



Project HOPE  
7500 Old Georgetown Road, Suite 600  
Bethesda, MD 20814-6133  
(301) 656-7401  
Fax: (301) 654-0629  
www.projecthope.org

**GAIL R. WILENSKY, Ph.D.**  
*Senior Fellow*

June 18, 2012

The Honorable Max Baucus  
Chair  
United States Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510-6200

Dear Senator Baucus:

At the end of the very interesting roundtable discussion of the Finance Committee on May 10<sup>th</sup>, you asked each of us to come back to you with ideas that would help resolve some of the problems with the RBRVS and SGR in the short and intermediate terms. As was true for my comments at the roundtable, the ideas I am suggesting here represent my own views and not any of the organizations I am affiliated with currently or have been affiliated with in the past.

My colleagues and I have sent under separate cover a letter describing the principles we support to make physician payments more sustainable and effective as well as amplification of these principles in the form of some actionable recommendations. In addition, like my colleagues, I am including in this letter some specific ideas and recommendations that I support as a way to reduce the current RBRVS/SGR impasse.

Unfortunately, I believe there is no real "fix" that is currently ready for implementation. However, I hope that next January's postponement of the scheduled legislated reduction in physician fees (which I believe needs to happen in order to protect beneficiary access to physician services) will contain the series of actions that needs to occur so that there can be a more stable and sustainable payment system in place three to five years from now.

### **Alternative Visions of a Future Physician Payment Strategy**

It would be helpful if the Congress were able to articulate the type of payment strategy it wished to see in place for physicians after the next three to five year period of experimentation although not critical that it do so at this juncture. The major choices are the use of a more aggregative payment system such as the DRG or episode payment used for other areas of Medicare or a more refined relative value system with a spending limit

**Board of Directors:** George B. Abercrombie, John D. Fowler, John W. Galiardo, Jack M. Gill, Ph.D., Bernard A. Harris, Jr., M.D., Edward J. Ludwig, Dennis J. Manning, Gerhard N. Mayr, J. Michael McQuade, Ph.D., Viren Mehta, Pharm. D, Walter G. Montgomery, Phebe Novakovic, Steven B. Pfeiffer, Esq., Stephen H. Rusckowski, Curt M. Selquist, Marshall Smith, Louis W. Sullivan, M.D., Henri A. Termeer, Christian Weinrank, Karen E. Welke, Bradley A.J. Wilson  
**Board Officers:** Charles A. Sanders, M.D., Chairman; John P. Howe, III, M.D., President and CEO; Richard T. Clark, Vice Chairman; Dayton Ogden, Secretary; William F. Brandt, Jr., Treasurer  
**Emeritus Members:** Mrs. Edward N. Cole, Maurice R. Greenberg, William L. Henry, Ben L. Holmes, Robert A. Ingram, James E. Preston, Jerry E. Robertson, Ph.D.

The Honorable Max Baucus

June 18, 2012

Page 2

that is more realistic than the SGR and hopefully has better incentives than the current SGR.

It is possible that Congress will allow physicians to continue to choose between these two strategies even after the development or piloting phase has been completed although provider choice of payment systems has not been used after the adoption of other payment reforms.

#### *Bundled Payment Pilot Programs*

The CMMI announced a bundled payment pilot program several months ago that will test four different models of bundled payments. Unfortunately, none of them focus only on physicians, instead bundle payments between hospitals and physicians or between hospitals and post-acute care facilities. While there has been a clear movement of physicians away from self or small group employment in favor of employment by some entity, I assume that substantial numbers of physicians will continue to practice apart from hospitals or integrated delivery systems for the foreseeable future. These are the physicians that need an alternative type reimbursement, such as their own bundled payment system, that is consistent with the goals of delivery system reform.

These physician-oriented pilot programs could include bundled payments covering all physician charges for most or all of the high cost, high volume interventions in Medicare. They would be similar to the recent ACE demonstrations and the less recent CABG Demonstration that started when I was administrator in 1991 but would not require that the hospital payment to be part of the bundled payment.

A second type of bundled payment pilot could extend the concept of the Patient - Centered Medical Home into a single blended payment that covered payments for building an infrastructure, the payment for visits and the monthly care management fee. Alternatively, an episode-based payment could be developed for high volume primary care practices that covers the cost of caring for individuals with single or multiple chronic conditions.

Physicians should also be encouraged to apply for other types of bundled payments that seem to them to be feasible and desirable to pilot.

#### *Refinements to the RBRVS*

There is widespread agreement that the RBRVS values have become distorted over time, either as a result of the updating process used, by the failure to account for

The Honorable Max Baucus

June 18, 2012

Page 3

changes in the work values associated with various CPT codes as a result of new technologies, by the use of inadequate samples to update the work and practice expense value or for other reasons. Efforts to refine the RBRVS if the Congress believes its continued use is desirable should be completed during this 3-5 year experimentation period.

Consideration should be given to appointing a group that is less specialty-dominated than the current RUC used to advise CMS.

#### *Refinements to the Spending Limit*

The current SGR has been the source of many complaints and frustrations. Serious questions can be raised about a spending limit that applies only to one area of Medicare although as long as physicians are paid using a very disaggregated fee schedule, such as one that is tied to thousands of CPT codes, not having a spending limit of some sort is likely to result in higher spending than is desired.

Some of the frustration with the SGR relates to the stringency of the explicit limit, that is, the attempt to tie aggregate physician spending to the growth of the economy, which has been extremely challenging in all but the most robust years of economic growth. Determining a more reasonable benchmark for future spending physician growth will depend in part on whether or not Congress wishes to push physicians away from the traditional fee for service. If it does, the spending limit should be more constrained than if it does not.

The greater concern to me about the SGR or its predecessor, the VPS, is the “disconnect” between the behavior that occurs at the level of the individual physician or the physicians’ practice and the updates that are produced by the level of physician spending in the aggregate. Since the spending limit neither affects nor is driven by spending by any individual physician or physician group, no matter how large the group or how egregious their spending, the incentives are, if anything, perverse. Physicians and group practices know that no more how much they increase their spending, their fees won’t be affected as a result of their own actions and conversely, no matter how conservatively their practice, their fees will also not be affected.

What would fix the “disconnect” is to set the update according to spending at the level of the physicians’ practice. Larger single specialty practices and all multi-specialty practices should be able to request a spending limit based on the practices’ spending experience over the previous two or three year period (risk adjusted).

The Honorable Max Baucus  
June 18, 2012  
Page 4

Various pilot projects should also be tried so that appropriate spending limits could be set for smaller practices.

### **Financing the SGR Postponement**

The CBO has published a list of options that provide various amounts of revenues which could be used to finance additional postponements of the SGR. I recognize that all of the options that haven't been used thus far contain political challenges, which is why they haven't been used.

Putting fees on first dollar Medigap coverage makes sense because of the additional cost first dollar coverage imposes on Medicare. Exemptions can be considered for certain types of preventive services or lower income populations.

Durable Medical Equipment competitive bidding should be pursued more widely. A recent Congressional hearing supported its limited use thus far.

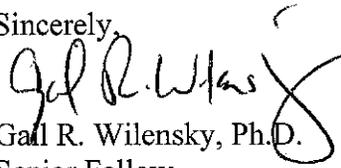
Equalizing outpatient and ambulatory reimbursement differences would be a good strategy to pursue for several reasons but need to be done in a way that doesn't introduce new distortions internally to ambulatory and outpatient reimbursements.

I am sure the Congress can come up with other options as well.

The major concern I have is that the postponement of the currently scheduled reduction in physician fees be accompanied by a set of activities that will facilitate the decisions that the Congress will need to make in the next three to five years. As I've indicated, I believe that during this period, the SGR will continue to need to be postponed in order to protect beneficiary access. The question is whether or not the Congress will get something in return. In the past, it has not.

Thank you, Mr. Chairman, for inviting me to share my views with you. I would be pleased to discuss further any of the issues I have raised in this letter with you or your colleagues or members of your staff.

Sincerely,

  
Gail R. Wilensky, Ph.D.  
Senior Fellow

Cc: Hon. Orrin G. Hatch, Ranking Member