

Medicare Physician Payments:  
Where We've Been;  
Where We Need to Go

Presented to

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By

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Chairman Baucus, Senator Hatch and members of the Finance Committee. Thank you for inviting me here to participate in a roundtable on Medicare Physician Payment Reform. My name is Gail Wilensky and like the other members of the roundtable, I have had the honor and privilege of directing the Medicare and Medicaid programs. I served as the Administrator of what was then called the Health Care Financing Administration, now named the Centers for Medicare and Medicaid Services, from Jan. 1990 to March of 1992. I also chaired the Physician Payment Review Commission from 1995 to 1997 and chaired the Medicare Payment Advisory Commission from 1997 to 2001. I am currently a senior fellow at Project HOPE, an international health education foundation.

Because I was the administrator when the RBRVS was implemented and perhaps because of my experience with other Medicare commissions, as well, I've been asked to provide some historical background as to how we have gotten to the position that we are now in where there is a high level of dissatisfaction with the way physicians are currently reimbursed under Medicare but little agreement about what type of reimbursement system should take its place. There is also the not insignificant hurdle that moving away from the current system would cost more than \$271 billion.

As the members of Congress know only too well, each year since 2003, Congress has felt forced to step in to prevent physicians who provide care to Medicare beneficiaries from experiencing a reduction in fees. Early on, the threatened

reduction was in the neighborhood of 4 to 5 percent. Next January, the threatened reduction in fees is 27 percent. Although it is difficult to imagine such a drastic cut occurring, given what it would likely do to beneficiary access, it is also not obvious what Congress is prepared to do to avoid this latest threat.

### **Medicare's Payment Origins**

When Medicare began, it modeled its payment strategies on the way Blue Cross and Blue Shield, the dominant form of insurance in the mid-1960's, paid hospitals and physicians. Like the private payers of that period, Medicare based its reimbursements to both physicians and hospitals, on the amounts that had been historically charged for various health care services. In 1984, when the program adopted a prospective payment system for hospitals, moving away from a charge-based per diem rate, it introduced the use of the Medicare Economic Index (MEI)—a measure of the annual increase in physician practice costs—for updating physician reimbursement. This not only marked a divergence with charge-based reimbursement but it also marked the beginning of a divergence between Medicare's reimbursement for physicians compared to the way Medicare reimburses other providers.

For most services, Medicare has gradually moved to a bundled payment strategy. This began with Medicare's adoption of the prospective payment system for inpatient hospital expenses in 1983. The use of a per diem rate was replaced with a single, prospectively-determined payment which was to cover all of the costs during

the inpatient stay and which was based on the patient's diagnosis at discharge. Gradually the use of some type of bundled payment strategy has been extended to capital payments for hospital inpatient care, as well as to outpatient hospital care, renal care, home care and nursing home care. Updates for the bundled payments are based on inflation measures, adjustments for productivity increases and changes reflecting new legislation. The per capita payment made for Medicare Advantage can be viewed as the ultimate bundled payment since it covers all Medicare services.

### **Physician Payment History**

Changes in physician payments have followed a different path. Although there was a time during the mid-1980's when Medicare (or at least the staff at HCFA) considered using physician DRG's, thus far there has been no serious move in that direction. Bundled payments are used to reimburse physicians in certain instances: surgeons receive a fixed payment that covers preoperative care, the procedure itself and some limited amount of post-operative care. I assume Medicare uses this type of bundled payment strategy for surgeons because it reflects the most common way surgeons are paid outside of Medicare.

In general, however, physicians are paid for providing discrete services according to a very disaggregated fee schedule that uses more than 7,000 different billing codes. A major change was made to how physician payments were constructed in 1989. Rather than being based on historical charges, the fee schedule was replaced with a Resource Based Relative Value Scale that attempted to assess the relative value of a

physician's work effort in providing a particular service, as well as the practice expenses and malpractice liability expenses involved. Among the many goals of the adoption of the RBRVS, was the intent to correct what had been perceived as an undervaluing of the services provided by primary care physicians and an overvaluing of at least some of the procedures done by specialists and also to correct differences between urban and rural payments that were regarded as larger than could be justified on the basis of differences in the cost of living or the costs of practicing medicine. There has been some debate about whether the RBRVS has succeeded in correcting these problems although payments for primary care services have increased faster than payments for all services.

Medicare's payment history has led to concerns about inappropriate volume increases whereby providers may seek to increase their income by inappropriately increasing volume for patients who don't really need services. It appears that the risk of inappropriate volume increases with more disaggregated and with charge-based billing systems although the penalties recently put in place for certain types of hospital readmissions indicates that concern can exist even with bundled payments.

Medicare's concern first arose when fees were based on historical charges from 1965 to 1984 and it was observed that charges and volumes of services increased rapidly. From 1984 (when PPS was introduced for hospitals), the growth in physician fees was limited by to the Medicare Economic Index but there was still a

rapid growth in spending because of volume changes. It became clear that controlling fees alone was not a very effective way to control spending, especially when a disaggregated fee schedule is being used as is the case for physician reimbursement.

Since the early 1990's and the adoption of the RBRVS fee schedule, some form of spending target has been used for physician payments. Initially the spending limit was set by a Volume Performance Standard (VPS) that tied the annual update to a target that was based on historical trends in physician costs, with a two-year lag between the adjustment and the data that was used for the adjustment. Because of the way the adjustment was calculated, it produced very unstable updates, with swings that were much greater than the changes in the underlying MEI. The variation in the MEI during its first 5 years was between 2% and 3.2% while the updates varied between 0.6% and 7.5%.

The VPS was replaced with the Sustainable Growth Rate (SGR) in the 1997 Balanced Budget Act. The SGR made several changes but also used a much more aggressive measure to control spending, tying the allowable increase in physician spending to the real GDP per capita growth rate. To increase its stability, a 10-year moving average of the GDP rather than a single year's GDP has been used since 2004. The update is the MEI adjusted by cumulative spending relative to the target. It's the cumulative spending feature combined with the way that Congress has bought itself

more time each year that has made the recent reductions implied by current legislation so large.

While the SGR has produced changes that are more stable than the preceding VPS, it has not been enforced since 2003 because of concerns by Congress about problems in access that would result. The concerns about the present system of physician payment reimbursement have occurred at least at two different levels. First, the use of a spending target for only one part of Medicare forces (if it were enforced) a rigid relationship between physician spending and the economy for only physician services. That led MedPAC, several years ago, to propose using expenditure targets throughout Medicare. While this might reduce some of the relative pressure on physician payments and would limit spending, if enforced, it doesn't consider the appropriateness of Medicare spending among the various components of the program that exist at a particular moment in time. Also, it does nothing to encourage quality improvements or any of the other goals Congress has set for Medicare.

Second, and of even more importance, the way the objectives of the SGR are inconsistent with the incentives it produces. The objective is to control total physician spending. However, the SGR neither affects nor is driven by spending by any individual physician or physician group, no matter how large that group is or how egregious their spending. If anything, individual physicians or physician groups are implicitly encouraged to increase spending, because nothing they can do

as individuals will affect overall spending but their fees will be affected by what other physicians do collectively, irrespective of their own behavior.

### **Future Options**

There are a number of short-term patches, either to the SGR or to the RBRVS, which have been proposed. The changes to the SGR include the use of multiple SGRs to reflect the differential spending growth among some specialists, and the use of multi-specialty SGRs for multi-specialty physician groups to encourage more to develop. Among some of the changes to the RBRVS that have been proposed are changes to the relative values for services that have experience significant productivity increases, improving the data that is used for updating the relative value and improving the estimates of practice expenses.

However, none of these strategies addresses the “disconnect” between behavior at the level of the individual physician or the physicians’ practice and the updates that are produced. What would fix the “disconnect,” is to have the SGR set at the level of the physicians practice. This would link the physician’s updates to the physician’s own behavior. It is not so hard to imagine this being done for group practices of some size. It is harder to imagine for very small groups or individual practices because of the adjustments that would be needed to correct for patients who were atypical in any way. Furthermore, a billing system that is based on more than 7000 billing codes makes it very difficult to encourage greater accountability and or reward better outcomes. We will see if the “value-based modifier” that is part of the

Affordable Care Act has much effect but because it will represent such a small share of the physicians' reimbursement, it's hard to imagine that it will.

The other option is to begin developing a more aggregative payment. This will not be easy nor will it be done quickly but it is important to start as soon as possible. In the near term, payments could be developed that cover all of the services that a physician provides to a patient for the treatment of one or more chronic diseases. This is consistent with the work that CMS has been doing with medical homes but would also include the physician services and ancillary services. In addition, a bundled payment should be developed for the high cost, high volume interventions. That would include all of the physicians' services involved in providing care to the patient for treating that procedure or DRG. The Innovation Center will include some pilots that bundle physician and hospital payments but it is important to develop payment systems that do not include payment to the hospital unless it is believed that all or almost all physicians will either be part of integrated delivery systems or employed by hospitals. Otherwise, this will be one more step that increases the power of hospitals at the expense of other providers and payers.

It is urgent that CMS devote more time than appears it has to redesigning how physicians are paid. It was disappointing to me that so little attention was paid to physicians in the ACA and it is even more disappointing that the early pilot studies from the Innovation Center are so focused on the hospital or are relatively limited in their scope. Physicians don't directly account for a large part of the health care

dollar but they have a disproportionate impact on how the health care dollar gets spent. It is hard for me to imagine reforming the health care delivery system until we figure out a better way to reimburse physicians—rewarding them for the kind of behavior we want to see.

There are no “quick fixes”. No replacement system is ready for “prime time”. Most importantly, removing the SGR and leaving in place the RBRVS, even an improved RBRVS, will only recreate the conditions that led to the development of a spending limit in the first place.