Higher earning clinicians make more money by ordering more procedures per patient

December 9 2014

In results characterized as "very surprising," UCLA researchers found for the first time that higher-earning clinicians make more money by ordering more procedures and services per patient rather than by seeing more patients, which may not be in patients' best interest.

The research team from the UCLA Department of Urology and the Veterans' Health Administration examined what Medicare was billed and what it paid to clinicians. The data reviewed was Medicare Part B payments from the 2012 calendar year, said letter first author Dr. Jonathan Bergman, an assistant professor of urology and family medicine at the David Geffen School of Medicine at UCLA and an urologist and bioethicist at the Veterans' Health Administration-Greater Los Angeles.

"Medicare spending is the biggest factor crowding out investment in all other social priorities," Bergman said. "With clinicians making more not by seeing more unique patients, but by providing more services per person, additional research needs to be done to determine if these additional services are contributing to improved quality of care. These findings suggest that the current health care reimbursement model - fee-for-service - may not be creating the correct incentives for clinicians to keep their patients healthy. Fee-for-service may not be the most reasonable way to reimburse physicians."

The research letter appears Dec. 8, 2014 in the journal *JAMA Internal Medicine*.

Bergman believes this review of the Medicare data is important because of its potential impact on public policy.

"Our findings suggest a weakness in fee-for-service medicine," he said. "Perhaps it would make more sense to reimburse clinicians for providing high quality care, or for treating more patients. There probably shouldn't be such wide variation in services for patients being treated for the same conditions."

Further research will need to be done to assess if treatment outcomes differ between those who had more services ordered versus those who had less services ordered. This may also show a clearer view of how to best target resources to maximize value for patients, Bergman said.

Going forward, Bergman and his team will look at alternative payment models, such as those used at Veterans Affairs facilities and in "safety net" hospitals to see if they make more sense than fee-for-service plans.

"The goals of payment reform are currently unrealized, as evidenced in these data. Physicians take an oath to care for patients using 'appropriate means and appropriate ends,' focusing on what is best for the patient, and this centuries-old oath still resonates with graduates of medical school classes," the research letter states. "Rather than react to externalities imposed by payers, clinicians can lead the movement toward a high-value, patient-centered care. We are uniquely empowered to ensure that all individuals access the procedures they need, and are not exposed to those they don't."

Provided by University of California, Los Angeles

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