Title
The other physician payment problem

Journal
JAMA - Journal of the American Medical Association, 313(21)

ISSN
0098-7484

Author
Bindman, AB

Publication Date
2015

DOI
10.1001/jama.2015.4797

Peer reviewed

For a decade, Aetna has offered a Compassionate Care program (http://aet.na/1aNtPOF). "We've eliminated the requirement for commercial members to give up curative treatment in order to be eligible for hospice services," Harold L. Paz, MD, MS, executive vice president and chief medical officer at Aetna, told the audience at the IOM meeting. Plus, he said, commercially insured members are eligible for hospice care if their life expectancy is a year, not the standard 6 months.

However, Aetna must comply with CMS regulations for its Medicare members, Paz said.

Nearly 3000 Aetna Medicare members enroll in the Compassionate Care program each year, he said. In 2012, 82% of them chose hospice care, virtually the same proportion as seen in commercially insured Aetna members, Paz said. Only a small number of commercially insured patients have opted to receive palliative care and curative care simultaneously, he said.

"Notably, we have not seen increased costs as a result of this," Paz said. In fact, for each member who has enrolled in the Compassionate Care program, Aetna estimates it has saved about $12 900, Paz said. "Certainly, palliative care is less costly than curative care." Aetna has also seen "impressive results" in terms of satisfaction on the part of members and their families, he added.

As of January 1, Cambia added about 20 codes to its Medicare Advantage plan, which pays for home health agencies, social workers, counselors, and palliative care providers that traditional fee-for-service Medicare does not, Csaba Mera, MD, deputy chief medical officer, said in an interview.

"Our view is that hospice is built into palliative care," Mera said. "But palliative care really should start much earlier. It doesn't mean that you have to stop active treatment."

"Physicians have been trained that death is the enemy," Cambia's Maguire said. "I think if we could reframe the conversation about wellness and living with quality for as long as possible, no matter your health condition, that's the cultural shift that we need to make." ■

The JAMA Forum

The Other Physician Payment Problem

Andrew B. Bindman, MD

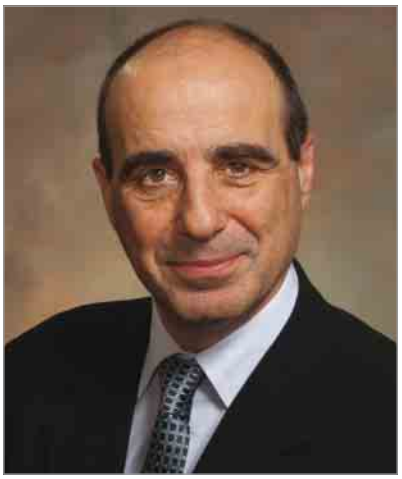
Although the US Congress has now passed legislation to permanently repeal the controversial formula used to pay physicians for caring for patients who receive Medicare, it is ignoring an even larger payment problem in Medicaid that has implications for an even greater number of patients. The Congressional Budget Office (CBO) estimates that in 2015 there will be 66 million (http://1.usa.gov/1HNCw7E) individuals enrolled in Medicaid compared with 55 million (http://1.usa.gov/1Qc7utX) in Medicare.

Much attention has been focused on a 21% decrease in physician payment for care provided to Medicare beneficiaries that would have occurred if Congress had not addressed the sustainable growth rate (SGR) formula used to calculate payment. Yet despite Medicaid's larger patient population, physician payments for the same services are already 34% lower in Medicaid (http://bit.ly/1adaS00) than they are in Medicare.

Medicaid payment rates vary widely across states, with the greatest disparity in Medicaid vs Medicare physician payments in many of the most populous states, including California, Florida, and New York. These disparities have a direct effect on physicians' willingness to care for Medicaid patients. The Centers for Disease Control and Prevention found physician participation in Medicaid to be among the very lowest in these 3 states (54% in California, 56% in Florida, and 57% in New York) compared with the national average in Medicaid of 69%, (http://1.usa.gov/1IDgbrB) even though physicians in these same states accept publicly insured patients in Medicare at rates that are not statistically different from the national average of 84%.

Why the Disparities?

Medicaid is jointly funded with resources from the federal and state governments. Although states, on average, pay only 38% of Medicaid's total costs and no state contributes more than 50% toward Medicaid physician payments for care, state Medicaid programs are allowed to determine physician payment rates. States set them low for the simple reason that this is one of the few ways that they can limit their costs for this entitlement program. States understand that low payment rates contribute to reduced physician participation and barriers to care, but they are rarely held accountable for the level of access that their programs provide.



Andrew B. Bindman, MD

One way physicians and other medical professionals have attempted to combat low Medicaid payment rates has been through the federal courts, by suing state Medicaid programs to raise rates, arguing that low payment rates prevent Medicaid programs from providing adequate access to care. Federal courts have been sympathetic to the access concerns, and in several cases the courts have required states to either raise their rates or roll back proposed payment cuts.

From Bad to Worse?

Although the threat of court action has prevented states from being even more aggressive in limiting physician payment in Medicaid, a recent Supreme Court decision alters the landscape and could lead to a decline in Medicaid payment rates and greater barriers to access for Medicaid patients.

In *Armstrong v. Exceptional Child Center* (http://1.usa.gov/1xvwVAo), the US Supreme Court not only overturned (by a 5 to 4 decision) a lower federal court's decision requiring Idaho to increase its Medicaid reimbursement rates for home-based and community-based service care, but, in doing so, stated that physicians and other providers do not have standing in federal courts to seek a remedy for low Medicaid fee-for-service payment rates.

In the wake of this decision, the prospects for improving physician payments in Medicaid have dimmed considerably. Without the threat of lawsuits, states may become even slower than they already are to keep pace with other payers, and there is little to prevent them from actually further reducing their already paltry reimbursement rates.

Some states are pursuing approaches that do not increase the burden on the state general fund to help ensure adequate access to care. For example, more than two-thirds of states have created a special Medicaid hospital tax (http://1.usa.gov/1aM9Xu9) as a way to boost federal matching funds, and then redistributing both the tax revenue and the matching funds to hospitals to help defray their Medicaid-related costs.

States have not employed physician taxes in the same way, but in theory, such taxes could raise revenue to support physicians who provide Medicaid services, as long as the physician tax is broad-based, uniformly applied, and does not guarantee that everyone who contributes to the tax will get an amount back that is at least as great as their contribution.

Congress could also act to make the necessary funds available to states to ensure adequate access to Medicaid physician services. For example, the President's fiscal year 2016 budget asked (http://1.usa.gov/1I5dRcV) Congress to extend the Medicaid primary care physician payment bump included in the Affordable Care Act (ACA). The ACA included new federal funding to states for primary care physician services and required that all Medicaid programs pay primary care physicians at least Medicare rates for those services. The primary care payment bump was funded for only 2 years, but it had a positive effect (http://bit.ly/1L51Abk) on improving access to care for Medicaid beneficiaries.

Although the bill just passed by Congress to address Medicare physician payments would have been the natural vehicle to also deal with the underpayments in Medicaid that threaten Medicaid beneficiaries' access to care, Congress chose to ignore this issue.

Other Options

The federal government's executive branch has some options to address Medicaid Funding even without Congress. The Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring (http://1.usa.gov/1GcrUNO) that state Medicaid programs enlist enough providers to furnish a level of service and care that is available to the general population. If CMS has concerns about a state's compliance with this requirement, the secretary of the Department of Health and Human Services can withhold a state's Medicaid funding. However, this is a drastic step that deprives states of the funding they need to address the violation, placing beneficiaries at even greater risk for access barriers.

A less drastic, but potentially effective, approach recommended by some medical associations calls on CMS to withhold approval of state waivers in states that do not provide adequate reimbursement rates. Medicaid waivers are requested by states to free themselves from some federal administrative rules and to derive additional federal funds for the state's Medicaid population. The potential loss of this flexibility and extra funding might encourage states to be more reasonable in setting their payment rates, and thereby ensure adequate access to physicians for Medicaid beneficiaries. Whether CMS is ready to play hardball with states over waivers at a time that the agency is still trying to encourage states to expand Medicaid coverage is debatable.

The wild card for physician payment in Medicaid is the growing use of managed care. Approximately 70% of Medicaid beneficiaries (http://bit.ly/1Qc8E8J) receive at least a portion of their services through managed care. Federal regulations require states to have standards to ensure that each Medicaid managed care organization has a network of physicians that is sufficient to provide adequate access to care for its enrollees.

However, the US Government Accountability Office (GAO) has found wide variation across states (http://1.usa.gov/1uX1AQF) in the application, monitoring, and enforcement of those standards. If CMS follows the GAO's recommendation to establish access standards in Medicaid managed care and to increase the federal oversight of the states' enforcement of those standards, then physicians could be paid for care for Medicaid beneficiaries at rates that more closely resemble those of other payers. ■

Author Affiliation: Andrew Bindman, MD, is professor of medicine, health policy, epidemiology and biostatistics at University of California, San Francisco (UCSF). He is the founder and director of the University of California Medicaid Research Institute, a multicampus research program that supports the translation of research into policy.

Corresponding Author: Andrew B. Bindman, MD (abindman@medsfgh.ucsf.edu).

Published online: April 15, 2015, at http://newsatjama.jama.com/category/the-jama-forum/.