MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Medicare payment to physicians

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Statement of
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Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

Chairman Deal, Congressman Brown, distinguished Subcommittee members. I am Glenn Hackbarth, chairman 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. CMS estimated in March of this year that spending related to the physician fee schedule for 2004 increased by approximately 15 percent, while the number of Medicare beneficiaries in FFS increased by only 1.1 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 and type of services provided we refer to as volume. To get good value for the Medicare program, the payment system should set the relative prices for services accurately and provide incentives to control unnecessary growth in volume.

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: an alternative method to updating payments; differentiating among providers through pay for performance, measuring physician resource use, and setting standards for imaging services; improving the internal accuracy of the physician fee schedule; and creating new incentives in the physician payment system.

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 that was believed to exist under the CPR method because it gave physicians an incentive to raise their charges.

Second, the fee schedule corrected distortions in payments that had developed under the CPR method. Evidence of those distortions came from William Hsiao and his colleagues at Harvard University who found that payments were lower, relative to resource costs, for evaluation and management services but higher for imaging and laboratory services. Further evidence came from analyses, conducted by one of MedPAC's predecessor commissions, the Physician Payment Review Commission, that revealed 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 of mispricing, and 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 gains to patients, or growth where there is currently underutilization of services, may be beneficial. But one indicator that not all growth is good may be its variation.

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

- Differences in volume among geographic areas is primarily due to greater use of discretionary services that are sensitive to the supply of physicians and hospital resources.
- 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.
- Areas with high levels of volume have slightly worse access to care on some measures.

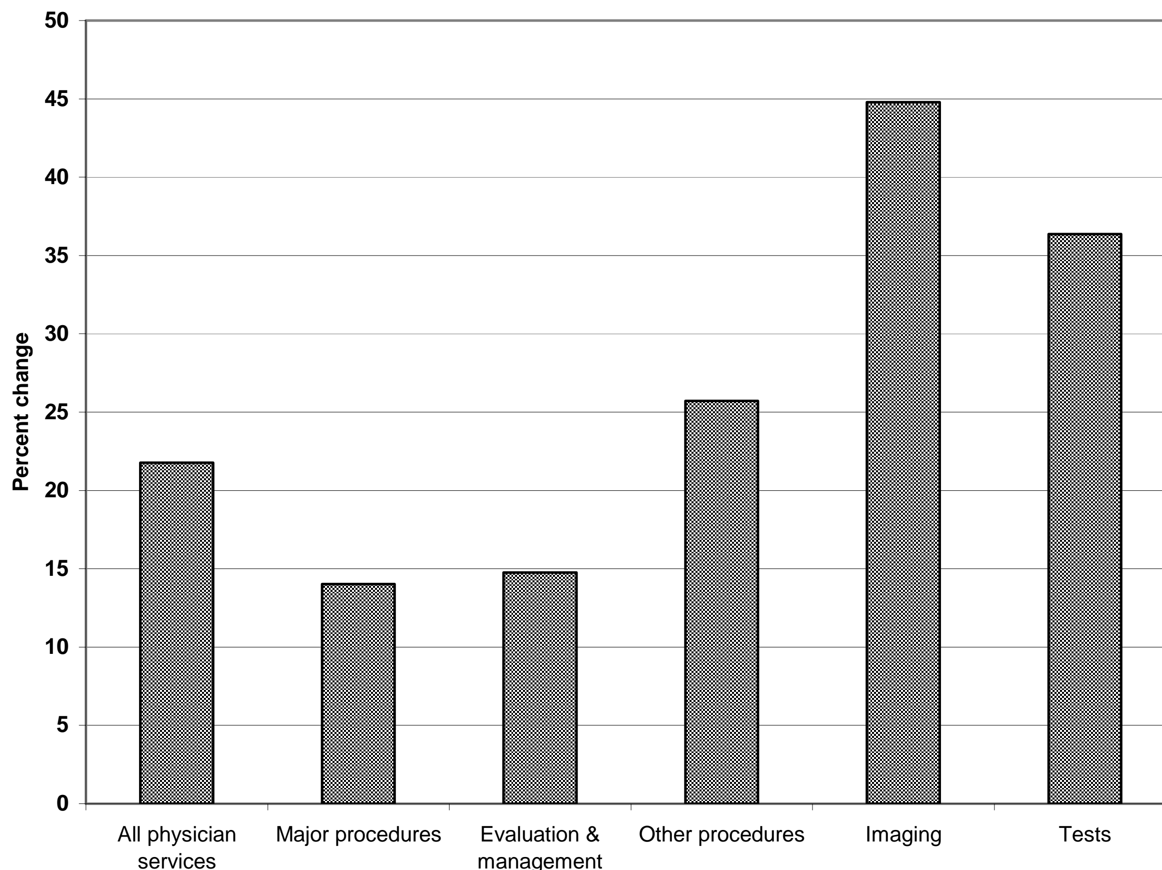
All this suggests that service volume may be too high in some geographic areas.

In addition, volume varies among broad categories of services: Cumulative growth in volume per beneficiary ranged from less than 15 percent for major procedures to almost 45 percent for imaging, based on our analysis of data comparing 2003 with 1999 (Figure 1). Although one would expect some variation as technology changes, one source of concern is that growth rates were higher for services which researchers have characterized as discretionary (e.g., imaging and diagnostic tests).

Impact on beneficiaries—For beneficiaries, increases in volume lead to higher out-of-pocket costs—copayments, 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, 17.3 percent in 2005, and 13.2 percent in 2006.

Impact on taxpayers—Volume growth also has implications for taxpayers and the federal budget. Increases in volume lead to higher Part B expenditures supported with 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 thus continue to put pressure on the federal budget. Increases in Medicare spending per beneficiary is an important reason for that growth, cited by the Congressional Budget Office and the Government Accountability Office (GAO), among others.

Figure 1. Cumulative growth in volume of physician services per beneficiary, by type of service, 1999-2003



Source: MedPAC analysis of claims data for 100 percent of beneficiaries.

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 to occur 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.

It then allows 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 spending target in the SGR combines all these factors. The basic SGR mechanism only lowers the update when cumulative actual spending exceeds target spending.

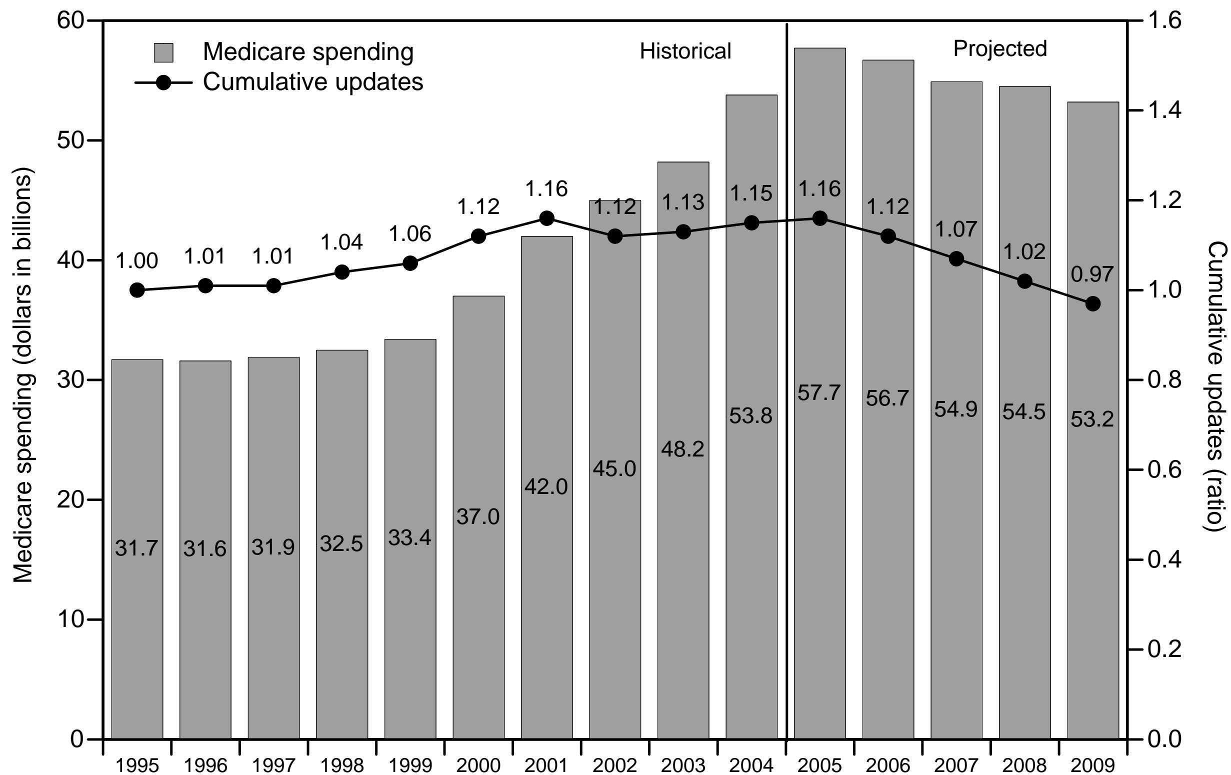
However, the SGR approach has run into difficulties as well. The SGR formula has produced volatile updates that in some years have been too high and in others too low. Updates went from increases in 2000 and 2001 of 5.4 percent and 4.5 percent, respectively, much larger than the increases in practice costs, to an unexpectedly large reduction in 2002 of 5.4 percent. This volatility illustrates the problem of trying to control spending with an update formula. The current projection, according to the Medicare trustees, is that annual updates of about negative five percent will occur for six consecutive years. The trustees characterize this series of updates as "unrealistically low" and in terms of budget scoring, these projections make legislative alternatives to the SGR very expensive.

There are two reasons why actual spending has exceeded target spending and the cumulative difference has become so great that multiple negative updates are projected.

- The first is that volume has continued to grow strongly even when updates have been small or even negative. Figure 2 shows that Medicare spending for physician services increased in 2002, the one year when the update was negative, continued to increase at a rate greater than the increase in the update through 2004, and is projected to continue to increase in 2005. The trustees projection assumes that negative updates will take place as determined by the formula and eventually reduce spending.
- The second reason is that the spending target turned out to have been too high several years in a row because growth in the economy slowed. At the same time, inadvertent omissions of some billing codes made actual spending appear lower than it really was. The result was the updates calculated in those years were too large. When the spending target and actual spending figures were corrected, a large gap between actual and target spending resulted. That gap has to be closed under the SGR formula, and can only be diminished by multiple negative updates or very large changes in the other factors.

In the MMA, the Congress attempted to reduce the volatility problem. The GDP factor in the SGR is now a 10-year rolling average, which dampens the effects of yearly changes in GDP growth. However, there is another source of volatility which has not been controlled—estimating changes in enrollment in traditional fee-for-service Medicare. CMS may need to reestimate enrollment growth as it gains experience with shifts in enrollment from traditional Medicare to Medicare Advantage. Under the SGR, this could lead to continued volatility in spending targets and updates.

Figure 2. FFS Medicare spending and payment updates for physician services, 1995–2009



Note: FFS (fee-for-service). Dollars are Medicare spending only, and do not include beneficiary coinsurance.

Source: 2005 annual report of the Boards of Trustees of the Medicare trust funds.

Even if all estimates of GDP and the other factors were always exactly right, the SGR approach is flawed.

- It disconnects payment from the cost of producing services. The formula produces updates that can be unrelated to changes in the cost of producing physician services and other factors that should inform the update. If left alone, fee cuts might eventually provide a budget control but in so doing would produce fees that in the long run could threaten beneficiaries' access to care.
- It is a flawed volume control mechanism. Because it is a national target, there is no incentive for individual physicians to control volume. There has been no consistent relationship between updates and volume growth, and the volume of services and level of spending are still increasing rapidly.
- 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, this assumption is incorrect because physicians do not respond to collective incentives but individual

incentives. An efficient physician who reduces volume does not realize a proportional increase in payments. In fact, an individual physician has an incentive to increase volume under a fee-for-service system; moreover, there is evidence that physicians have increased volume in response to reductions in fees. The sum of those individual incentives will result in an increase in volume overall, if fees are reduced, and trigger an eventual further reduction in fees under an expenditure target.

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. The Commission recognizes the desire for some control over rapid increases in volume. However, instead of relying on a formula, MedPAC recommends a different course—one that involves explicit consideration of Medicare program objectives and differentiating among physicians. Updates should be considered each year to ensure that payments for physician services are adequate to maintain Medicare beneficiaries' access to necessary high quality care.

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 treating all services and physicians alike will produce inequitable results not only for physicians, but also for the beneficiaries and taxpayers who have to pay for unwarranted volume. Volume growth that adds value should be treated differently from volume growth that does not.

Improving value

We recommend a series of steps to improve payment for physician services. They are important steps that will improve quality for beneficiaries and lay the groundwork for obtaining better value in the Medicare program. They will not, by themselves, solve the problem of rapidly growing expenditures for physician services, but neither does the SGR. The SGR does not control volume; it only establishes budget targets, targets that have become unrealistically low. As a result, even sound policies often carry large budget "scores," a problem that will only get worse with time. Meanwhile, the SGR may be encouraging increases in volume, even while it creates serious inequities and the potential for future access problems.

To begin improving payment for physician services, 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.
- 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.
- Measuring physicians' use of Medicare resources when serving beneficiaries and providing information about practice patterns confidentially to physicians.
- 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 based on factors influencing the unit costs of efficiently providing physician services.

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 2005 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. This August and September 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. 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 March Report to the Congress we 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), measuring physician resource use, and managing the use of imaging services. Although some of these actions may be controversial, we must ask ourselves what the cost is of doing nothing—how long can we afford to pay physicians without regard to quality or 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 recently 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, including submission of laboratory values using common vocabulary standards, and of prescription claims data from the Part D program. The laboratory values and prescription data could be combined with 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

Medicare beneficiaries living in regions of the country where physicians and hospitals deliver many more health care services do not experience 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 in tandem 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.

Right now, we know there are wide disparities in practice patterns, all of which are paid for by Medicare and many of which do not appear to be improving care. Yet many physicians have few opportunities to learn about how their practice patterns compare to others or how they can improve. MedPAC and CMS are working on measuring resource use through episodes of care. This recommendation would help inform physicians and is crucial to starting the process of improvement.

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 and increasing use of imaging procedures in physician offices 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.

These factors have contributed to 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. These variations in oversight, coupled with rapid volume growth, may mean that beneficiaries are receiving unnecessary or low quality care. 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.

Requiring physicians to meet quality standards as a condition of payment for imaging services provided in their offices represents a major change in Medicare's payment policy. Traditionally, Medicare has paid for all medically necessary services provided by physicians operating within the scope of practice for the state in which they are licensed. The Commission concludes that requiring standards is warranted because of evidence of low-quality providers, the lack of comprehensive standards for physician offices, and the growth of imaging studies provided in this setting. There is precedent for this approach. According to GAO, the Mammography Quality Standards Act has increased mammography facilities' compliance with quality standards and led to improvements in

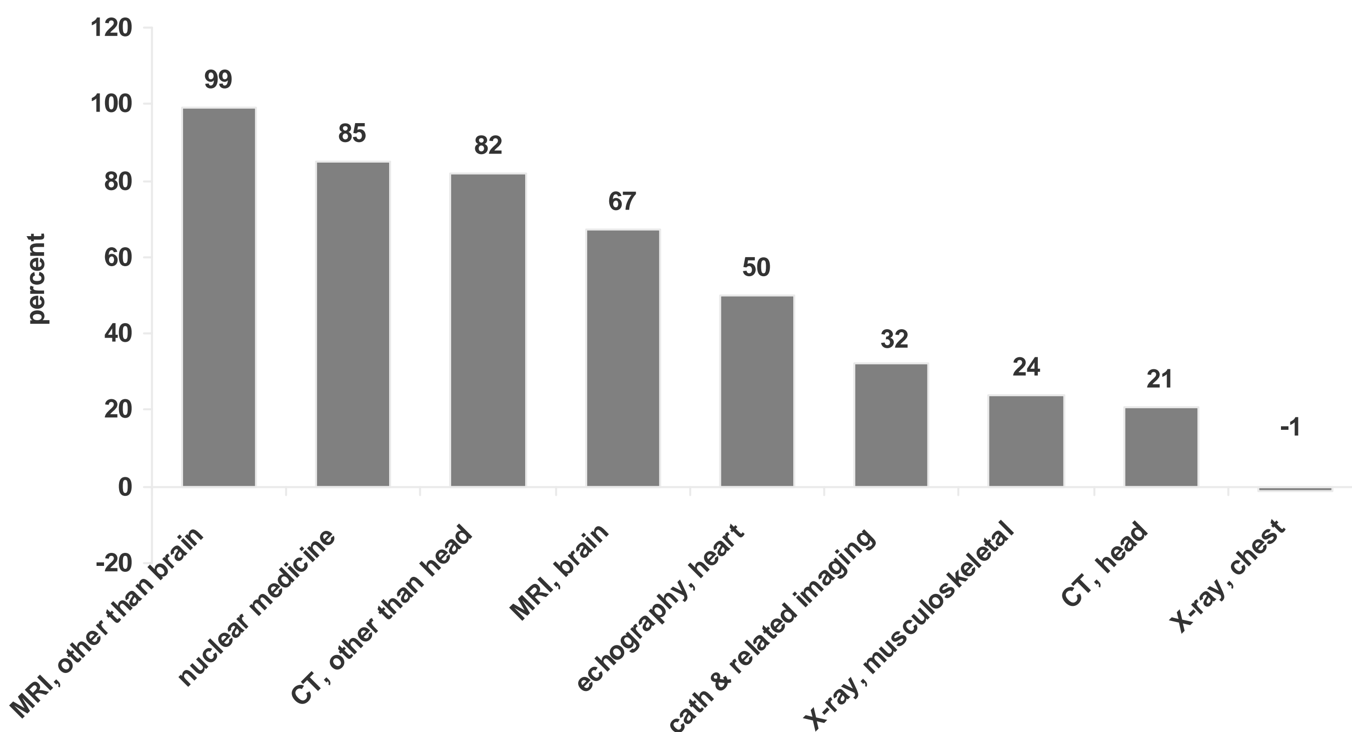
image quality. After the Act took effect, the share of facilities that were unable to pass image quality tests dropped from 11 percent to 2 percent.

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 perforemed 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 restricting physician investment in nuclear medicine facilities to which they refer patients and reducing payments for multiple imaging studies.

Figure 3. Growth in imaging volume per beneficiary varies (1999-2003)



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 paying physicians 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.
- Misvaluation 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 than others.

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

- The system for reviewing the relative value units (RVUs) which determine the fee schedule prices may be biased. The system identifies undervalued codes for review more often than overvalued codes; it creates a presumption that current relative values are accurate (even though the work associated with some services, especially new services, should change over time); and it may favor procedures over evaluation and management services.
- The method for adjusting payments geographically for input prices may be distorting relative prices and hence misvaluing services. There are two aspects to this issue. First, the boundaries of the payment localities have not been revised since 1997 and may not correspond to market boundaries for the inputs physicians use in furnishing services. Second, the share of the practice expense payment that is not adjusted geographically is the same for all services, although the cost of equipment and supplies (which this share is supposed to represent) is not. This means that payments may be too low for equipment-and-supply-intensive services (such as imaging) in some areas and too high in others.
- New data are needed for determining practice expenses and the current method is complex and not transparent.

The Commission is working on options to improve relative pricing accuracy in the physician fee schedule.

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, and reform of payments for imaging services—can help Medicare beneficiaries receive high-quality, appropriate services and improve the value of the program. Although the Commission's preference is to directly target policy solutions to the source of inappropriate volume increases, as discussed in the previous section on imaging, we recognize that the Congress may wish to retain some budget mechanism linked to volume. However, the mechanism should more closely match physicians' incentives to their individual performance. In our March 2005 Report to the Congress, we presented potential ideas for

volume control methods that encourage more collaborative and cost effective delivery of physician services in accordance with clinical standards of care; these are described briefly below.

Potentially, the SGR could be modified by creating smaller groups subject to a spending target. Research shows that reducing the size of groups subject to collective incentives may increase the likelihood that the actions of individuals within the group will be influenced by the incentives. Faced with such incentives, smaller, more cohesive groups of physicians may establish new guidelines for care that will reduce volume growth and improve quality. Although these smaller groups will differentiate updates more than a single update, many of the problems that accompany controlling volume growth through an update may persist. These methods will also require a means of risk adjustment. Four ways in which Medicare could move from one national spending target to multiple spending targets are:

- Create one or more alternate pools based on membership in organized groups of physicians. Alternate pools could be formed, for example, for group practices, independent practice associations (IPAs), or hospital medical staffs. Organized groups of physicians would apply for inclusion, and services provided by group members would be aggregated in this separate pool. In order to participate in the pool, groups would have to meet certain criteria, such as functioning clinical IT systems, quality recognition programs, and a commitment to the use of evidence-based medicine. Continued membership would be subject to performance standards.
- Divide the United States into regions and adjust the annual conversion factor based on changes in the volume of services provided in each region. An SGR-type formula could be used to determine how much spending growth society could afford, but the overall target would be adjusted regionally. Because reducing volume growth would be more difficult to achieve in areas where the volume of services provided was already low, the formula would have to take into account the initial volume level.
- Set targets based on the performance of hospital medical staffs. Research shows that hospital medical centers can function as de facto systems of care. Medical staff would be defined as all the physicians practicing in a given hospital. Updates would be higher for medical staffs that controlled spending growth and lower for staffs for whom spending grew at rates above average.
- Adjust fees differentially by service or types of service. Fees for services with very high volume growth would be reduced, or not increased at the same rate as fees for other services. Either volume targets or growth thresholds would have to be established with exceptions where warranted.

All of these ideas raise many questions about design, implementation, and policy. MedPAC has not endorsed any of these approaches, but we will explore them further if the Congress is interested in investigating them.