

Medicare payment to physicians

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Statement of
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Chairman Deal, Ranking Member Brown, distinguished Subcommittee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss payments for physician services in the Medicare program.

Medicare expenditures for physician services are growing rapidly. In 2005 spending on physician services increased 8.5 percent, while the number of beneficiaries in FFS Medicare increased only 0.3 percent. Medicare expenditures for physician services are the product of the number of services provided, the type of service, and the price per unit of service. The number of services is often referred to as service volume, the type of services as intensity. For example, substituting an MRI for an X-ray would be an increase in intensity. To get good value for the Medicare program, the payment system should set the relative prices for services accurately. Providing incentives to control unnecessary growth in volume and intensity would be desirable, but it is much more difficult. (For simplicity, in the remainder of this testimony we will use the term volume as shorthand for the combined effect of volume and intensity.)

In this testimony we briefly outline the history of the Medicare physician payment system and discuss several ideas for getting better value in the Medicare program including differentiating among providers through pay for performance and measuring physician resource use, better managing imaging services, and improving the internal accuracy of the physician fee schedule.

Historical concerns about physician payment

Physicians are the gatekeepers of the health care system; they order tests, imaging studies, surgery, and drugs as well as provide patient care. Yet the payment system for physicians is fee for individual service; it does not reward coordination of care or high quality—by definition it rewards high volume. Several attempts have been made to address this tendency to increase volume and payments.

The Congress established the fee schedule that sets Medicare's payments for physician services as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). As a replacement for the so-called customary, prevailing, and reasonable (CPR) payment method that existed previously, it was designed to achieve several goals. First, the fee schedule decoupled Medicare's payment rates

and physicians' charges for services. This was intended to end an inflationary bias in the CPR method that gave physicians an incentive to raise their charges.

Second, the fee schedule corrected distortions in payments that had developed under the CPR method—payments were lower, relative to resource costs, for evaluation and management services but higher for surgeries and procedures and there was wide variation in payment rates by geographic area that could not be explained by differences in practice costs. (As we discuss later, there is evidence that relative prices in the fee schedule may have once again become distorted.)

The third element of OBRA 89 focused on volume control, which is still a significant issue for the Medicare program. Rapid and continued volume growth raises three concerns: Is some of the growth related to provision of unnecessary services? Is it a result, at least in part, of mispricing? Will it make the program unaffordable for beneficiaries and the nation?

Some volume growth may be desirable. For example, growth arising from technology that produces meaningful improvements in care to patients, or growth where there is currently underutilization of services, may be beneficial. But one indicator that not all services provided may be necessary is the range of geographic variation in the volume of services provided, coupled with the finding that there is no clear relationship between increased volume of services and better patient outcomes.

Volume varies across geographic areas. As detailed in our June 2003 Report to the Congress, the variation is widest for certain services, including imaging, tests, and other procedures. Researchers at Dartmouth have reached several conclusions about such variation:

- Differences in volume among geographic areas is primarily due to greater use of discretionary services (e.g., imaging and diagnostic tests) that are sensitive to the supply of physicians and hospital resources, and less due to differences in the volume of non-discretionary services such as major procedures.
- On measures of quality, care is often no better in areas with high volume than in areas with lower volume. The high-volume areas tend to have a physician workforce composed of relatively high proportions of specialists and lower proportions of generalists.

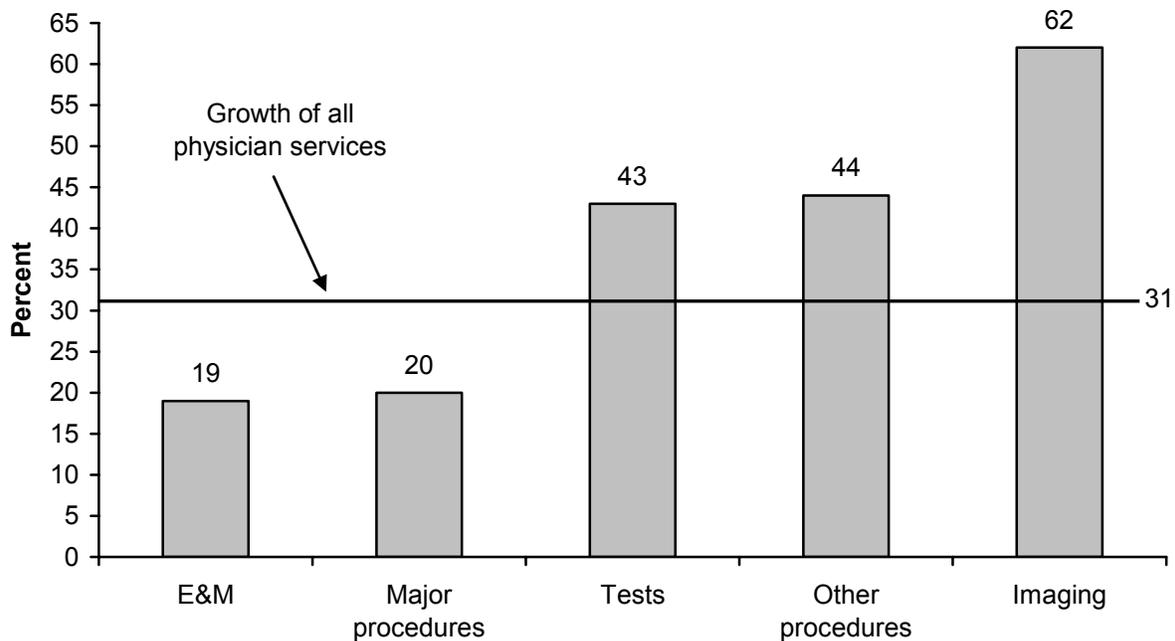
The Dartmouth researchers focus on variation in the level of volume. Growth in volume also varies among broad categories of services: Cumulative growth in volume per beneficiary ranged from about 19 percent for evaluation and management to almost 62 percent for imaging, based on our analysis of data comparing 2004 with 1999 (Figure 1), and growth rates were higher for services which researchers have characterized as discretionary.

Impact on beneficiaries—For beneficiaries, increases in volume lead to higher out-of-pocket costs in the form of coinsurance, the Medicare Part B premium, and any premiums they pay for supplemental coverage. For example, volume growth increases the monthly Part B premium. Because it is determined by average Part B spending for aged beneficiaries, an increase in the volume of services affects the premium directly. From 1999 to 2002 the premium went up by an average of 5.8 percent per year. By contrast, cost-of-living increases for Social Security benefits averaged only 2.5 percent per year during that period. Since 2002 the Part B premium has gone up faster still—by 8.7 percent in 2003, 13.5 percent in 2004, 17.4 percent in 2005, 13.2 percent in 2006, and a projected 11.2 percent in 2007. Beneficiaries also pay coinsurance of 20 percent for most Part B services and supplemental insurance premiums will eventually reflect higher volumes of coinsurance.

Impact on taxpayers— Volume growth also has implications for taxpayers and the federal budget. Increases in volume lead to higher Medicare Part B program expenditures that are supported by the general revenues of the Treasury. (The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a trigger for legislative action if general revenues exceed 45 percent of total outlays for the Medicare program.) Medicare is growing faster than the nation's output of goods and services, as discussed in the Medicare trustees' report, and will continue to put pressure on the federal budget, raising questions about the long run sustainability of Medicare.

FIGURE 1

Imaging shows highest cumulative growth in services per beneficiary, 1999–2004



Note: E&M (evaluation and management).
Source: MedPAC analysis of Medicare claims data.

OBRA 89 established a formula based on achievement of an expenditure target—the volume performance standard (VPS). This approach to payment updates was a response to rapid growth in Medicare spending for physician services driven by growth in the volume of those services. From 1980 through 1989, annual growth in spending per beneficiary, adjusted for inflation, ranged widely, from a low of 1.3 percent to a high of 15.2 percent. The average annual growth rate was 8.0 percent.

The VPS was designed to give physicians a collective incentive to control the volume of services. But, experience with the VPS formula showed that it had several methodological flaws that prevented it from operating as intended. Those problems prompted the Congress to replace it with the sustainable growth rate system in the Balanced Budget Act of 1997.

The sustainable growth rate (SGR) system

Under the SGR, the expenditure target allows growth for factors that should affect growth in spending on physician services namely:

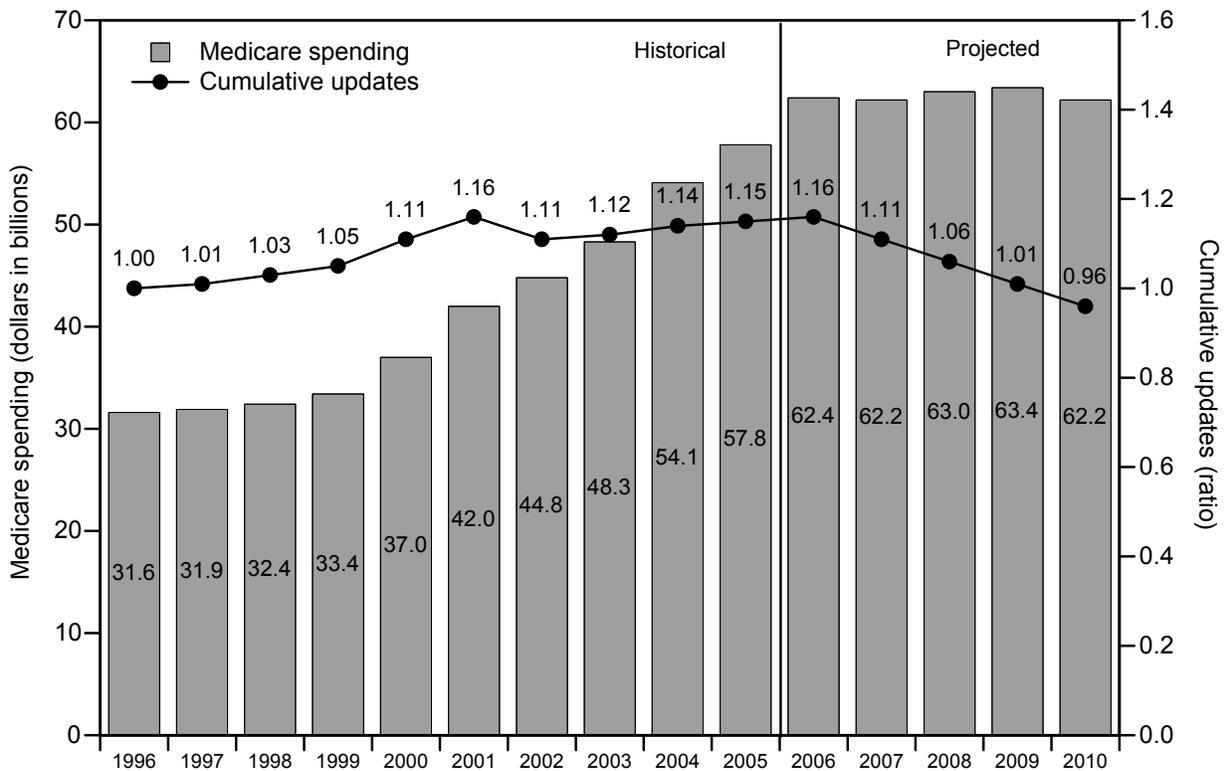
- inflation in physicians' practice costs,
- changes in enrollment in fee-for-service Medicare, and
- changes in spending due to law and regulation.

The SGR also has an allowance for growth above those factors based on growth in real gross domestic product (GDP) per capita. GDP, the measure of goods and services produced in the United States, is used as a benchmark of how much additional growth in volume society can afford. The basic SGR mechanism only lowers the update when cumulative actual spending exceeds target spending.

Like the VPS, the SGR approach has run into difficulties. The SGR formula is based on a cumulative spending target. If actual spending exceeds the SGR system's allowance for growth, excess spending continues to accumulate until it is recouped by reduced updates. The SGR system calculated negative updates beginning in 2002. In 2002 the update was negative 5.4 percent. However, from 2003 on, legislative actions modified or overrode the negative updates calculated by the SGR system, resulting in fee increases in 2003 (1.6 percent), 2004 (1.5 percent), and 2005 (1.5 percent) and in flat fees for 2006. Volume has continued to grow strongly throughout this period. Figure 2 shows that Medicare spending for physician services has been growing rapidly despite the restraint on fee increases since 2002. The conversion factor in 2006 is the same as in 2001, yet spending is 49 percent higher. This rapid growth has created an ever-larger gap between target and actual spending. CMS estimates that by the end of 2006, actual spending will exceed allowed spending by more than \$47 billion. To work off this excess, according to the Medicare trustees, the SGR will call for annual updates of about negative five percent (the largest allowed under the system) for nine consecutive years. The trustees have characterized this series of updates as "unrealistically low." In terms of budget scoring, these projections make legislative alternatives to the SGR very expensive.

**FIGURE
2**

**FFS Medicare spending and payment updates
for physician services, 1996–2010**



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance. For 2006, the Deficit Reduction Act froze the fee schedule's conversion factor, but refinements in relative value units resulted in a small increase in payment rates.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

The SGR approach has other flaws as well:

- It is a flawed volume control mechanism. Because it is a national target, there is no incentive for individual physicians to control volume.
- It is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume-influencing behavior.
- It treats all volume increases the same, whether they are desirable or not.

The underlying assumption of an expenditure target approach, such as the SGR, is that increasing updates if overall volume is controlled, and decreasing updates if overall volume is not controlled, provides physicians a collective incentive to control the volume of services. However, physicians do not respond to nationwide incentives. An efficient physician who reduces volume does not

realize a proportional increase in payments. In fact, such a physician stands to lose twice, receiving lower income from both lower volume and the nationwide cut in fees. Not surprisingly, there is evidence that in such circumstances physicians have increased volume in response to fee cuts.

MedPAC has consistently raised concerns about the SGR—both when it set updates above and when it set updates below the change in input prices. Instead of relying on a formula, MedPAC recommends that updates should be considered each year to ensure that payments for physician services are adequate to maintain Medicare beneficiaries' access to care.

The Commission recognizes the desire for some control over rapid increases in volume particularly given the evidence that higher volume is not always associated with better quality. Volume growth must be addressed by determining its root causes and designing focused policy solutions. A formula such as the SGR that attempts to control volume through global payment changes that treat all services and physicians alike will produce inequitable results for physicians.

Improving value

We recommend a series of steps to improve payment for physician services. They will not, by themselves, solve the problem of rapidly growing expenditures for physician services. However, they are important steps that will improve quality for beneficiaries and lay the groundwork for obtaining better value in the Medicare program. MedPAC recommends the following steps, which we discuss in more detail below:

- A year-to-year evaluation of payment adequacy to determine the update.
- Approaches that would allow Medicare to differentiate among providers when making payments as a way to improve the quality of care. Currently, Medicare pays providers the same regardless of their quality or use of resources—Medicare should pay more to physicians with higher quality performance and less to those with lower quality performance.
- Measuring physicians' use of Medicare resources when serving beneficiaries and providing information about practice patterns confidentially to physicians.
- With regard to imaging, a rapidly growing sector of physician services, ensuring that providers who perform imaging studies and physicians who interpret them meet quality standards as a condition of Medicare payment.
- Ensuring that the physician fee schedule sets the relative price of services accurately.

A different approach to updating payments

In our March 2002 report we recommended that the Congress replace the SGR system for calculating an annual update with one that balances a range of factors. A new system should update payments for physician services based on an analysis of payment adequacy, which would include the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity. Updates would not be automatic (required in statute) but be informed by changes in beneficiaries' access to physician services, the quality of services being provided, the appropriateness of cost increases, and other factors, similar to those MedPAC takes into account when considering updates for other Medicare payment systems. Furthermore, the reality is that in any given year the Congress might need to exercise budget restraints and MedPAC's analysis would serve as one input to Congress's decision making process.

For example, we used this approach in our recommendation on the physician payment update in our March 2006 Report to the Congress. Our assessment was that Medicare beneficiaries' access to physician care, the supply of physicians, and the ratio of private payment rates to Medicare payment rates for physician services, were all stable. Surveys on beneficiary access to physicians continue to show that the large majority of beneficiaries are able to obtain physician care and nearly all physicians are willing to serve Medicare beneficiaries. In August and September of 2005, for example, we found that among beneficiaries seeking an appointment for illness or injury with their doctor, 83 percent reported they never experienced a delay. This rate was higher than the 75 percent reported for privately insured people age 50 to 64.

A large national survey found that among office-based physicians who commonly saw Medicare patients, 94 percent were accepting new Medicare patients in 2004. We have also found that the number of physicians furnishing services to Medicare beneficiaries has kept pace with the growth in the beneficiary population, and the volume of physician services used by Medicare beneficiaries is still increasing. CMS has found that two subpopulations of beneficiaries more likely to report problems finding new physicians are those who recently moved to a new area and those who state that they are in poor health. The Center for Studying Health Systems Change has found that rates of reported access problems by market area are generally similar for Medicare beneficiaries and privately insured individuals. This finding suggests that when some beneficiaries report difficulty

accessing physicians, their problems may not be attributable solely to Medicare payment levels, but rather to other factors such as population growth.

Differentiating among providers

In our reports to the Congress we have made several recommendations that taken together will help improve the value of Medicare physician services. Our basic approach is to differentiate among physicians and pay those who provide high quality services more, and pay those who do not less. As a first step, we make recommendations concerning: pay for performance and information technology (IT), and measuring physician resource use.

Pay for performance and information technology

Medicare uses a variety of strategies to improve quality for beneficiaries including the quality improvement organization (QIO) program and demonstration projects, such as the physician group practice demonstration, aimed at tying payment to quality. In addition, CMS has announced a voluntary quality reporting initiative for physicians. MedPAC supports these efforts and believes that CMS, along with its accreditor and provider partners, has acted as an important catalyst in creating the ability to measure and improve quality nationally. These CMS programs provide a foundation for initiatives tying payment to quality and encouraging the diffusion of information technology.

However, other than in demonstrations, Medicare, the largest single payer in the system, still pays its health care providers without differentiating on quality. Providers who improve quality are not rewarded for their efforts. In fact, Medicare often pays more when poor care results in unnecessary complications.

To begin to create incentives for higher quality providers, we recommend that the Congress adopt budget neutral pay-for-performance programs, starting with a small share of payment and increasing over time. For physicians, this would initially include use of a set of measures related to the use and functions of IT, and next a broader set of process measures.

The first set of measures should describe evidence-based quality- or safety-enhancing functions performed with the help of IT. Some suggest that Medicare could reward IT adoption alone. However, not all IT applications have the same capabilities and owning a product does not

necessarily translate into using it or guarantee the desired outcome of improving quality. Functions might include, for example, tracking patients with diabetes and sending them reminders about preventive services. This approach focuses the incentive on quality-improving activities, rather than on the tool used. The performance payment may also increase the return on practices' IT investments.

Process measures for physicians, such as monitoring and maintaining glucose levels for diabetics, should be added to the pay-for-performance program as they become more widely available from administrative data. Using administrative data minimizes the burden on physicians. We recommend improving the administrative data available for assessing physician quality by combining clinical laboratory values with prescription data and physician claims to provide a more complete picture of patient care. As clinical use of IT becomes more widespread, even more measures could become available.

Measuring physician resource use

For Medicare beneficiaries living in regions of the country where physicians and hospitals deliver many more health care services there is no clear relationship with better quality of care or outcomes. Moreover, they do not report greater satisfaction with care than beneficiaries living in other regions. This finding, and others by researchers such as Wennberg and Fisher, are provocative. They suggest that the nation could spend less on health care, without sacrificing quality, if physicians whose practice styles are more resource intensive moderated the intensity of their practice.

MedPAC recommends that Medicare measure physicians' resource use over time, and feed back the results to physicians. Physicians could then start to assess their practice styles, and evaluate whether they tend to use more resources than their peers. Moreover, when physicians are able to use this information with information on their quality of care, it will provide a foundation for them to improve the efficiency of the care they and others provide to beneficiaries. Once greater experience and confidence in this information is gained, Medicare might begin to use the results in payment, for example as a component of a pay-for-performance program.

In our June 2006 Report to the Congress we discuss early results from using episode groupers to measure Medicare resource use. An episode grouper links all the care a beneficiary receives that is related to a particular spell of illness or episode.

Managing the use of imaging services

The last several years have seen rapid growth in the volume of diagnostic imaging services when compared to other services paid under Medicare's physician fee schedule. In addition some imaging services have grown even more rapidly than the average (Figure 3). To the extent that this increase has been driven by technological innovations that have improved physicians' ability to diagnose and treat disease, it may be beneficial. However, other factors driving volume increases could include: possible misalignment of fee schedule payment rates and costs, physicians' interest in supplementing their professional fees with revenues from ancillary services, patients' desire to receive diagnostic tests in more convenient settings, and defensive medicine.

There is an ongoing migration of imaging services from hospitals, where institutional standards govern the performance and interpretation of studies, to physician offices, where there is less quality oversight. In addition, according to published studies and private plans, some imaging services are of low quality. Therefore, we recommended that Medicare develop quality standards for all providers that receive payment for performing and interpreting imaging studies. These standards should improve the accuracy of diagnostic tests and reduce the need to repeat studies, thus enhancing quality of care and helping to control spending.

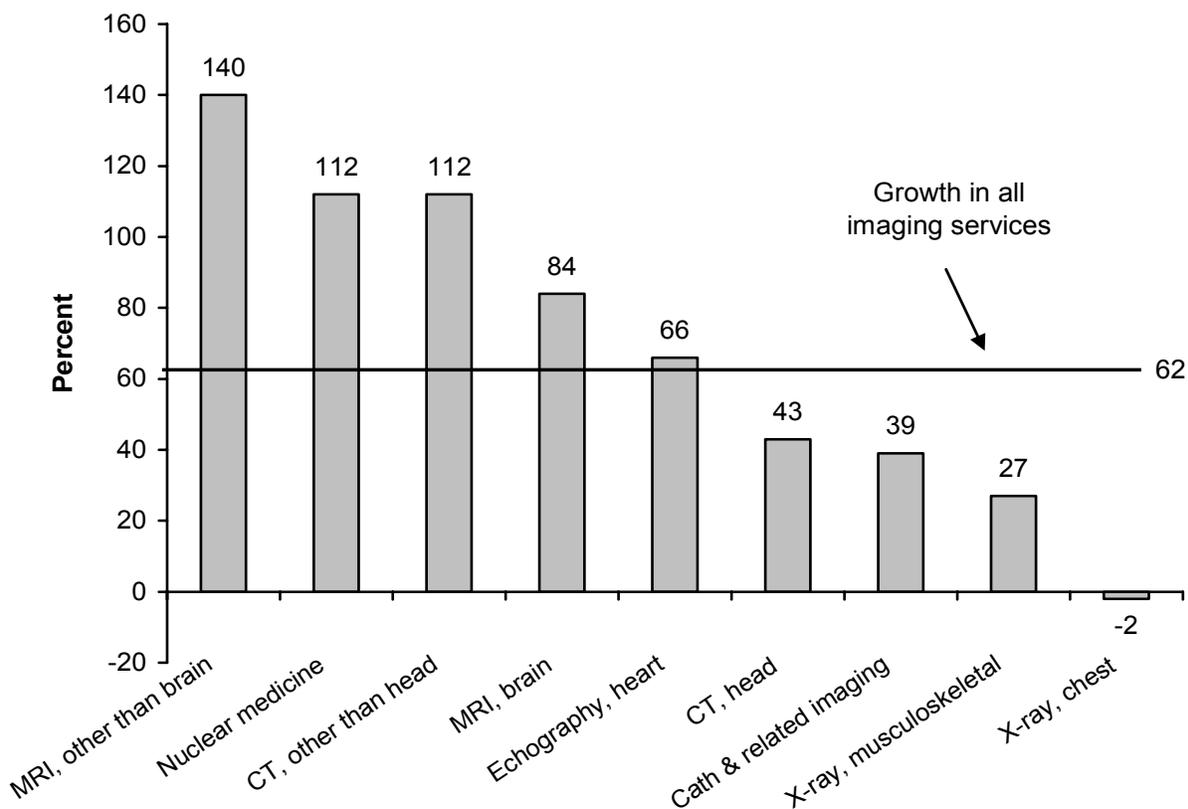
- In addition to setting quality standards for facilities and physicians, we recommended that CMS:
- measure physicians' use of imaging services so that physicians can compare their practice patterns with those of their peers,
- expand and improve Medicare's coding edits for imaging studies and pay less for multiple imaging studies performed on contiguous parts of the body during the same visit, and
- strengthen the rules that restrict physician investment in imaging centers to which they refer patients.

CMS adopted some of these recommendations in the 2006 final rule for physician payment by prohibiting physician investment in nuclear medicine facilities to which they refer patients and

reducing payments for multiple imaging studies performed in the same session on contiguous parts of the body. The Congress (as part of the Deficit Reduction Act) also adopted our recommendation to reduce payments for multiple imaging services. (Please see our July 18 testimony to this Committee for a fuller discussion of managing the use of imaging services.)

FIGURE 3

Cumulative growth in imaging volume per beneficiary varies, 1999–2004



Note: MRI (magnetic resonance imaging), CT (computed tomography), cath (cardiac catheterization).
 Source: MedPAC analysis of Medicare claims data.

Improving the physician fee schedule

As progress is made on the steps discussed above, it is also important to assure that the relative rates for physician services are correct. Medicare pays for physicians' services through the physician fee schedule. The fee schedule sets prices for over 7,000 different services and physicians are paid each time they deliver a service. It is important to get the prices right because otherwise, Medicare would pay too much for some services and therefore not spend taxpayers' and

beneficiaries' money wisely. In addition, inaccurate rates can distort the market for physician services. Services that are overvalued may be overprovided. Services that are undervalued may prompt providers to increase volume in order to maintain their overall level of payment or opt not to furnish services at all, which can threaten access to care. Over time, whole groups of services may be undervalued, making certain specialties more financially attractive to new physicians than others, potentially affecting the supply of physicians.

The Commission is examining several issues internal to the physician fee schedule that could be causing the fee schedule to misvalue relative prices.

In our March 2006 Report to the Congress we examined the system for reviewing the relative value units (RVUs) for physician work which determine much of the fee schedule prices. Changes to the review process are necessary because it does not do a good job of identifying services that may be overvalued. The Commission recommended improvements that will help reduce the number of physician fee schedule services that are misvalued, thereby making payment more accurate. We recommended that the Secretary establish a standing panel of experts to help CMS identify overvalued services and to review recommendations from the American Medical Association's relative value scale update committee (RUC), and that the Congress and the Secretary ensure that this panel has the resources it needs to collect data and develop evidence. In consultation with this expert panel, the Secretary should initiate reviews for services that have experienced substantial changes in factors that may indicate changes in physician work, and identify new services likely to experience reductions in value. Those latter services should be referred to the RUC and reviewed in a time period as specified by the Secretary. Finally, to ensure the validity of the physician fee schedule, the Secretary should review all services periodically.

In our June 2006 Report to the Congress we reviewed the data sources that CMS uses to derive practice expense payments—another important determinant of pricing accuracy in the physician fee schedule. One source, a multispecialty survey on the costs of operating physicians' practices, dates from the 1990s. Several specialties have submitted more recent data, but updating the physician fee schedule using newer data from some but not all specialties may introduce significant distortions in relative practice expense payments across specialties. We recognize that collecting and updating practice cost data will substantially increase demands on CMS. However,

because it will improve the accuracy of Medicare's payments and achieve better value for Medicare spending, the Congress should provide CMS with the financial resources and administrative flexibility to undertake the effort.

We are also concerned about the accuracy of Medicare's payment rates for imaging studies. In a recent proposed rule, CMS proposed basing payments for the technical component of imaging services on resource use (these rates are currently based primarily on historical charges). These resources include clinical staff, medical equipment, and supplies. Equipment is a large share of the cost of many imaging services, such as MRI and CT. CMS's estimate of the cost of imaging equipment per use may be too high. The agency assumes that imaging machines (and all other types of equipment) are used 50 percent of the time a practice is open for business. We surveyed imaging providers in six markets and found they were using MRI and CT machines much more frequently, which should lead to lower costs per use. In addition, CMS assumes that providers pay an interest rate of 11 percent per year when purchasing equipment, but more recent data suggest that a lower interest rate may be more appropriate (a lower interest rate would reduce the estimated cost of equipment). CMS should revisit the assumptions it uses to price imaging equipment.

Creating new incentives in the physician payment system

MedPAC has consistently raised concerns about the SGR as a volume control mechanism and recommended its elimination. We believe that the other changes discussed previously—pay for performance, encouraging use of IT, measuring resource use, setting quality standards for imaging services, and improving payment accuracy—can help Medicare beneficiaries receive high-quality, appropriate services and help improve the value of the program. Although the Commission's preference is to directly target policy solutions to the source of inappropriate volume increases, we recognize that the Congress may wish to retain some budget mechanism linked to volume. An ideal volume control mechanism would overcome the incentive under fee-for-service to increase volume and instead create incentives for physicians to practice in ways that improve care coordination and quality while prudently husbanding Medicare resources. The Congress has tasked the Commission to evaluate several alternative volume control mechanisms including differing levels of application such as group practice, hospital medical staff, type of service, geographic areas, and outliers. We will report on these alternatives in March 2007.