# The Doc Fix – What Happens Next? Why The Medicare Fee Schedule Needs to Be Fixed

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# FFS Not Inevitably As Dysfunctional As Ours Has Proved to Be

- Many countries rely on fee schedules for docs without our problems (but with problems) – see France, Germany, other social insurance countries
- Can improve fee schedule to reduce some of the problems with self-referral and volume growth of discretionary services
- Problems of lack of coordination and lack of attention to prudent spending are probably inevitable in FFS. So, especially in Medicare, it is preferable to move to new payment and care delivery models
- But, albeit imperfectly, some of the higher value objectives can be fostered even using fee schedules

# FFS Attributes

## Advantages

- ***Rewards activity/industriousness***
- Theoretically can target to encourage desired behavior
- Implicitly does case-mix adjustment
- Commonly used by payers and physicians
- Can readily apply patient cost-sharing

## Disadvantages

- Can produce too much activity, physician-induced demand
- ***Maintains fragmented care provided in silos***
- Relatively high administrative and transaction costs
- ***What is not defined as reimbursable is marginalized***
- Complexity makes it susceptible to gaming and to fraud
- ***Susceptible to pricing distortions that alter behavior***

# The Medicare Physician Fee Schedule – End It or Mend It?

- Alternatives are not easy – operationally or politically
- In best case, unlikely to have 100% replacement
- Some successful, payment models are FFS-based hybrids, see Denmark – 60% FFS, 40% capitation
- Current payment rates are used to calculate bundled/global payments – maintain the distortions
- Divergence in FFS-based incomes makes provider integration more difficult – specialists won't play
- Current level of distorted payments (i.e., payments >> costs of production) not inevitable – see results of DRA of 2005 reduction of imaging fees for + impact – decreased prices and decreased volume growth rate

# Some Immediate Steps to Improve Physician Payment

- Repeal the SGR (especially now that it is on sale)
- No new volume control formula but allow CMS some flexibility to alter prices to affect volume and intensity
- Narrow the Stark in-office ancillary exception
- Overhaul current evaluation & management code descriptors, which currently produce up-coding and compromise the integrity of medical records
- Reduce or eliminate site-of-service differential that pays hospitals as much as 2Xs the payment to independent practices (can do it budget neutral for hospitals by raising rates for uniquely hospital services -- inpatient, ER