Repeal of the SGR Calls for the Establishment of a Balanced Payment Model

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INTRODUCTION

As physicians and healthcare provider organizations have been struggling against cuts from the government for more than five years, this ongoing fight to prevent Medicare reimbursement cuts has recently reached a new level of threats to physician payments that could continue for more than a decade. Medical providers are currently facing the greatest challenge in more than 25 years, which will have a significant impact on the nature of the U.S. healthcare delivery model for many years to come. Moreover, the potential impact of this debate will not be limited to the amount of compensation that doctors receive for their services. Indeed, this discussion will have a direct impact on the quality and nature of care that patients can expect to receive from the future American healthcare system.

This report provides analysis and discussion covering some of the recent efforts and proposals from policymakers within the federal government related to reimbursement payments for physicians under Medicare. This analysis also attempts to look into the future in order to estimate and evaluate the likely impact that can be expected related to the financial strength of the healthcare industry, as well as those key stakeholders therein, if such policy proposals and recommended changes were to be integrated within the current landscape.

THE SGR DEBATE

In late September 2011, the Medicare Payment Advisory Commission (MedPAC) released a draft proposal that recommended to Congress to repeal the Sustainable Growth Rate (SGR), which had previously proposed to cut physician reimbursement by 30 percent as of January 1, 2012. The net effect is that repealing the SGR means more reimbursement cuts are in store for physicians.

The SGR has been at the center of the debate over Medicare reimbursement since 2005 when the first cuts were recommended by MedPAC.
The conflict with the SGR has always been that it does not account for the rising costs of providing care, nor does it have any mechanism for inflationary adjustment. As such, for the past few years, Medicare has been forced to recommend payment cuts to Congress, which were prevented only by legislative action to prevent the cuts from going into effect.

With the elimination of the SGR and the prevention of the 30 percent cuts, this means that there will be a negative revenue impact for the federal government. MedPAC has estimated that the government would risk up to $300 billion in lost revenues once this proposal goes into effect. To make up for these losses, along with eliminating the SGR, Medicare has proposed to freeze payments to primary care physicians for up to 10 years. Likewise, specialist physicians would see cuts of almost 6 percent annually for three years, after which their reimbursement would be frozen for the remainder of the 10 years.

Even with these adjustments, however, the estimated savings to the federal government would only cover one-third of the projected losses. Thus, the government would have to cut payments in numerous other healthcare services, in order to make up the rest. These areas that would be cut include clinical labs, medical equipment vendors, and certain long-term care facilities.

As MedPAC opened the discussion up to the public encouraging feedback on the plan from healthcare industry stakeholders, it did not take long at all for the industry to come back with harsh response to this proposed solution from the government. This was bittersweet news for those within the healthcare provider community. With all of the work that this sector has been doing to repeal the SGR and replace it with an equitable payment model for the past seven or so years, freezing payments for another 10 years would likely be equally as bad as keeping the SGR in place.

Many physicians argued that this proposal is not just a negative short-term solution, but that it would actually end up being much worse than leaving the model as it currently is structured. Some stated that this proposed solution would ultimately put the industry back in the dark ages, figuratively speaking, as it related to healthcare reform. A drastic and long-term policy such as this
could set medical provider reimbursement back decades, which is detrimental in today’s environment when many physicians can no longer afford to stay in private practice.

The healthcare provider community also argued that a 10-year outlook of frozen physician payments would significantly add to the challenge that the industry already faces with declining numbers of new providers entering the medicine. Furthermore, it would only continue to drive the increasing number of physicians that are reasonably close to retirement to leave practice, due to the growing financial and administrative burden the system has on their ability to maintain profitability.

**Physicians and Hospitals Align**

In response to the many economic pressures that physicians have been experiencing for the past five to 10 years, many providers have shifted their operating models to affiliate and align more closely with health systems. This trend has become known as “clinical integration” or “hospital-physician alignment” within the industry, and as the burdens for physicians continue to escalate, we can expect them to consider alignment as a more attractive alternative for years to come.
As such, these newly proposed solutions for Medicare reimbursement continue to drive physicians towards greater alignment with hospitals, such as employment and/or employment-like arrangements, which have already become very popular. Particularly, this applies for specialists, such as cardiologists, radiologists and obstetricians/gynecologists physicians, who have already made significant shifts toward integration, due to the impact that reimbursement cuts over the past three to five years have had on their ability to make money in private practice.

Further, we can now expect this alignment trend to continue expanding to other specialties, even those that have historically had favorable payment models, such as orthopedic surgeons, gastroenterologists, and plastic surgeons. As hospitals try to maintain a reasonable allocation of primary care physicians and specialists within their employed medical staffs, these proposed changes would most likely increase the rate at which these physicians are affiliating with hospitals.

**NEGATIVE OUTCOMES**
Whether this increased push towards greater clinical integration is one of the government’s objectives with the MedPac proposal remains to be determined. However, the impact that the medical provider community would likely experience if such a plan were to take place is overall negative, with very little upside, particularly within the 10-year timeframe in which this model would be executed. There are other outcomes related to these proposed changes that are also worth considering.

- Changes in industry transactions. First, the clinical integration trend has dramatically changed the nature and landscape of transactions within the healthcare industry. Transactions between hospitals and other types of medical provider entities, such as practices, surgery centers, and ancillary facilities, have evolved to become in many ways much more complex than the standard acquisition of a business as a going concern or merger between two or more entities.

  The traditional merger and acquisition (M&A) model among healthcare facilities have shifted more toward asset-based transactions with very little upfront value being accredited to the entity being purchased. However, the bulk of the value is concentrated in the second element of these transactions, which is an employment agreement for the physicians involved. So, a hospital may acquire even a large practice and at close they will pay a relatively small amount, which is attributed to the value of the entity's tangible assets (i.e., equipment, supplies, etc.). However, most of the deal's value is found in the ongoing agreement for the physicians in that practice will now become part of the hospital that purchased them.

  These agreements often involve full employment of the physicians, but not always. Physicians are not always limited to the hospital employment route, which often has negative connotations and/or is generally an unpleasant alternative for the physician. As a result, a wide range of transaction structures have emerged over
the past few years, which provide alternative models for the physicians to work with the hospital after they sell their practice. Some of these arrangements include professional services agreements (PSAs), management services agreements (MSAs), clinical co-management agreements, and various other types of joint venture (JV) structures. These allow the physicians to maintain a more active role in the ongoing management, oversight, and profits of an entity.

- Changes in the valuation landscape. In conjunction with the evolving nature of M&A transactions among healthcare provider organizations, we can also see how the trend of clinical integration has changed the valuation landscape for these entities throughout the nation. Further, we can now start to weigh into our consideration how future reimbursement trends are likely to impact provider-driven organizations, and the results are not in favor of the independent practice model. Valuations attributed to these entities have been declining for the past 20 or so worse the valuations ultimately become.

As an example, let’s consider a relatively large cardiology group that has 30 physicians and is contemplating alignment options with one or more local hospitals. A group this size can easily have up to $50 million in total annual revenue. However, the prospect of having any real “enterprise value” (i.e., the value of a company’s earnings) is low, because those physicians’ are likely compensated based on the practice’s profits after expenses and overhead are covered. With $50 million in revenue, it would not be unreasonable for this practice to have 30 percent profit leftover after expenses five or so years ago. This would mean that each of the
physicians would roughly make $500,000 in annual compensation, which would be a relatively average level of compensation for a cardiologist.

In today’s environment, however, the prospect of 30 percent margins would be outstanding for a practice of any size, much less one that has a large amount of overhead required to support the work of that many physicians. Still, even if there were two physicians in the practice, the likelihood of making that much in compensation each year is very low, because the costs of providing care only continue to increase. So, today we would likely anticipate somewhere around 10 percent to 20 percent profit margins for that entity (if that), which could result in the physicians’ compensation being reduced by more than half.

To the general public, it may seem that all physicians earn a lot and $500,000 is definitely a big paycheck. However, the training, education, and years of experience it takes to become a skilled physician, coupled with the long days of excruciatingly detailed and pressure-induced work they do, more than justifies those levels of compensation and more. Indeed, most patients would rather the person working on their heart to be paid very well. No one wants the cardiologist that has not earned a high level of compensation, nor do they want one that is disgruntled because they can barely pay their bills with the payments they are making from that procedure.

- Impact on the 2012 Elections. One other issue that we can expect to emerge as a result of this newly proposed solution of eliminating the SGR and cutting / freezing reimbursement for 10 years will be seen over the next 12 or so months as Washington and the country is already well into the 2012 election cycle. The physician community and overall healthcare industry has proven to be a formidable foe for any politician threatening to impugn their ability to make money. This is because at the core of the free-market economic model, quality is inherently driven
by value. If value is not there or if it is restricted, then how can we ever expect for us to achieve the quality that we must have in something as critical as our healthcare services?

- Downstream Affect on Healthcare Value Chain. Furthermore, this new model would not just impact physicians alone or a certain group of physicians. Healthcare companies understand very well the negative impact to the cash flow cycle that occurs when the government (or any entity) tampers with physicians’ income. A trickle effect throughout the industry of restricted value opportunities occurs when physician reimbursement declines, because at the core of this industry are the patient and the physician. If one of those parties is paid less today than they were yesterday for the same service, then you can expect for there to be generally less to go around for those further down the healthcare value chain.

  Cuts to physician reimbursement will have a negative impact on equipment vendors; drug suppliers; ancillary providers; home health and alternate site facilities; healthcare information technology vendors; and many other types of healthcare businesses. Even healthcare insurance companies will make less, which on the surface does not seem like a bad thing; however, in most cases when payers’ revenues decline, then that means the payments going to the providers are also declining.

**LONG-TERM PROBLEM**
So, this issue is not likely going anyway anytime soon. Or, if this debate does appear to subside, it will most likely bring on the posturing and delay that often results from policymakers putting on their political hats and dodging challenging issues. Not until after the election, when they are safe to deal with pressing matters of state again, will they deal with these matters. But, those of us within the industry should not and cannot afford to be deceived into believing that this problem will just automatically go away. The fact that a policy makes no sense from a fiscal or quality perspective, or that it is generally a bad idea for everyone involved, often has not been enough in the past to stop inside the beltway policymakers and bureaucrats from continuing to push through those flawed policies. Ultimately, we can expect this issue to continue posing a challenging to medical providers well after the 2012 elections.

**The Solution: A Balanced Payment Model**

So what can we do about all of this? Do we just have to succumb to the realization that the industry is doomed to the removal of value from the healthcare delivery model at the current alarming rates? Can we stop this downward momentum that has seemed to build up as the situation grows more and more grim?

In order to find a reasonable solution to this and the many other related challenges that healthcare providers and healthcare services organizations face in today’s environment, we must first understand and then address the core drivers behind these issues. The healthcare system has simply outgrown the current delivery model. The fact of the matter with Medicare reimbursement is that it will likely never go back up, because the Medicare system is out of money. When the only way to make up the federal government’s deficits are through cuts to the most critical components
of the system (i.e., the physicians), then we have likely hit a wall. The volume of Medicare beneficiaries has not even remotely reached its expected peak in the coming years. However, the system cannot cover the costs to physicians for providing the care with the current levels of payment, which are inadequate. Moreover, the only solution that seems to emerge is to cut these payments even further. This ultimately brings us back to the discussion of wide-scale reform, which of course is a much larger conversation and requires consideration of many more variables. However, the issue of Medicare reimbursement and the negative impact of any proposed cuts to physician payments are helpful in understanding just how critical physician compensation is to the overall discussion. Since that trickle-down effect of the physician-patient value chain is so acute and spreads so quickly throughout every element of the healthcare industry, this is perhaps one of most vital organs that make up the system’s central nervous system. Without sufficiently addressing that piece, we can essentially forget the other proposals.

The community of medical providers has been able to come together on the issue of Medicare reimbursement reform more so than perhaps any other issue within the last half-century. According to many physicians that Coker has worked with in the past, the threat of Medicare cuts is the number one issue driving volatility in physician practices’ financial strength and is forcing far too many physicians to either sell their practices or leave the practice of medicine altogether. These healthcare industry stakeholders agree that without a solution to this issue, we are essentially attempting to bandage a gunshot wound with paper towel.

The piece that is still missing, however, is what solution can be found that will fix this problem. Physicians want to know what they can do today to more effectively secure the financial

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and operational strength of their organizations for years to come. However, there has yet to be a proposal from the federal government that the industry can get behind, and CMS continues to tell policymakers that without reimbursement decreases and cuts to other programs under Medicare, the system will not be able to adequately fund the care for beneficiaries.

**CONCLUSION**

One thing that has become much more apparent over the past five to 10 years for both providers and policymakers is that without a balanced payment model that allows for equitable payments to medical providers based on the level of care provided, we can expect to see further declines in important benchmarks throughout the industry for the foreseeable future. For instance, there has been a great deal of research that concludes the poignant correlation between quality of care and a decent physician payment model. Further, the industry has been able to determine the significant impact that Medicare payments have on a medical practice’s operational efficiencies. But, the source of the problem is and will continue to be with the reimbursement model and the declining payments going to the medical providers. At the end of the day, how can we expect the high level of care that we all believe should be there as patients when those providing that care are not even getting paid enough to cover the overhead required to deliver the services you need? This is the problem and until policymakers are able to understand this and more importantly, take non-partisan action to implement the much needed total overhaul of the current model, then we can unfortunately continue the descent down this slippery slope.

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