for-service system by providing access to group prepaid plans. The system granted access to both hospital and physician services for a fixed and prepaid fee. The goal of HMOs was to encourage fewer hospital admissions, more outpatient procedures, and fewer referrals to specialists. Physicians and other professionals contracted with HMO plans in exchange for a steady stream of customers.

While HMOs succeeded in providing an alternative to the fee-for-service model, group healthcare plans failed to dramatically reduce healthcare expenditures and were only implemented in a limited number of geographic

areas. As the 1970s drew to a close, healthcare costs continued to escalate.

Prospective Payments and DRGs

While Medicare proved successful in providing care to the elderly, physician payment rates and fees were getting out of hand. In another attempt to limit spending, the government switched to using diagnosis-related groups (DRGs) as its method of paying hospitals for providing services to Medicare patients.

In the early 1970s, Yale University developed DRGs to describe all types of patient care (*The Evolution of DRGs,* American Health Information Management Association, April 2010). The DRG method assigned a numeric value to a diagnosis, which served as a relative weighting factor intended to represent the resources needed to provide care. The DRG assignment would then determine the payment to the hospital.

In an attempt to reduce hospitalization costs, Congress and the Reagan administration implemented DRGs through the Prospective Payment System (PPS) in 1983. Rather than simply reimbursing hospitals whatever costs they charged to treat Medicare patients, the new model paid hospitals a predetermined, set rate based on the patient's diagnosis. The payment was "prospective," based on what Medicare projected the service should cost, rather than "retrospective," and based on the hospital's cost to provide the service after the fact. PPS paid hospitals a flat-fee determined by Medicare for each patient based on 467 DRGs describing an episode of care (an appendectomy is an example of a DRG). Hospitals were paid for the overall episode of care rather than for individual, a la carte services. The number of DRGs today exceeds 1,000.

The goal of the payment change was clear. Medicare wanted to eliminate paying hospitals on costs to reduce excess expenditures. DRGs limited patients' hospital stays based on their diagnosis. After a DRG-established hospital length-of-stay period expired, Medicare stopped paying a hospital, regardless of a patient's true medical condition. Also, Medicare paid the DRG rate regardless of the amount of care consumed by a particular patient.

Private insurers also adopted the Prospective Payment System, though usually at higher reimbursement rates per DRG than Medicare.

DRGs were not applied, however, to critical access hospitals (CAHs), children's hospitals, or long-term care facilities, which continued to be based on a retrospective, cost-based model. Teaching hospitals also have a reimbursement exception, as they are paid extra by Medicare/Medicaid for both the "direct" and "indirect" cost of training residents. Direct costs may include salaries for residents, which today range from about $45,000 to $80,000 per year, while indirect costs include the equipment and infrastructure needed to maintain teaching facilities. Federal Medicare/Medicaid payments to teaching hospitals for these costs now total approximately $15 billion per year (Washington Post, July 29, 2014).

Quicker but Sicker

Following the rule of unintended consequences (and the maxim that you get those behaviors you reward) hospitals under DRGs began to discharge patients "quicker but sicker."

The elderly and chronically-ill became liabilities to hospitals as they required more care and longer periods of care, even though under DRGs hospitals were paid the same rate to treat sicker patients as they were healthier patients. The financial motivation was to diagnose patients at the highest reimbursement level possible under DRGs ("DRG creep") and to discharge those patients as quickly as possible. DRG guidelines led to hospitals discharging patients quicker than necessary and without returning them to full health. As a result, readmission rates skyrocketed.

In addition, DRGs were generally not applied to other providers in the care continuum, including physicians and long-term care facilities. Because physicians must discharge patients from the hospital, conflicts arose between hospitals who were financially motivated to discharge patients quickly and physicians who were not so motivated. The use of "hospitalists," typically general internists specializing in hospital-based medicine, began to rise, as these physicians are adept at utilizing hospital resources effectively, ideally providing the right care at the least cost so that patients can be discharged as early as possible but also as healthy as possible.

Due in part to payment models, hospitals, physicians, and post-acute care facilities remained financially and philosophically misaligned in many circumstances, leading to the popular bromide that "hospital administrators are from Mars, physicians are from Venus."

The government insurance model was not the only area where spending needed to be curtailed. Due to the use of the fee-for-service model, private insurance needed some adjustments of its own. The fee-for-service model did not produce incentives to economize; rather, it encouraged physicians to recommend unnecessary and overpriced procedures. Thus, under both government and private pay, providers earned more when they treated more. The fee-for-service payment model resulted in less preventive care and heavier use of medical technology.

Capitation and HMOs Do Not Catch Fire

In the 1980s, the pre-payment model developed by Kaiser Permanente and others rose to the forefront again as a mean to eliminate the improper motivations the fee-for-service model generated. Capitation, as implemented through health maintenance organizations (HMOs) was seen as a "course correction" because it was thought to create incentives for efficiency, cost control, and preventive care.

Under capitation, a doctor, medical group, or hospital receives a predetermined flat fee every month for each individual assigned to them, regardless of the cost of that individual's care or whether they seek care during

that time period.

Capitation relies heavily on the premise that the majority of individuals enrolled in a health plan will not require health care services within a given month. Therefore, those enrolled members who use little or no health care every month should balance out the cost of treating high-utilizing patients. Capitation theoretically prompts physicians to provide preventive care since they are responsible for the enrolled member's health regardless of cost.

While capitation eliminated incentives for unnecessary procedures and increased efficiency, it did have its critics. First, some believed there was an incentive for under-utilization. By providing less expensive care or in some cases withholding care, physicians were not providing the best care possible. Second, some believed capitation encouraged providers to be selective when offering care to patients. Providers may want to avoid accepting sicker patients in order to evade challenging decisions on how to allocate the funds they receive from prepayment. Some feared capitation would create disincentives to care, rather than encouraging the most efficient care possible.

Physicians and other providers also said the prepayments they received were too low to fund the kinds of preventive care services that capitation encouraged. Health plans and providers felt that payment rates were too low to make participation successful. In addition, the move to “manage” care through utilization review, and the implementation of “clinical pathways” dictating to physicians the treatments they could provide (“cook-book medicine”), was irksome to many doctors, who resented this intrusion into the physician/patient relationship. Patients, in turn, became distrustful that they were receiving the care they needed, since physicians in this model are rewarded for doing less.

During the 1990s through much of the Clinton administration, HMOs were seen as the key to health reform, and many hospital systems purchased physician practices to create the large physician networks necessary to implement group health under this model. Practice management groups such as Phycor also aggregated large groups of mostly primary care physicians for the same purpose. In many cases, physicians were paid salaries that were not tied to productivity (i.e., number of patients seen, revenue collected, etc.) Again under the rule of getting the behaviors you pay for, many salaried physicians became less productive and consequently many hospitals abandoned the employed physician model while most practice management groups went out of business.

Capitation caught on slowly as a payment method and failed to reach the heights many hoped it would. Physicians and hospitals found that they very often lost money on capitated contracts, and many returned to using fee-for-service payment.

CPTs and the RUC

Medicare and Medicaid's use of diagnosis-related groups had not proved effective in controlling costs nor in reducing the U.S. budget deficit. In order to cut the budget deficit without raising taxes, President George

H.W. Bush signed the Omnibus Budget Reconciliation Act (1990), which replaced "reasonable" charges with relative value units (RVUs) as a method of determine Medicare reimbursement.

In 1985, Harvard University commissioned a multi-disciplinary team to determine how much money medical providers should be paid. The study, which came to be known as the Resource-Based Relative Value Scale (RBRVS), proposed a system of assigning relative values to physician services based on time and intensity of services performed, or "work per unit time" (*US Approaches to Physician Payment: The Deconstruction of Primary Care*, Society of General Internal Medicine, 2010).

The Omnibus Budget Reconciliation Act instituted the RBRVS system. The new payment system's major goals were to decrease Medicare's long-term spending growth rate for physician services and to divide Medicare physician payments more equitably. Physician payments were to be updated annually based on the MEI and the application of an adjustment factor, the Medicare Volume Performance Standard (MVPS). It also established a Medicare Fee Schedule, a list of about 7,000 services that can be billed.

The services are classified under a nomenclature based on the Current Procedural Terminology (CPT) to which the American Medical Association holds intellectual property rights. Physicians bill their services using procedure codes developed by a seventeen member committee known as the CPT Editorial Panel. The AMA nominates eleven of the members while the remaining seats are nominated by the Blue Cross and Blue Shield Association, the Health Insurance Association of America, CMS, and the American Hospital Association. The CPT Committee issues new codes twice each year (*A Brief History of Physician Payment*, Margaret C. Tracci, July 2015).

The RVUs themselves are largely decided by a private group of physicians known as the American Medical Association's Specialty Society Relative Value Scale Update Committee (RUC). The committee meets three times a year to set new values, determines the RVUs for each new code, and revalues all existing codes at least once every five years. The RUC has 29 members, 23 of whom are appointed by major national medical societies. The six remaining seats are held by the Chair (an AMA appointee), an AMA representative, a representative from the CPT Editorial Panel, a representative from the American Osteopathic Association, a representative from the Health Care Professions Advisory Committee and a representative from the Practice Expense Review Committee (*The Little-Known Decision-Makers for Medicare Physicans Fees*, The New York Times, December 10, 2010).

The RBRVS for each CPT code is determined using three separate factors: physician work, practice expense, and malpractice expense. The average relative weights of these are: physician work (52%), practice expense (44%), malpractice expense (4%). The RUC examines each new code to determine a relative value by comparing the physician work of the new code to the physician work involved in existing codes. The three RVUs for a procedure are each geographically weighted and the weighted RVU value is multiplied by a global Conversion Factor (CF), yielding a price in dollars. Today, that conversion factor per RVU is $34.

ICD-10

In a typical patient encounter, a physician will diagnose a patient based on one of many International Classification of Disease (ICD) codes. Under the new ICD-10 system, which went into effect in October, 2015, physicians have 68,000 diagnostic codes from which to choose. These codes indicate whether the patient presented with something basic, such as a cold or headache, or something considerably more arcane, including whether a patient was injured by burning water skis or bitten by a turtle.

This diagnosis will then be submitted to Medicare or other payers with the accompanying CPT code indicating what the physician did to treat the patient for the diagnosed illness. In the case of Medicare, the bill will be sent to one of various fiscal intermediaries (FIs), private companies that contract with Medicare to review and process claims. The fiscal intermediary may dispute the physician's bill if it determines it was not properly coded, and private insurance companies may do the same. If it is determined the physician deliberately miscoded to obtain better reimbursement ("upcoding") he or she may be subject to criminal prosecution.

Coding Latitude and RAC

Physicians have some latitude in how they code, particularly for diagnostic services. While a surgical procedure may be paid at a fixed rate, physicians can code at various levels (Levels 1-5) for typically office-based consultations. A basic consultation for a simple problem should be coded a Level 1 while an extremely complex consultation with a patient with multiple chronic problems should be coded a Level 5. Physicians who almost always code at Level 1 either have relatively healthy patients or they are afraid of drawing government scrutiny from auditors and are cautiously coding too low (and losing considerable sums of money for doing so). Physicians who almost always code at Level 5 either have very unhealthy patients or they are not coding appropriately. Outliers in the latter group may be in for a visit from a Recovery Auditing Contractor (RAC), Medicare auditors who can require physicians or hospitals to pay back a portion of their Medicare payments if the audit finds improper coding practices.

Physicians therefore spend an inordinate amount of time obtaining "pre-authorization" from payers for the services they wish to provide to patients on the front end, and battling for reimbursement when bills are disputed by payers on the back end. They also spend a good deal of time studying the new ICD-10 codes to insure they have diagnosed properly and studying updated CPT codes to insure they indicated the appropriate treatment for the diagnosis.

Under this system prices often are somewhat arbitrarily set. A hospital may charge $1,000 for a service for which Medicare only pays $600, and will therefore only collect 60% of that particular bill. Private insurance companies may pay a higher rate for the same service, and hospitals therefore will collect the higher rate and may prefer privately insured patients for that reason. In many cases, prices traditionally have been set at 2 ½ times the Medicare payment rate for a particular service, which again is a somewhat arbitrary amount. Hospital and physician prices therefore fluctuate widely within given markets for the same services. In the past, patients paid relatively little attention to these prices as the bills were largely paid by third parties. As

patients pay a higher proportion of their bills through deductibles and co-pays, price transparency is becoming a more important issue.

Clearly, this is a rather cumbersome and convoluted payment system, and after its introduction some were still skeptical of the new payment model considering it did not include adjustments for outcomes, quality of service, severity, or demand. They feared paying providers based on effort rather than effect would skew incentives, leading to overuse of complicated procedures without consideration for outcomes (again, you get the behaviors you reward).

The Balanced Budget Act and SGR

A few years after the switch to RVUs, Congress made another change in Medicare. For the first time since its inception in 1965, Medicare was expanding its options. With the passage of the Balanced Budget Act of 1997 (BBA), Medicare beneficiaries were given the option to receive their benefits through capitated health insurance Part C plans, instead of through the original fee for service system. Medicare Part C was established as the Medicare+Choice program and was later renamed the Medicare Advantage Program.

The government hoped the revisions it instituted would reduce the future cost of Medicare. In order to do so, the rate of increase in PPS payments was lowered by 7% across all DRGs by the BBA, disproportionate share payments to hospitals serving the economically disadvantaged were reduced, and teaching hospital GME payments used to train residents were capped. The GME payment cap is a primary reason why the number of physicians trained in the U.S. has remained static compared to population growth for close to 20 years and why there is a growing physician shortage. The BBA reduced payments for most hospital services, including inpatient acute care, outpatient care, home health care, skilled-nursing care, medical education, and indigent care. The goal of these changes was to reduce net spending by $116.4 billion from 1998 to 2002 (Gorman).

Because Medicare patients comprised a large percentage of all hospitalized patients, reductions in Medicare payments had a significant impact on hospital revenues. Data from the Medicare Payment Advisory Commission (MedPAC) estimated that overall Medicare margins decreased from 10.3% in 1996 to 1.7% in 2002. In order to preserve profits, hospitals decreased operating expenses and spent less on patient care, while cost shifting to privately insured and self-pay patients. Reductions in nursing staff, reduced efforts to improve staff performance, and less investment in infrastructure led to a decline in quality of care.

The Balanced Budget Act also altered how physician payments were to be calculated on an annual basis. CMS introduced the Sustainable Growth Rate (SGR) to replace MVPS when updating physician payments. CMS replaced MVPS with SGR to ensure that the yearly increase in the expense per Medicare beneficiary did not exceed the growth in GDP, tying physician payments to the growth of the economy. If Medicare payments to physicians grew less than the economy, payments would be adjusted upward. If payments grew faster than the economy, Medicare reimbursement to physicians would be cut.

As part of the process, CMS was to send a report outlining the previous year's total expenditures and the target expenditures to the Medicare Payment Advisory Commission, which advised the U.S. Congress. On March 1st of each year, Congress could either implement the physician fee schedule update to meet the target SGR (cutting physician Medicare payments, as it turned out, since these payments generally exceeded economic growth) or move the cuts down the road. Routinely, Congress elected to postpone the cuts. The annual ritual was referred to as the “doc fix”. The repeated task of implementing a "doc fix" lasted for 17 years at which time the required cuts would have totaled some 24% of physician Medicare payments. These cuts could not have been absorbed by physicians and the threat of them put doctors at an impasse.

In 2006, Medicare experienced one more change. A fourth part of Medicare, known as Part D, to help pay for prescription drugs not otherwise covered by Part A or Part B, was implemented. Through the passage of the Medicare Modernization Act, Part D provided access to prescription drug insurance coverage for all beneficiaries upon payment of a premium.

The Push for Quality

While the changes to Medicare provided increased options for the elderly, hospitals were becoming upset with their diminishing margins. At the same time, the United States Institute of Medicine published *To Err is Human: Building a Safer Health System*, a report outlining the medical errors seen in the United States healthcare system. The study concluded that between 44,000 and 98,000 people die each year as a result of preventable medical errors.

After reading the results of the study, patients became concerned with the issues of medical error and patient safety. The government determined that only by broad planning could the problems addressed in the report be reduced. The need for systematic changes had arisen yet again.

In order to better gauge patient perceptions of care, CMS sought out the Agency for Healthcare Research and Quality (AHRQ) to develop a measurement system for hospital performance accessible to the public. The system would provide consumers with more detailed information in order to aid them in selecting a hospital and would be known as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Failure to report scores and required quality measures resulted in a 2% Medicare APU reduction. Critical access hospitals (CAHs), psychiatric hospitals, and children’s hospitals were not included.

With Medicare reimbursement tied to HCAHPS scores, high-quality patient care shifted from a goal to a financial priority. The push for patient safety, quality improvements, and quality-based payment models had moved to the forefront.

The Grand Bargain

Expanding healthcare coverage and cutting healthcare costs continued to be a high priority for the government. Access was deemed a major issue as some 45 million Americans lacked health insurance. In an attempt to expand access and shift to quality-based payment models in an effort to reduce costs, Congress enacted the Affordable Care Act (ACA) in March, 2010.

As a result of this legislation, 11.4 million people have enrolled in insurance plans offered through the state insurance exchanges established through the ACA. In addition, five million Americans have enrolled in Medicaid since 2012, after Medicaid eligibility was expanded by the ACA. Medicaid payment rates to physicians were temporarily increased to Medicare levels, though this equivalence ended in January 2015. Medicare payments to primary care doctors in underserved areas for certain services were increased by 10% (though this increase will terminate in 2016). According to Gallup, all of this has resulted in a drop in the rate of uninsured adults from 18% in 2013 to 11.4% in 2015, the lowest uninsured rate on record in the history of the United States.

Expanding coverage has proved to be a relatively simple task compared to finding successful quality-based payment models. CMS announced in 2015 that the number of Medicare payments flowing through value-based entities must be from 30% to 50% by 2018, and for 90% of payments to be tied in some way to quality by the same year (*The Obama administration wants to dramatically change how doctors are paid*, The Washington Post, January 26, 2015). In order shift away from fee-for-service payment models, the ACA charged CMS to experiment with a variety of Alternative Payment Models (APMs). APMs include pilot projects such as:

- **Accountable Care Organizations (ACOs):** Networks of doctors, hospitals, and other health care providers that share responsibility for coordinating care and meeting health care quality and cost metrics for a defined patient population. Delivering care under the pre-determined cost metrics allows the physicians to share the savings.
- **Bundled Payments:** Payers compensate providers with a single payment for an episode of care, which is defined as a set of services delivered to a patient over a specific time period.
- **Pay for Performance (P4P):** Providers are reimbursed based in part on whether they achieve a predetermined set of quality measures. **Hospital Value-Based Purchasing (VBP**) is a P4P program authorized by the Affordable Care Act.
- **Patient Centered Medical Homes (PCMH):** Facilitates the coordination of care through a patient's primary care physician. The model integrates mental health and specialty services, and involves a team-based approach consisting of physicians, nurses and medical assistants, pharmacists, nutritionists, social workers and care coordinators.
- **Hospital Readmission Reduction Program (HRRP):** Hospitals with readmission rates that exceed the national average are penalized by a reduction in payments across all of their Medicare admissions.
- **Pay for Prevention:** Encourages use of prevention-oriented services through payment incentives with the goal of saving money on treatment at a later date.

To achieve quality payments, systems have been put in place to monitor the quality measures taken by physicians. The **Physician Quality Reporting System (PQRS),** a reporting program for Medicare quality of care, has been in place in some form or another since 2006, while the **Hospital Inpatient Quality Reporting (IQR) Program** was authorized by the Medical Prescription Drug, Improvement, and Modernization Act of 2003.

PQRS gives participating physicians and group practices the opportunity to assess the quality of care they provide to their patients, helping to ensure that patients get the right care at the right time. Group practices can participate in PQRS through the **Group Practice Reporting Option (GPRO)** when two or more physicians have assigned their billing rights to a single Tax Identification Number (TIN) and then participate in PQRS by being analyzed at the group level. By reporting on PQRS quality measures, individual and group practices can quantify how often they are meeting a particular quality metric and receive financial rewards. This is one reason why the financial stimulus bill provided $20 billion in payments to physicians to implement electronic health records (EHR). Only through the implementation of EHR can physician quality measures be tracked and evaluated.

In order to ensure compliance with new mandates, practices who fail to report PQRS data will face financial penalties. Beginning in 2015, practices that failed to report PQRS data in 2013 will be penalized 1.5% in their Medicare reimbursements. In 2016, the rate increases to 2%. Because PQRS is a Medicare-based incentive program, only providers who care for patients with Medicare insurance must report PQRS data.

In 2015, CMS identified 254 quality measures for which providers may choose to submit data. In 2013, providers only had to submit data on one of the measures to achieve compliance with PQRS. Yet, standards for eligibility continue to become more stringent. In 2015, providers will have to submit data on nine of the measures in order to be in compliance.

According to the Wall Street Journal, almost 40% of eligible providers did not submit PQRS data in 2013. By failing to submit data, those providers lost 1.5% in total reimbursements for CMS patients in 2014. On the other hand, the 642,000 providers who met PQRS criteria received a 0.5% increase in CMS reimbursements.

Beginning in 2015, a new program was added on top of PQRS to improve the quality of care for Medicare beneficiaries. The Value-Based Modifier (VBM) will provide for differential payment to physicians under the Medicare Physician Fee Schedule (MPFS) based upon the quality of care provided compared to the cost of care during a performance period.

Further promoting the use of EHR, CMS requires participants to use a certified EHR and meet the criteria for “meaningful use” objectives in order to receive federal incentive money from Medicare.

Hospital Value-Based Purchasing

Hospital Value-Based Purchasing (VBP) is part of CMS' effort to tie Medicare payments to quality of care, in this case, quality of care provided in the hospital inpatient setting. Payment for inpatient hospital stays represents the largest share of Medicare spending.

Under VBP, hospital Medicare inpatient payments based on diagnosis related groups (DRGs) were reduced by 1.7%. The resulting savings are then redistributed to hospitals based on their Total Performance Scores (TPS). The actual amount earned by each hospital depends on the range and distribution of all eligible/participating hospitals for a given Fiscal Year. It is possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction in DRG payments for that program year. Adjustments in payment are based on how hospitals perform on 25 measures of quality, patient experience and spending. These measures are tracked by the Hospital Inpatient Quality Reporting Program (IQR) referenced above.

More than 3,000 hospitals are subject to VBP, and the number of hospitals seeing a positive adjustment for Medicare inpatient service payments has increased.

	Value-based Improvement	
Hospitals receiving bonuses:	2015	1,648
	2016	1,806
Moving from bonus to penalty	**Moving from penalty to bonus**	**No change**
317	475	2,250

Source: Modern Healthcare, November 2, 2015

As Modern Healthcare notes: "the money at stake in each individual program is modest – 1% to 3%. But performance across all programs, combined with incentives to adopt electronic health records, will account for 7% of Medicare reimbursement this year, and will increase 8% in 2016" (Modern Healthcare, November 2, 2015).

In addition, Modern Healthcare further notes a report from The Advisory Board Co. which found that 85% of hospitals took a cut in Medicare payments after calculating the combined effects of value-based purchasing and the ACA's initiatives mandating Medicare payment cuts for hospital readmissions and hospital acquired conditions.

The changes brought on by the ACA guaranteed increased use of quality-based payment models, but concerns with the reimbursement formula remained.

MACRA Means Physicians Must Make a Choice

On April 16, 2015, another major adjustment to physician reimbursement occurred. The Medicare Access and CHIP Reauthorization Act (MACRA) repealed the SGR mechanism to the PFS. By repealing SGR, Congress has made the fee-for-service structure less attractive in an attempt to move providers to a fee-for-value model.

Under the new model, Medicare payments will increase by 0.5% a year from July 2015 to December 2018. In January 2019, a new replacement Medicare formula will require doctors to pick from two ways to participate in Medicare's payment system:

1. **Merit-Based Incentive Payment System (MIPS):** Combines PQRS, VBM, and meaningful use into one larger program that gives doctors a quality score. If their scores are above the average, doctors' reimbursement rates will go up, if at the average, there will be no adjustment, if below the average, Medicare payment will be cut.

2. **Alternative Payment Models:** Innovative payment arrangements that require a group of doctors to band together and take a lump sum of money to care for a certain group of patients. If they can provide the care for less — and hit certain quality metrics — they get to keep some of the leftover cash. The hope is that these models will force physicians to be vigilant against wasteful care, since they will have a financial incentive to spend less than their lump sum amount. Physicians who are eligible and who choose to participate in a qualifying APM, will receive a 5% bonus each year from 2019 through 2024 on top of all their other Medicare payments. Beginning in 2026, they will qualify for a 0.75% increase in their payments each year. APMs include ACOs and must place material financial risk for monetary losses on providers, use quality measures comparable to MIPS, and use certified EHR technology.

Under both payment models, physicians will still be provided with a fee-for-service payment based on the Physician Fee Schedule. From 2020 to 2025, existing Medicare fee-for-service rates will remain at 2019 levels with no updates. By retaining a fee-for-service component it is hoped that physicians will remain productive as they will continue to be rewarded for volume of patients seen or volume of work done as measured by RVUs. Realizing these payment systems may not appeal to some physicians, the law requires that CMS report on the number of doctors dropping out of Medicare.

Payment Scores Under MIPS

The MIPS program will assess physicians in four categories. Physicians will receive a score of 0 to 100, according to their performance in each of the four categories.

- PQRS: Quality of their care (30%)
- EHR meaningful use (25%)

- VBU: Use of healthcare resources (30%)
- Activities undertaken to improve clinical practice (15%)

Medicare will compare a physician's composite score with a performance threshold that will be the mean of the scores for all clinicians subject to MIPS. Clinicians who score above this threshold will receive bonuses funded by the penalties imposed on physicians who fall below the threshold. Physicians at the threshold will receive no payment adjustment. Scores will be publicly available through "Physician Compare". Adoption of telehealth and remote patient monitoring by physicians participating in MIPS are specifically named as potential score-boosters. Since from 2020 to 2025 Medicare fee-for-service rates will remain at 2019 levels with no updates, it is these scores that will determine the total amount physicians participating in MIPS earn from Medicare payments.

Bonuses offered will max out at 3 times the penalties. In 2019, MIPS scores will impact physician Medicare payments plus or minus 4%, plus or minus 7% in 2020, and plus or minus 9% in 2021. An additional incentive payment for "superstars" will be available, capped at an aggregate amount of $500 million for each of the years 2018-2023.

Hypothetically, in 2021 a MIPS participating physician could receive a $100 fee-for-service payment for treating a particular Medicare patient. With a high MIPS score, that payment could increase to $109. With an average MIPS score it would remain $100. With a poor MIPS score it could decrease to $91. Given current profit margins for many physician practices, low MIPS scores would be difficult if not impossible to maintain.

What is an Alternative Payment Model?

If a physician or healthcare organization chooses to opt-out of MIPS and pursue an APM, they have another choice to make – which type of APM? Participation in ACOs, a PCMH, or a bundled payment model will qualify as an APM under MACRA.

Accountable Care Organizations

One way physicians can participate in an ACO is through the Medicare Shared Savings Program (MSSP). Like other ACO models, the MSSP rewards ACOs that lower growth in health care costs while meeting performance standards on the quality of care. To become part of the program, eligible providers can create or participate in an ACO.

Participants must meet quality performance measures from four domains: patient/caregiver experience, preventive health, care coordination/patient safety, and at-risk populations. Much like MIPS, providers must meet a threshold (at least the 30th percentile) in order to be eligible for the shared savings. Paying for performance will be phased in over subsequent years.

This type of payment model encourages *population health management* in which large healthcare organizations such as ACOs attempt to control costs and improve quality through patient interventions that address unhealthy behaviors, by addressing the societal determinants of ill-health, and through rigorous management of care (for more information on population health management see the Merritt Hawkins' white paper *Population Health Management and Physician Staffing*).

Patient Centered Medical Home

Another option for an APM is the PCMH model. Research from the Patient-Centered Primary Care Collaborative (PCPCC) indicates that PCMHs reduce visits to the emergency room by 57% and readmissions by 29%. In addition, a 57% reduction in cost provides evidence that PCMHs may prove to be extremely effective.

Yet, experts say that the PCMH model requires significant up-front investment, and costs for continued support can be very expensive as well. The time, effort, and spending it takes to produce a substantial return may signify that the model is not as universally applicable as may be desired.

Bundled Payments

Beginning in 2012, the ACA-founded Medicare and Medicaid Innovation Center established the Bundled Payments for Care Improvement (BCPI) to assess the ability of a variety of payment models to improve patient care and lower costs to Medicare. The BCPI began evaluating the four models in 2013. These models include:

- **Model 1:** Inpatient stay in the acute care hospital
- **Model 2:** Retrospective bundled payment where actual expenditures are reconciled against a target price for an inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge
- **Model 3:** Retrospective bundled payment where actual expenditures are reconciled against a target price for an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency
- **Model 4:** Single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. This is considered the preferable model for enhancing care and reducing costs toward which healthcare organizations are encouraged to move.

Source: CMS

Models 2, 3, and 4 include two phases. The first phase is the "preparation" period. In the second phase participants assume financial liability.

As of July 1, 2015, the BPCI initiative had 2115 voluntary participants in Phase 2. Skilled nursing facilities make up just over half of the providers with 1,071 participants. Acute care hospitals (423), physician group

practices (441), home health agencies (101), inpatient rehabilitation facilities (9), and long-term care hospitals (1) make up the remainder of participating providers.

A key difference between the global/bundled payment/ACO models of today and the capitated model prevalent during the HMO/managed care boom of the 1990s is that today's models typically include a quality component that helps ensure that appropriate treatment is provided. To be paid under these models, providers generally have to follow stipulated quality measures, such as following up with patients post-surgery, to ensure full payment. These quality measures are derived from the comparatively much more robust data available on treatment effectiveness available today through EHR. At least in theory, providers cannot be paid more simply by doing less.

Orthopedic Bundled Payments

Under the ACA, Medicare can "scale up" payment models that have been found to reduce costs without limiting quality through BPCI model evaluations. In July, 2009, CMS announced it will require hospitals in 75 geographic areas, including Los Angeles and New York, to participate in a test of bundled payments for hip and knee replacement (*Modern Healthcare, July 9, 2015*). Some 800 hospitals will be affected.

The announcement is a signal that the federal government does not believe that voluntary efforts to participate in bundled payments will be enough to move the needle and is a further signal of its intention to move away from fee-for-service payments.

According to Modern Healthcare:

> "The program will begin January 1, 2016 and run for five years. Episodes included in the bundle will begin with admission to the hospital and end 90 days after discharge. The hospital will bear financial risk for the procedure, the inpatient stay and all care related to the patient's recovery."
>
> "The hospitals will continue to get paid for their services under Medicare's fee-for-service system. At the end of the year, depending on the hospital's quality and cost performance, the hospital will receive an additional payment or be required to repay Medicare for a portion of the episode costs. Hospitals will not be at risk for the first year but must absorb losses starting in year two."

More of the Same Coming

In addition to hip and knee replacements, CMS is likely to scale up bundled payments for other services, the most likely being services to treat chronic obstructive pulmonary disease (COPD) and percutaneous coronary interventions.

In addition, in 2016, CMS will launch its Oncology Care Model, a reimbursement plan that will incentivize oncologists to reduce hospital and pharmacy costs through better care coordination.

Site-Neutral Medicare Payments

To this expanding list of changes must be added the Site-Neutral Medicare Payments mandated by the November 2, 2015 Bipartisan Budget Act of 2015. The act implements a two-year federal budget that diminishes some of the spending reductions put forward through budget sequestration and avoids a potential default on U.S. debt obligations.

Of significance to healthcare, Section 603 of the Act provides that effective January 1, 2017, Medicare payments for most items and services furnished at an off-campus department of a hospital that was not billing as a hospital service prior to the date of enactment of the law will be paid under the applicable non-hospital system.

In short, if the outpatient setting was billing under the Medicare Physician Fee Schedule (MPFS) before enactment of the law it must continue to bill under the MPFS. This "site neutrality" ensures that a hospital that that owns a physician practice/outpatient setting cannot bill under both the MPFS and also get paid a hospital facility fee under the Hospital Outpatient Prospective Payment System (OPPS). This may discourage some hospitals from acquiring physician practices, though others will continue to do so as a method for increasing market sharing and achieving the integration of physician services necessary to operate as an ACO.

The "Cadillac Tax"

Over the past decade, employer healthcare costs have tripled. According to the Kaiser Foundation, employer contributions to healthcare premiums have reached nearly $12 billion.

In another attempt to curtail healthcare spending, the government intends to introduce the ACA-mandated "Cadillac Tax" in 2018, a 40% corporate tax on employee health coverage above a certain monetary threshold. The threshold for individual coverage is $10,200. For family coverage, the threshold is $27,500. Companies have already begun to make changes to their health coverage programs (reducing benefits, higher copayments, or higher deductibles) in order to avoid the tax.

The pending tax on high-cost plans has firms worried and taking anticipatory steps with 64% of employers expecting it to have an impact on their company (Source: PwC 2015 Health and Well-Being Touchstone Survey). As expected, employees are not very excited about cuts to their healthcare coverage.

Employees interested in finding an alternative have turned to private-exchange enrollment. Accenture forecasts enrollment of employees under 65 years old and dependents in private-exchange programs will grow to 12 million in 2016 and 22 million in 2017. The trend toward private insurance exchanges has grown exponentially, and it may continue to do so over the next few years as a result of the Cadillac Tax. However, policy makers from both sides of the aisle are discussing repealing or amending the Cadillac Tax and its fate currently is in doubt.

Value-Based Models in Action

As Medicare transforms its reimbursement metrics, hospitals and health systems are emphasizing value rather than volume in their business models. Earlier this year, CMS announced a goal of linking 50% of Medicare payments to value-based financial models by 2018.

Large health systems are leading the way in adopting this mantra through the implementation of a wide range of value-based payment models said to increase efficiency and improve clinical outcomes. According to HealthLeaders, more than 58% of healthcare organizations have at least implemented pilot efforts to make the transition from fee-for-service models to value-based care. Nearly 20% of healthcare organizations have completed their pilot efforts and have initiated a full rollout.

Examples include:

- **Bon Secours Health System** in Marriottsvile, Maryland has introduced a shared savings model for their physicians called the **Primary Care Quality Incentive Program (PCQIP)**. The model incentivizes physicians to work within ACOs. Physicians must first meet their budgeted target volumes, then they become eligible to receive a quality bonus. PCQIP bonus requirements include citizenship, meaningful use, and quality measures (metrics similar to MIPS). Physicians can earn a partial bonus for meeting only one or two of the requirements. Bon Secours are above the threshold for all performance measures required to be eligible for shared savings in their model
- **Meriter Hospital** in Madison, Wisconsin has contracted with the CMS **BPCI initiative**. According to HealthLeaders, “Meriter’s bundled payment programs have resulted in a 12% reduction in patient length of stay, a 23% decrease in discharges to skilled nursing facilities, and a 68% drop in hospital readmissions.”
- **Intermountain Healthcare** in Utah and Idaho has implemented their value-based payment model **Shared Accountability** with great success. In an interview with HealthLeaders, senior vice president and chief strategy officer, Greg Poulsen, said that one-third of Intermountain’s healthcare services are tied to value-based payments. Intermountain relies on its Geographic Committees to assess their performance and make necessary adjustments for improving their system.

While the implementation of value-based payment models has been led by hospitals and health systems, other providers are joining the fray. In October 2015, the Blue Cross Blue Shield Association announced a new value-based network called Blue Distinction Total Care for large businesses with employees across the nation.

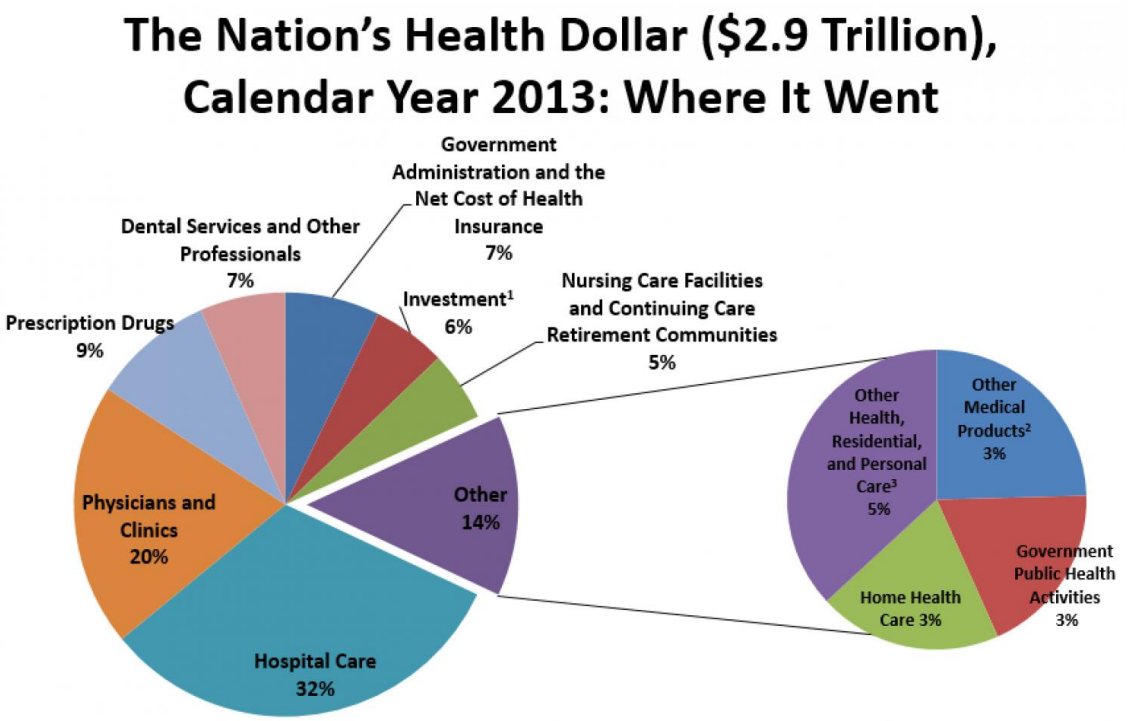
The network will take effect in January 2016, and will allow employees of large companies to access nearly 450 patient-focused care programs from 36 independent BCBS providers operating in 37 states. In order for the program to have success, employers must find it financially beneficial and employees must be convinced the care they receive meets their standards. The Blue Cross Blue Shield Association believes expansion will

be achievable if the initial program proves to be a success.

While these models may be gaining traction, for many physicians and healthcare organizations value based payments remain aspirational and fee-for-service/volume payment models still predominant. Of the 3,138 physician search assignments Merritt Hawkins conducted from April 1, 2014 to March 31, 2014, only 23% of searches offering a production bonus featured a quality based component. The industry at large is still seeking the physician payment "Goldilocks zone" – a system that is not too volume driven, not too quality driven, but is "just right."

Healthcare Spending Today – Where Does it Go?

Despite efforts to curtail healthcare spending, the U.S. now spends close to $3 trillion a year on healthcare. The chart below illustrates how this money is spent:



Source: CMS Office of the Actuary

This rate of spending is considered unsustainable, but whether new delivery and payment models can control it remains to be seen. In addition, it is noteworthy that only 3% of spending is devoted to public health activities which could address health challenges on the front end and that the great majority of

spending is devoted to treating illness after it occurs.

The Effect on Physician Staffing

Perhaps the biggest challenge for healthcare organizations shifting to value-based payment models will be physician engagement. According to HealthLeaders, 66% of healthcare executives cite physician engagement as being one of their organization's top alignment objectives. Since the days of DRGs and even before, physicians and hospitals often have not been financially or organizationally aligned.

Such alignment is necessary when both hospitals and physicians are sharing in one global payment, or when payments are based on shared EHR data or on quality measures that must be followed through the continuum of a patient encounter, a continuum that might range from a physician office visit, a hospital inpatient procedure, a skilled nursing facility stay and a rehabilitation program.

But how will physicians react to these changes? Will they align with larger entities, try to maintain their status as independent practice owners, retire or pursue some other course?

The answer to this question lies in the current attitudes and dispositions of physicians, a topic explored in more detail in *A Survey of America's Physicians: Practice Patterns and Perspectives*. This survey of over 20,000 doctors, conducted by Merritt Hawkins on behalf of The Physicians Foundation, suggests that physicians today labor under an increasingly burdensome, and in their view often meaningless, number of reporting requirements that take time away from patients and fail to help them improve their quality of care.

According to the survey, 81% of physicians are either at their workload capacity or are overextended. Furthermore, roughly 56% of physicians say their morale is somewhat or very negative. Those with the highest levels of dissatisfaction by a significant margin are practice owners and older physicians. It can be anticipated that these doctors will seek some alternative to the traditional style of independent practice, and the survey indicates this already is happening.

The survey shows that in 2014, 53% of physicians identified themselves as employed by a hospital or medical group, up from 44% in 2012. Given the complexities of payment models such as MIPS, it is likely that even more physicians will embrace employment and join alternative payment models (APMs) which virtually by definition must be larger, integrated entities.

About 28% of physicians are 60 years old and older and many of these doctors, who grew up in the fee-for-service era, can be expected to retire as soon as they have the means to do so. Other physicians may choose to circumvent third party payers and practice on a direct pay/concierge basis. A growing number also can be expected to forego full-time practice and work on a temporary ("locum tenens") basis, accept non-clinical roles, or switch to part-time practice.

Those who do choose to operate in today's evolving payment system as employees are likely to adopt nine

to five schedules (as opposed to the longer hours worked by medical practice owners) and to change jobs more frequently, leading to higher levels of medical staff turnover. Both physician alignment and physician recruitment/retention will continue to be challenging as a result of today's reimbursement transformation.

In addition, the types of physicians being recruited may be subject to change based on evolving reimbursement models. When fee-for-service reimbursement was predominant, the majority of Merritt Hawkins' clients were seeking high revenue generating physicians such as orthopedic surgeons, cardiologists, radiologists and others. Those types of physicians still are in demand, but primary care doctors such as family physicians and general internists, who are responsible for coordinating care and allocating resources appropriately in global payment models, have been our number one search assignment for nine years in a row. Where once highly entrepreneurial specialists willing to be busy were highly prized candidates, in the future it is possible that physicians who show a pattern of minimal procedures and tests may be the most valued.

The reality is that reimbursement in healthcare is dramatically more convoluted and arcane than in almost any other sector of the economy, in which professionals or businesses generally determine their price, submit a bill to the recipient of the goods or services provided, and are paid by the recipient the amount they invoiced. The ability of healthcare administrators and physicians to understand and adapt to the vagaries of reimbursement will largely determine their professional satisfaction and success.

About Merritt Hawkins

Established in 1987, Merritt Hawkins is the leading physician search and consulting firm in the United States and is a company of AMN Healthcare (NYSE: AHS), the largest healthcare workforce solutions organization in the nation. Merritt Hawkins' provides physician and advanced practitioner recruiting services to hospitals, medical groups, community health centers, telehealth providers and many other types of entities nationwide.

The thought leader in our industry, Merritt Hawkins produces a series of surveys, white papers, books, and speaking presentations internally and also produces research and thought leadership for third parties. Organizations for which Merritt Hawkins has completed research and analysis projects include **The Physicians Foundation, the Indian Health Service, Trinity University, the American Academy of Physician Assistants, the Association of Academic Surgical Administrators, and the North Texas Regional Extension Center.**

This is one in a series of Merritt Hawkins' white papers examining a variety of topics directly or indirectly affecting the recruitment and retention of physicians and advanced practice professionals, including physician assistants (PAs) and nurse practitioner (NPs).

Additional Merritt Hawkins' white papers include:

- Psychiatry: "The Silent Shortage"
- Physician Supply Comparisons: Physicians by Select Specialties Practicing in Each State and Licensed in Each State but Practicing Elsewhere
- The Aging Physician Workforce: A Demographic Dilemma
- Nurse Practitioners and Physician Assistants: Supply, Distribution, and Scope of Practice Considerations
- The Physician Shortage: Data Points and State Rankings
- Physician Supply Considerations: The Emerging Shortage of Medical Specialists
- RVU FAQ: Understanding RVU Compensation in Physician Employment Agreements
- The Economic Impact of Physicians
- Ten Keys to Physician Retention
- Trends in Incentive-Based Physician Compensation

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