

Physician Payment Reform: What Can We Learn From Pilot Projects

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Project HOPE

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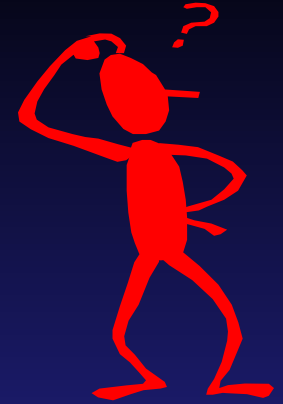


Physician Payment – Not Just an SGR Challenge



- ◆ SGR exacerbates the problem with its across the board fee reductions
- ◆ SGR/RBRVS combination that's the problem
 - RBRVS pays on basis of individual services
 - uses a very disaggregated billing system
 - hard to hold physicians accountable/responsible”, “paying for volume; not value”

So --- What's the Problem?



- ◆ If Congress *only* removes the SGR,
 - spending for physician services will increase faster than desired (that's why its there!)
 - would still be rewarding *volume*, not *value*

But ...

No viable alternative to RBRVS *now* ready for *prime time*

Good News/Bad News



- ◆ Many public sector pilot projects being funded by CMMI
 - bundling demos; PCMH's, multi-payer Adv. Primary Care practices
- ◆ Lots of pilots being done in the private sector
 - Blues plans (MI is esp. active); UHG, Aetna, Wellpoint, Cigna, all have pilot projects, *but* ...
- ◆ Many pilots run until 2014; heavily primary care oriented
- ◆ Evaluations are likely to vary in quality

What Was Learned By GAO Study?

(9 entities; 12 activities)



Better to measure performance at the practice level

Important to use nationally endorsed measures; need a standardized set metric

Better to use absolute benchmarks/absolute+improvement

Better to provide incentive payments as soon as possible
(not like the government)

Challenges Translating Pilots To Action

- ◆ *Self-selection* is always a problem; so is the “*Hawthorne Effect*” (people being watched behave differently)
- ◆ Hard to measure real “*net effects*”
 - real savings can be hard to calculate
 - need good risk adj; adj for infrastructure inv.
 - need to know whether results can be generalized to all patients or only selected subsets
 - need to distinguish between one-time savings and on-going savings