June 15, 2012

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

Dear Senator Baucus:

I very much appreciate your invitation, subsequent to the excellent roundtable the Committee on Finance held on May 10, to elaborate further on some of my ideas and recommendations about ways to fix the Medicare Physician Fee Schedule (MPFS) and the problems created by the Sustainable Growth Rate (SGR) formula.

I must emphasize that the views expressed in this letter are entirely my own, and that in this capacity I am not speaking for or representing any other individuals or organizations, specifically including my employer, Nexera, Inc., the Greater New York Hospital Association, or any of its subsidiaries or affiliates. Although I have drawn heavily on the wisdom and insights of others in preparing these comments, I am solely responsible for them. I would also call your attention to the joint letter sent by Mark McClellan, Tom Scully, Gail Wilensky, and me, which is consistent with this letter but somewhat more narrow in focus.

I have taken the liberty of organizing my suggestions into relatively brief discussions of five topics:

1. Fixing the Resource-Based Relative Value Scale (RBRVS);
2. Finding new approaches to paying rural physicians;
3. Encouraging the creation of new payment "bundles" for Medicare Part B services;
4. Abolishing the SGR formula; and
5. Developing a new formula to constrain total Part B expenditures.

The discussion of each of these follows.

1. Fixing the RBRVS

As I noted in my prepared Remarks for the May 10 Roundtable, whatever forms of payment – ranging from full capitation to full fee-for-service – come to dominate the policies of Medicare and other payors, some mechanism to measure and compare the work of different physicians will always be necessary. Even when physicians are salaried, their employers generally prefer to provide some standards or incentives for productivity, measured by comparative work effort or other contributions.

While the initial RBRVS resulted from enormous efforts, and was never fully completed (the RBRVS still lacks empirically-based relative practice expenses), it justifiably remains the industry standard for measurement of comparative physician activity. On the other hand, it is widely acknowledged that the process of updating the RBRVS scale over the last two decades has introduced serious distortions, shifting more weight to interventional and technical procedures, and thereby undervaluing cognitive services. Many of us also feel that the very mechanism that has been employed to recommend updates to the scale, comprised as it is of representatives of specialty societies, has an intrinsic and unavoidable pro-specialist bias.

What's needed is a complete overhaul of the RBRVS, and a new mechanism for conducting that overhaul and updating it over time. The best approach, in my view, would be for the Congress to direct DHHS to identify an appropriate group of experts actively engaged in the management of multi-specialty physician enterprises – including group-model health plans; free-standing group practices; faculty practices; or similar organizations – along with appropriate academic experts in medical practice, physician organization, and health economics. Those experts should consult with HHS about obtaining and using large data bases, including those from the private insurance sector, health plans, and other entities, of a sort that were generally not available when the RBRVS was first developed. These data bases would permit analysis of objective measures of resource use, such as time per procedure, rather than having to rely on surveys or individual guesstimates. HHS should then identify and fund an appropriate contractor to work with those experts and those data bases to reconstruct the RBRVS. Depending on how well that process went, a similar group of experts could then be charged with periodic updating of the relative value scale. It would not be inappropriate to finance that effort from the Supplemental Medical Insurance (Part B) Trust Fund.
Recreating the RBRVS, as described above, will take several years, at a minimum. In the meantime, I believe the Congress should adopt, in essence, MedPAC's recommendation, and provide annual updates for primary care and related cognitive services, while freezing other components of the fee schedule. Doing so would counteract some of the less desirable aspects of the current system, while probably easing the transition to a new fee scale once the development work for it has been completed.

2. Finding New Ways to Pay Rural Physicians

Just as Medicare has long recognized that the economics of rural hospitals are different from those in more densely-populated areas, and provided different payment mechanisms for them, it may well be time to acknowledge that the MPFS doesn't work very well for rural physicians in small practices, and find a different way to pay them. While I don't have a detailed proposal to suggest at this time, I would suggest that it should not be that difficult to establish a formula that retains incentives for continuing to work hard while insuring that rural physicians with an average proportion of Medicare patients are able to earn an income sufficient, after practice expenses, to keep them in rural communities, while attracting new physicians to such underserved areas. One approach might involve a lump-sum, "base" subsidy to help address practice expenses and educational debt.

3. Encouraging the Creation of New Payment Bundles

As was discussed by my colleagues during the Roundtable, there is considerable work currently underway in a number of venues to develop appropriate "bundles" of codes or services for physician and related Part B services, for which a single price could be established that provides appropriate incentives for efficient, high-quality care while reducing Medicare expenditures. The question is how to determine which bundles should be paid for by Medicare, how they should be priced, and how quality and efficiency should be assured.

I would turn this question on its ear. In a way not dissimilar from the Center for Medicare and Medicaid Innovation's current Bundled Payments demonstration project, I would encourage groups of providers to identify the bundles for which they wanted to be paid, and have Medicare agree to set a price for any bundle proposed by a sufficiently large group of physicians that met the following criteria:

- The bundle involved treatment of a specific diagnosis, for which there is a well-established medical standard of care;
- Quality and appropriateness measures for treatment of that condition are generally accepted, and data to monitor quality and appropriateness performance is readily available; and
- The group of physicians proposing the bundle has treated, and continues to treat, a sufficiently large number of Medicare patients with that condition to provide statistically reliable data on quality and outcomes.

Bundles meeting those criteria should be automatically recognized by Medicare contractors, and priced, at least for the initial three years after approval of the bundle, at 90% of what Medicare paid those physicians for treatment of those conditions in the appropriate prior time period. Beneficiary copayments should be adjusted to ensure that beneficiaries receive proportionate savings. Thereafter, assuming excellent performance on quality measures, the physicians and Medicare could negotiate price updates to take into account Part A and Part D savings arising from this bundled approach, new technologies, procedures, and the effects of practice learning curves.

4. Abolish the SGR

There's no need to belabor the dysfunction created by the SGR formula, or the need to replace it with something better as soon as possible. If, in fact, the Congress is able to act later this year, or soon thereafter, on some relatively comprehensive approach to meeting the government's revenue needs and reducing the deficit, that will provide an opportunity to abolish the SGR that should not be missed. The SGR fixed can be "paid for" with any of a number of revenue or other expenditure measures. It is critical, however, that the "pay fors" not include further cuts to Medicare itself. Any changes in Medicare policy must be evaluated and acted on on their own merits, not to achieve some arbitrary savings goal as has been the case in previous "Doc fixes," or in parts of the Affordable Care Act. I personally believe that there are any number of steps the Congress could take to further reduce the trajectory of future Medicare expenses, many of which involve, not Medicare per se, but retirement policies or subsidization of private insurance for older working people and their dependents. I'd be happy to share my views with you on those approaches in a separate conversation. But relative to the SGR itself, I believe, as I said my remarks at the Roundtable, that the Congress

should finally rectify the mistake it made in the Balanced Budget Act, in a way similar to that in which it corrected other Balanced Budget Act mistakes more than a decade ago.

5. A New Formula to Replace the SGR

Of course, once the SGR is abolished, it will be necessary to have some mechanism to impose appropriate limits on total Medicare expenditures for physicians' services. As noted above, I would recommend a three-year freeze on non-primary care physician fees during a transition to a reconstituted RBRVS, with some appropriate inflation adjustment for primary care services, and perhaps an additional lump-sum add-on for practices that meet the standards of Primary Care Medical Homes. Thereafter, we should have some sense of whether such innovations as accountable care organizations, shared savings programs, or bundled payments are actually producing any savings to Medicare, or whether we have finally reached the point at which Medicare is saving money through its payments to Medicare Advantage plans. Those findings should serve as a "benchmark" for updating fee-for-service payments, along with the more customary adjustments for input price inflation, new technologies, and so forth.

Again, I did not think it was appropriate or relevant to provide a more detailed proposed formula in this context; three years should be plenty of time for the Executive Branch and the Congress to work out something closer to what is now employed for the Inpatient Prospective Payment System or other Medicare provider payment systems.

Again, Mr. Chairman, I very much appreciate your kind invitation to submit this letter and your interest in my views. I would, of course, be happy to discuss any of these issues further with you, any of your colleagues on the Committee, or members of your staff.

Many thanks.

Sincerely,

Bruce C. Vladeck, Ph.D.
Senior Advisor

cc.: Hon. Orrin G. Hatch, Ranking Member