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Toward Fixing the SGR



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During the 2010 lame duck session of Congress, physicians lobbied Congress to fix the sustainable growth rate (SGR) calculation to stop the looming 21 percent reduction in Medicare fees. Congress calls this the “doc fix.” Congress may “kick the can down the road” by postponing the looming reduction.

This SGR problem is like a bad penny, always turning up. Congress’ rationale for the SGR is that docs largely control the volume of medical services provided. If the collective volume of services per patient is too high, collectively the docs are responsible and should be paid less for each service. The problem with this logic lies with the tragedy of the commons. (If you do not know the story, “google” it.)

The docs’ response to proposed SGR reductions is always the same: increase our fees or we walk! They refuse to negotiate with CMS to develop a win-win solution. Docs see themselves as victims of Medicare’s fixed fee authority, not as partners with our government to help patients.

The fixed fees that docs must accept may constitute a covenant. For this benefit, the doc can see the patient and be paid less than most commercial plans pay. But, because of their age, Medicare patients require much more time for the same level of E&M service. Commercial plan patients are younger and the plans usually pay better than Medicare. In fact, the Medicare covenant is one sided, so really it is not a covenant, is it? It is more like slavery. What do the docs get for agreeing to Medicare’s price fixing? In my view, we get nothing.

Considering this, I have proposed to CMS and to the CMA an alternative strategy to fix the SGR. I am sharing it with you in hopes some of these ideas will resonate with you and lead to a better way to fix the SGR than hours of complaining, begging, and threats.

Idea #1: Stop fraud and abuse which adds to the SGR problem.

Require providers post a performance bond to qualify for Medicare enrollment and re-enrollment. The performance bond would insure the Trust Fund against fraud and certain cases of abuse. Your medical liability carrier could issue the bond. Your medical liability insurer also could vet you for enrollment as a Medicare provider much faster than your local Medicare Administrative Contractor’s (MAC) Provider enrollment staff, more accurately, and with better customer service. The MAC’s job will be to finish the enrollment vetted by your insurer. Imagine signing up for Medicare as quickly as for medical liability insurance, plus enjoying hassle free changes if you relocate or add another doc!

Idea #2. Tort Reform. To offset the cost of a performance bond, physicians who enroll in Medicare should be granted the right to refer all medical malpractice litigation claims filed on behalf of a Medicare beneficiary to federal court and/or a dispute resolution process established by the federal government similar to the method used when a government physician employee is sued for negligence. Medicare beneficiaries could opt out of this process and revert to litigation under state law, but by doing so waive their right to not be balanced billed for charges in excess of the Medicare limited charge. This would be a real quid pro quo — limiting charges in exchange for tort reform — a real covenant, not slavery.

Idea #3. Change the Claims Processing System. Medicare should change its claims processing system to one that operates like credit card transactions, so that fraud and abuse can be detected and stopped on the first, second, or third transaction, not after the 3,000th transaction (called “pay and chase”). Physicians will benefit because the cost to submit a credit card charge is much less than the cost to send a bill to Medicare. Docs can be paid as quickly as pharmacists. The Medicare patient should have a bank issued photo ID Medicare card with a PIN number. The card would be used to conduct the financial transaction. Claims submissions can be analyzed in real time sorted by both the doc and the patient and across a robust claims history of potentially duplicative services.

If you find any of these ideas helpful, or have other ideas, I encourage you to write to your CMA representative so the CMA can develop a new strategy to fix the SGR and present it to CMS for a discussion towards a win-win solution, instead of “kicking the can down the road” endlessly.

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