

STATEMENT BY BRUCE C. VLADECK, PH.D

**Roundtable on “Medicare Physician Payments: Understanding the Past
So We Can Envision the Future”**

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Introduction

Mr. Chairman, members of the Committee, fellow members of the Administrators' Alumni Association, it is a privilege and an honor to have been invited to participate in this Roundtable today. I congratulate the Committee for its willingness to confront the difficult issues surrounding Medicare payments to physicians, and for its creative efforts to provide a novel forum in which to explore them.

I wrote a couple of years ago that the Sustainable Growth Rate (SGR) and other aspects of the Medicare Physician Fee Schedule (MPFS) presented an extraordinarily difficult knot of interconnected policy and political problems. The intrinsic difficulty of the issues is compounded by the current political environment, the pervasiveness of a variety of hidden agendas on the part of major stakeholders and decision-makers, and the desire of many members of the policy community for conceptual and technical elegance, occasionally at the expense of attainable progress. I fear that all of those forces make identification of practical, achievable solutions to the problems more difficult, if not impossible.

Any health care financing system must address, among many other issues, two basic questions: how to pay physicians, and how to limit the costs both of direct payments to physicians and the related behaviors such payments may encourage or deter. If we start from that basic point, I believe we can better explain some of the problems associated with the MPFS and the SGR. By applying a little common sense, and remaining skeptical of all-encompassing or overly sweeping approaches, I think we might also begin to see our way clear to a means of exiting the box in which we find ourselves. The case for proceeding incrementally and pragmatically is further reinforced, I would note, by the surprisingly poor quality of most of the data we have about physician practice, physician incomes, and physician practice expenses. Physician services are a \$500 billion-a-year industry, frequently employing some of the world's most advanced technologies, but the system's fragmentation, proprietary interests, and

diffusion of accountability have left us with remarkably little information about some of its most important characteristics.

Paying Physicians

There are really only a few basic ways to pay physicians. You can pay them specific fees for specific services, as most American and Canadian physicians, and many physicians in the rest of the world, are paid. Those services can be highly fragmented and itemized, or highly bundled, as is the case for most obstetricians and other surgeons. You can supplement that system with bonuses or penalties tied to any number of performance parameters, from quality to group profitability. You can pay a salary – a flat amount for a defined period of work – although many salaried physicians in this country also receive incentive payments tied to the quantity of services they provide. Or you can pay physicians per patient, as primary care practitioners in the British National Health Service are paid; such payments can be designed to cover just the physician’s income and practice expenses, or also include an at-risk provision for separately billable services the physician orders. Each of these approaches has advantages and shortcomings, and none is inherently more virtuous than the others. Rational policymaking will thus require efforts to maximize the system’s advantages and counteract its shortcomings. But in a health care system like that of the United States, where we insist on multiple independent payors and a sharing of responsibility between public and private sectors, it’s hard to escape fee-for-service in some form.

I know that much of the current conventional wisdom in American health policy discussions portrays fee-for-service payment of providers as somehow inherently evil, and the source of most of our problems with health care costs and quality. To put the matter as politely as I can, that view is logically powerful, but inconsistent with the facts. Health care systems in nations that provide higher quality care at lower cost than the United States pay their physicians fee for service, and many of the health

systems in the United States we most admire for their high quality and parsimonious resource use developed in a world of fee-for-service payment, and still derive a considerable share of their income from fee-for-service payments. Most capitated health plans pay physicians fee-for-service, either directly or through sub-capitation to large physician groups which in turn allocate the funds at least partially on the basis of volume. In other words, the payor may perceive that it is making capitated or bundled payments, but the individual physicians are paid fee-for-service, or some amalgam of salary and fee-for-service-based incentives. The proportion of physicians paid on a fee-for-service basis in low-cost, high quality Medicare service areas is not that dissimilar from that in high-cost, low quality markets.

Fee-for-service systems do contain a built-in incentive to oversupply certain services. That's the problem the SGR was meant to solve, which I will discuss later. But salary systems contain the symmetrically opposite incentive – to underprovide services – a lesson many hospitals learned to their sorrow in the wave of physician hiring and practice purchases in the 1990s. And just as there is no absolutely “correct” way to pay physicians, there is no abstractly correct price for any particular service, or level for any particular salary. In the early years of the Medicare program, it sought to pay physicians the “market price” for their services, but that market was badly flawed and seriously distorted, and we have been struggling to come up with something better ever since.

From a policy perspective, what is important about a physician payment system is not only the absolute level of prices, but the relative levels. The pre-MPFS market, it was widely believed, overpaid specialist services at the expense of primary care, and provided inadequate incentives for physicians to locate their practices in rural or low-income communities. The MPFS was designed to fix that. Through development and adoption of the Resource-Based Relative Value Scale, it was supposed to provide a “scientific” basis for the relative prices of different physician activities, which would have the expected

effect of narrowing the payment gap between “cognitive” and “procedural” services, thereby narrowing the gap between primary care and specialist incomes. Other components of the MPFS were designed to redress the imbalance between rural and inner-city practitioners, on the one hand, and those based in more affluent areas.

There is some data that suggests that, in the early years of the MPFS, the intended effect of transferring expenditures from procedural to cognitive services was achieved. By the late 1990s, however, the effects of the system began to swing in the opposite direction due, it is generally believed, to the process by which the Relative Value Scale is updated. Certainly, the income disparities between primary care physicians and specialists have continued to increase throughout the last decade. While not the sole cause, that widening gap is generally believed to contribute to the growing shortage of primary care physicians in many communities, which will substantially worsen if current trends in specialty choices among medical school graduates continue. Primary care residency slots go unfilled while some of the more lucrative specialties are oversubscribed.

It’s important to emphasize that the misallocation of spending between primary care and specialist physicians is not just a Medicare problem. In the absence of alternative benchmarks, many private payors and organizations that employ physicians use the Relative Value Scale as the basic metric of physician services. Physician productivity is measured in Relative Value Units, and physician compensation systems – including many salaried systems in employment settings, group practices, and faculty practices – generally use RVU-based measures. Based the available data, the disparity between primary care and specialist payments is at least as severe in the private sector as it is in Medicare, although both private and public payors have taken steps in recent years, such as supplemental payments to Primary Care Medical Homes, to redress some of that imbalance.

If we're going to stanch the hemorrhaging of physician-provided primary care in many of our communities in the foreseeable future, we're going to have to find a way to substantially improve the income of primary care physicians, and because of its place in the market, Medicare will have to play its part, if not take a leading role. Of course under current budgetary constraints, not to mention the problems posed by the SGR, it may appear hard to identify where those funds might come from, although MedPAC and others have suggested that they might, over time, come at least in part from a reduction in the fees paid to certain specialists. Obviously, members of the specialist community object strenuously to such proposals. I note three things in this regard. First, by any standard of international comparison, American specialists are extremely well-compensated compared to their counterparts of similar training and experience elsewhere, both in absolute terms and relative to primary care physicians. Second, the concern that reductions in relative Medicare fees to certain specialties might create access problems for Medicare beneficiaries should be considered in light of the extent to which Medicare beneficiaries constitute a disproportionate share of all patients for many of the best-compensated specialties. On the other hand, I would restate the earlier point that there is no abstractly correct, Platonically precise means of determining either absolute or relative physician payments. In a badly flawed, imperfect market, the choice is ultimately social and political, and I don't envy you the responsibility of making it.

Controlling Costs

Regardless of payment system, payors need a method to determine updates, customarily applied annually, to reflect input price inflation, changes in technology, changes in utilization patterns, and policy objectives. Since the enactment of the Social Security Act Amendments of 1972, and more systematically since the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress and

successive Administrations have developed and applied prospective formulas with the primary objective of controlling the rate of increase in Medicare expenditures. Such policies or formulas apply to every category of Medicare fee-for-service coverage. Most are adjusted annually, or once every several years. Many are controversial, and not all of them work as well as policymakers might hope. But only the SGR creates the kinds of problems that have absorbed so much energy, and have created so much anxiety in the policy community, over the last decade.

The SGR has become such a problem, I would suggest, for two reasons. First, it is the only one of the formulas for annual Medicare payment updates that relies so heavily on a measure wholly outside the health system. Why the Congress chose in 1997 to cap the rate of growth in Medicare physician payments at the growth in real GDP per capita is unclear to me, but doing so was clearly a mistake. While limiting the growth in health care expenditures to the growth in the overall economy may be a laudable goal to shoot for over time, it is a far more stringent standard than payors, public or private, in the United States and elsewhere, have generally been able to meet in the absence of extraordinary circumstances. Further, to impose such an exogenous benchmark on one set of services, comprising less than one quarter of Medicare outlays, while using other update formulas for other services, makes policy distortions almost inevitable. In the case of physician fees, those distortions run directly counter to the broader policy goal of migrating an increasing share of Medicare services from institutional to office and home-based care. Still further, while it might be desirable, in the abstract and in general, to more closely link changes in Medicare outlays with changes in the broader economy, precisely one of the reasons why Medicare Parts A and B (along with Social Security) operate through Trust Funds is to dampen the short-term impact of macroeconomic fluctuations and ordinary workings of the business cycle on payment systems where some modicum of stability is critical to providers and patients alike. The experience of the last decade, in which real GDP per capita actually fell, was clearly not anticipated by the creators of the SGR, but has made that problem all the more acute.

The deficiencies of the SGR are compounded exponentially by its relationship to the processes required by the Congressional Budget Act. When Medicare mis-guesses about expenditure growth in non-physician services for any given year, as it also often does, it has a variety of mechanisms to compensate for those errors in future years. While those corrections sometimes generate some controversy –most recently on the issue of changes in hospital inpatient coding – they can generally be handled in the course of routine annual business. But the formula driving the SGR is cumulative, to the date of origin of the policy, so the difference that needs to be corrected grows every year. Further, because of the way the SGR is defined in the statute, the cumulative gap grows every year, compounded, throughout the budget projection period.

Thus, I was astonished to learn that, while the CBO estimates the cost of permanently “fixing” the SGR at something in excess of \$250 billion, the actual differences, through the end of calendar 2011, between the targets the SGR formula produces and actual Medicare outlays since the enactment of the SGR are less than \$13 billion, or roughly 1.2% of total outlays. I think I thoroughly understand the logic of budget projections and the difference between a current law baseline and a baseline adjusted for policy changes, but there is something fundamentally irrational about a formula that requires a fee reduction of 27% to recoup a difference of just over 1%. A similar logic applied to an ordinary commercial obligation would violate every anti-usury law I’ve ever seen.

In other words, we have been paralyzed on Medicare physician payment issues for the better part of the last decade because of the projected variance over ten years between two hypothetical lines, one projecting the SGR target and the other actual MPFS outlays. Replacing the SGR with something more sensible, and easier to adjust in the face of changing circumstances, would neither change any underlying economic facts nor have an overwhelming effect on the federal deficit or policies that are constructed to address it. But I fear that short-term political dynamics often frame the discussion in

ways that confuse the unavoidable arbitrary conventions of the budget process with some underlying reality.

And this is not just a theoretical problem, or one confined to discussion of Medicare physician payment policy. As was illustrated in this year's most recent "fix" to the draconian, SGR-mandated reductions in physician's fees, the Congress increasingly turns to other parts of the Medicare program for offsets, even though those other providers are already experiencing significant reductions in Medicare payments mandated by the Affordable Care Act, the Budget Control Act, and various other legislation. These incremental, piecemeal actions have tangible effects on hospitals and other health care providers already struggling to keep their economic heads above water, and they also make more systematic, comprehensive Medicare reform more difficult, not easier. It would actually be much more sensible, political considerations aside, for this or the next Congress to simply acknowledge that its predecessors made a mistake, repeal the SGR, and replace it with an update factor of the sort that is now employed for hospitals or ambulatory surgical centers or home care agencies. Even more elegant update formulas could also be designed, although I would suggest that simpler is generally better, especially because circumstances will inevitably change and the formula will probably have to be altered again in the next year or two.

Conclusion

In summary, I don't believe that what I'm proposing is that novel or unconventional; each part has been proposed by others more knowledgeable than I in recent years. We should create separate conversion factors for the Medicare Physician Fee Schedule that reward Evaluation and Management Services more highly than others, pending a thoroughgoing overhaul of the Resource-Based Relative Value Scale. And we should abolish the SGR and replace it with an alternative update factor similar to those which apply to other Medicare providers. This is not, at root, a conceptual problem, but a challenge to the

willingness of both Congress and the Administration to cut through political symbolism and inside-the-Beltway minutiae to permit the application of some common sense, no matter how fleetingly. The last decade does not provide much basis for optimism on that score, but I think you, Mr. Chairman, and your colleagues on this Committee, by your presence here today, reaffirm my confidence in your ability to accomplish that.

Again, I'm most grateful for the opportunity to appear before you today, and I look forward to participating in the discussion today and in the future.

Thank you very much.