

How Not to Fix the “Doc Fix”

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The Balanced Budget Act of 1997 was written in another time and, though very successful, produced a legacy for Medicare that 15 years later can have a calamitous impact on doctors and hospitals.

The sustainable growth rate (SGR) formula for Medicare—adopted as a footnote in the Balanced Budget Act—has been a ticking time bomb. The SGR pegs Medicare physician payments to the nation’s GDP, rather than to the actual costs of running a medical practice. It was developed as a way to control federal spending on doctors, but the formula did not anticipate that Medicare patients would increase their use of physician services—which, for preventive and maintenance health, is desirable. So Medicare spending on doctors has grown faster than the overall economy, which is exactly what the SGR sought to avoid.

As such, year after year the SGR formula proposes to cut Medicare physician payments to align them with the GDP, but at the last minute, the realignment is averted and the spending gap grows ever larger. This year’s potential cut is a draconian 27.4 percent. Reductions of this magnitude would be impossible for physicians to absorb and would, in turn, jeopardize their ability to provide care to Medicare beneficiaries.

Since 2002, Congress has avoided these cuts through a series of so-called “doc fixes” that stop reductions from going into effect. Now, with partisan bickering driving policy, this year’s doc fix is in jeopardy, and the proposed solution could be even worse than the problem it is trying to fix.

To pay for the doc fix, the U.S. House of Representatives has proposed cutting Medicare

payments for hospital outpatient clinic evaluation and management (E/M) services. This idea stems from the misguided notion that hospitals should be able to provide the same services at the same costs as physicians do in their offices. It disregards significant hospital costs such as for caring for the uninsured and underinsured, having 24-hour standby and emergency facilities, and treating patients with more severe conditions.

The purported solution also fails to realize the vast differences in clinical billing regulations between hospitals and offices. Hospitals must accept a single fee that often includes multiple items and procedures that are essential to good care. Offices bill these items separately, with a lower fee for the primary consultation, but additional bills for necessary related costs such as imaging or certain drugs.

Hospitals already lose money treating Medicare patients, and under this doc fix, they would stand to lose another \$6.8 billion over ten years. Hospital payments would be reduced by almost 75 percent—to about \$15 per visit. It is absurd to think that this begins to cover costs for comprehensive E/M care. Medicare beneficiaries in underserved communities who rely on hospital-based clinics for care would be particularly impacted as these community resources are forced to close. Nearly one-third of the proposed hospital cuts would impact just 6 percent of hospitals—America’s teaching institutions.

It is time for this shell game to stop. You cannot help physicians—or patients—by hurting the hospitals where they train and work, or by pitting doctors and hospitals against one another. Other solutions for the doc fix must be found.

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