# THE COMMITTEE ON ENERGY AND COMMERCE

## INTERNAL MEMORANDUM

May 3, 2011

**To:** Members of Energy and Commerce Committee

**From:** Committee Staff

**Re:** Hearing on Medicare Physician Payment Reform

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On May 5, 2011, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled, "The Need to Move Beyond the SGR." At the hearing, the Subcommittee will examine potential models to reimburse physicians under the Medicare program that focuses on value and quality.

**Witnesses:**

**Mark B. McClellan, MD, Ph.D.**
Director, Engelberg Center
The Brookings Institution

**M. Todd Williamson, MD**
Coalition of State Medical and
National Specialty Societies

**Harold Miller**
Executive Director
Center for Healthcare
Quality and Payment Reform

**Cecil B. Wilson, MD**
President
American Medical Association

**David B. Hoyt, MD**
Executive Director
American College of Surgeons

**Roland Goertz, MD**
President
American Academy of Family Physicians

**Michael Chernew, Ph.D.**
Professor of Health Policy
Harvard Medical School

**Background:**

When Medicare was implemented in 1966, providers were paid according to the Customary, Prevailing, Reasonable (CPR) system.[1] The incentives in this payment system led to rapid increases in both the price and volume of services.

[1] In the CPR system, physicians were paid the lowest of three possible fees: the actual charge submitted, the fee customarily charged by a particular physician, or the prevailing fee charged by physicians in a given locality.

**Medicare Economic Index:** By the mid-1970s, in an attempt to limit costs, prevailing fees were linked to the Medicare Economic Index (MEI), a measure that was supposed to reflect changes in the medical marketplace, including practice costs. The MEI methodology, implemented in 1975, limited charge inflation but placed no control on the volume of services that physicians deliver.

**The 1989 Physician Payment Reform:** In the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress created a new system based on the resource-based relative value scale (RBRVS) for Medicare physician payments. This legislation also included limits on the right of physicians to balance-bill.[2] The RBRVS system attempted to link physician payment to the resources, or "inputs," that were used in providing medical services. In an attempt to control total spending for physicians' services driven by volume increases, OBRA also tied the annual update of the fee schedule to the trend in total spending for physicians' services relative to a target that was based on historical trends in volume. This method, effective in 1992, became known as the Medicare Volume Performance Standard (VPS). This system led to unstable and unpredictable physician payment updates.

**Sustainable Growth Rate:** In 1997, the Balanced Budget Act (BBA) replaced VPS with the Sustainable Growth Rate (SGR) system. Unlike the VPS, the SGR target is tied to growth in the nation's gross domestic product per capita and adjusts physician payments by a factor that reflects cumulative spending relative to the target. While the SGR targets are not limits on expenditures, they represent a "sustainable" trajectory for cumulative spending on Medicare physician services from April 1996 forward.

Medicare payments for Part B services[3] provided by physicians and certain non-physician practitioners are currently made on the basis of a fee schedule, a list of over 7,000 tasks and services for which physicians bill Medicare. The annual update to the conversion factor calculation for physician fees is based on (1) the Medicare Economic Index (MEI), which measures the weighted average annual price changes in the inputs needed to produce physician services; (2) the Update Adjustment Factor (UAF), used to equate actual and target (allowed) expenditures; and (3) allowed expenditures, equal to the actual expenditures updated by the SGR.

The SGR sets both the cumulative and allowed expenditures under the UAF formula and consists of the following components: (1) the estimated percentage changes in physicians fees; (2) the estimated percentage changes in the number of fee-for-service beneficiaries; (3) the estimated percentage growth in real gross domestic product (GDP) (10-year moving average); and, (4) the estimated percentage changes resulting from changes in laws and regulations.

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[2] Balance billing allows physicians to charge patients directly for the portion of the bill not covered by Medicare.

[3] Physicians and other health professionals perform a broad range of services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services. These services are furnished in all settings, including physicians' offices, hospitals, ambulatory surgical centers, skilled nursing facilities, other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Among the 1 million clinicians in Medicare's registry, approximately half are physicians who actively bill Medicare. The remainder includes other health professionals such as nurse practitioners, chiropractors, and physical therapists. These health professionals may bill Medicare independently (accounting for 10 percent of physician fee-schedule spending) or provide services under physician supervision.

**Legislative actions:** Each year since 2002, the statutory method for determining the annual updates to the Medicare physician fee schedule, known as the sustainable growth rate (SGR) system, has resulted in a reduction in the reimbursement rates (or a "negative update"). With the exception of 2002, when a 4.8% decrease was applied, Congress has passed a series of bills to override the reductions. However, these actions have required repeated attention from the Congress.[4]

The budgetary effect of legislative actions: ***First***, federal spending for Medicare Part B benefits grew more than it would have otherwise. ***Second***, because the legislation specified that increases in the payment rates should not be considered a change in law or regulation for purposes of determining the expenditure target, the gap between cumulative spending and the cumulative target became larger than it would have been otherwise. In January, 2012, under current law, physicians face a 29.4% reduction in the conversion factor for the fee schedule update.[5]

**Payment reform:** Spending on physician services continues to rise. In 2009, fee-for-service (FFS) Medicare spent about $64 billion on physician and other health professional services, accounting for 13% of total Medicare spending and 20% of Medicare's FFS spending.

The reform problem has two sides:

***Budgetary*:** Currently, it will take $298 billion in offsets just to wipe out the accumulated debt so far and restart from the baseline, according to the most recent CBO estimate.[6] Going forward, simply maintaining a zero percent update through 2020 will cost $275.8 billion.[7]

***Policy*:** The current system for reimbursing providers in Part B rewards physicians for the volume of services they provide, not the value of the services or medical outcomes, and simply rebasing the current SGR will not alter those incentives. In determining the optimal method for reimbursing physicians in Medicare going forward, solutions should preserve access to services while also ensuring the program does not incentivize excessive spending.

**Independent Payment Advisory Board:** An additional threat to physician payment reform is the creation of the Independent Payment Advisory Board (IPAB). The Patient Protection and Affordable Care Act (Section 3403 of PPACA) established a 15-member IPAB "to extend Medicare solvency and reduce spending growth through the use of a spending target system and fast-track legislative approval process." Beginning in determination year 2018, the target will be set at the nominal gross domestic product per capita + 1.0%. If future Medicare spending is

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[4] For 2011, the Congress passed a 1-year override; for 2010—two 1-month overrides, two 2-month overrides, and one 6-month override.

[5] Letter to Glenn Hackbarth, Chair, MedPAC, from Jonathan Blum, Deputy Administrator and Director Center for Medicare and Medicaid Services, March 7, 2011

[6] CBO Report, March, 2011

[7] CBO Estimate of Changes in Net Federal Outlays from Alternative Proposals for Changing Physician Payment Rates in Medicare, April, 2010

expected to exceed the targets, the IPAB will propose recommendations to Congress and the president to reduce the growth rate. The IPAB's first set of recommendations would be proposed on January 15, 2014. If Congress fails to pass legislation by August 15 each year to achieve the required savings through other policy changes, the IPAB's recommendations will automatically take effect.

PPACA states that hospital payments may not be changed by the IPAB through 2019 and as such the board has very little in the way of options to reduce spending other than reducing payments to doctors and reducing reimbursement for drugs. This will put an added burden on providers who are already facing payment cuts of 29.4% in 2012.

**Conclusion:**

This hearing will explore specific options for moving beyond SGR. Issues to be discussed include:

- what should an ideal payment/delivery system look like;
- what is the role of newer payment/delivery systems now being evaluated (Accountable Care Organizations, bundled payments, medical homes, shared decision-making, etc);
- how do you measure quality;
- how do you pay for value, not volume;
- is there a role for private contracting or balance-billing;
- how do you incentivize beneficiaries to make better choices?

Should you have any questions regarding the hearing, please contact John O'Shea or Ryan Long at 5-2927.