Testimony

Before the Committee on Finance,

United States Senate

# SGR AND THE MEDICARE FEE SCHEDULE: CONSIDERATIONS FOR A POST-SGR WORLD

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Mr. Chairman and Members of the Committee:

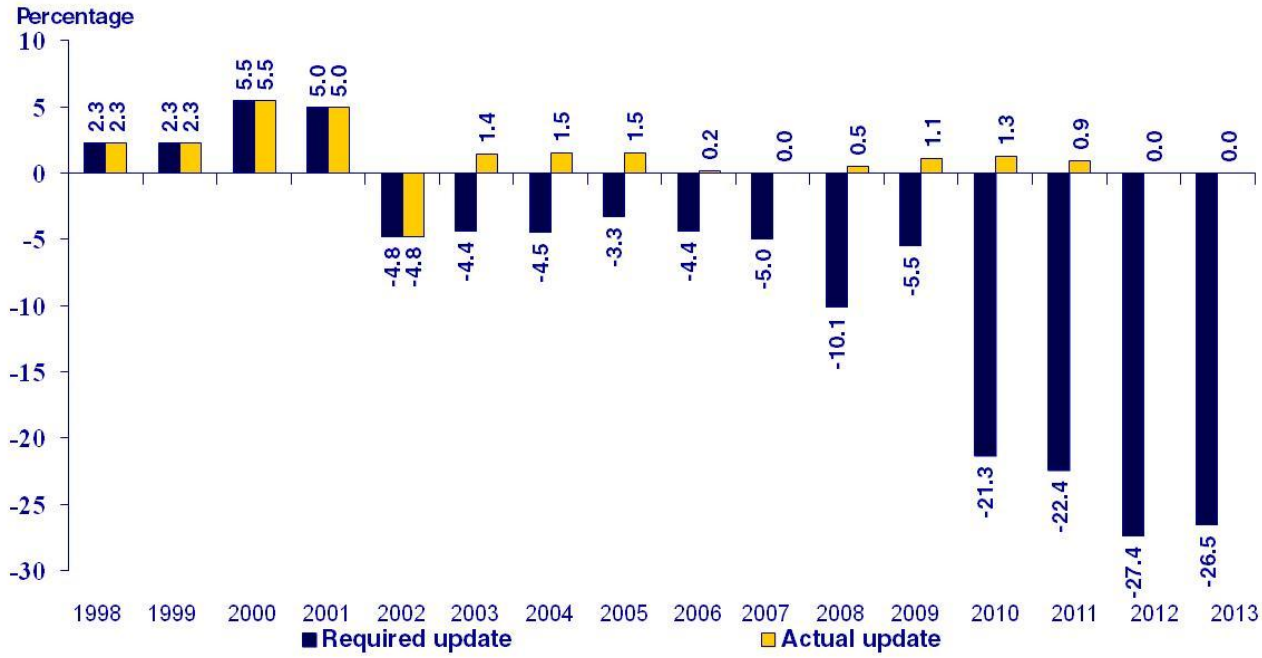
Thank you for inviting me here today to participate in your hearing on Medicare payment reform. I am Bruce Steinwald, head of a small consulting practice consisting of myself and a home office where I prepared this statement. For several years I was with the Government Accountability Office (GAO) Health Care Team where I directed many health care -related studies and testified before congressional committees on Medicare payment and health care spending issues. This work includes several studies, testimonies, and presentations on Medicare's Sustainable Growth Rate (SGR) system for controlling spending on physician services under Medicare Part B.

In my remarks today I will emphasize three points. First, while the circumstances may be favorable for finally doing away with the SGR, the problem that SGR was designed to address, excessive spending under the Medicare fee schedule, will not go away by itself. Second, this problem arises from the very powerful incentives to increase volume when services are paid for on a fee-for-service basis. Last, because the fee schedule and fee-for-service payment are likely to be with us for some time, policies need to be developed that encourage providers to elevate value as the chief criterion for determining which services are performed.

LOOKING BACKWARD

Much has been written about how the Medicare Fee Schedule (MFS) and the SGR were designed to work together.[i] Rather than review this material, I begin with a graphic representing how the SGR has not worked. Chart 1 shows the history of MFS payment updates since the late 1990s.

Chart 1: Actual Updates compared to Required Updates, 1998-2013

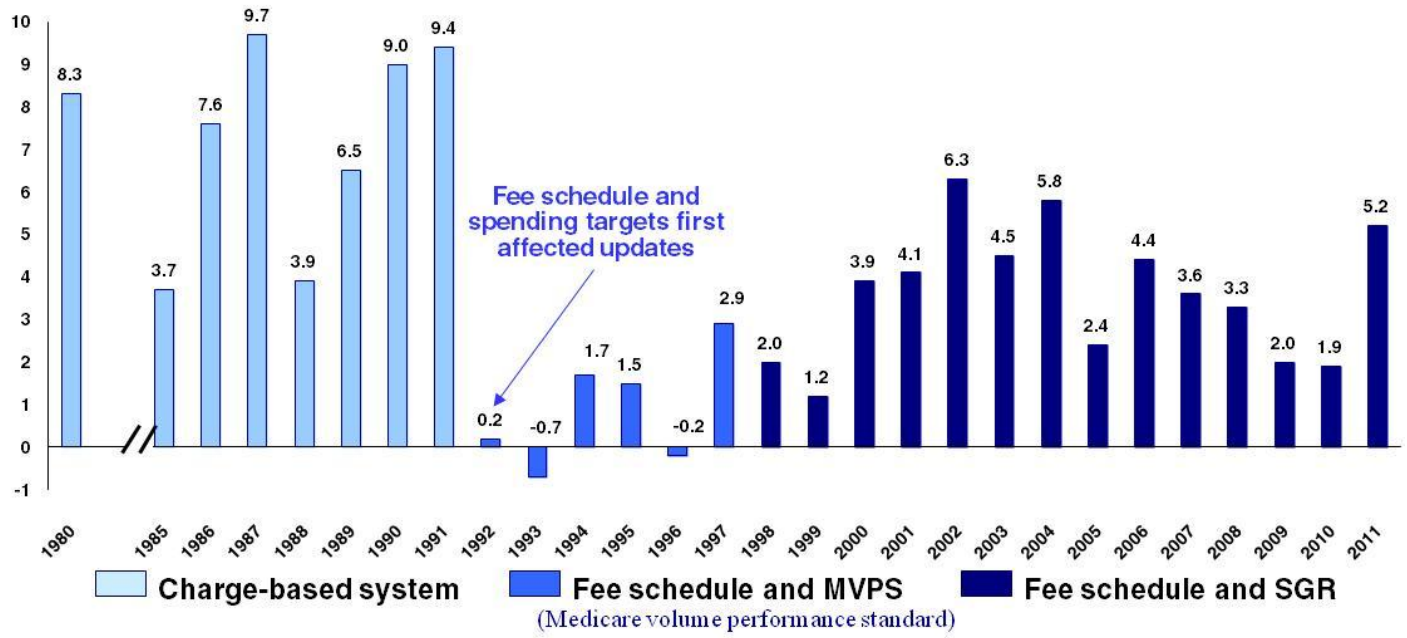



Source: Data from the Medicare Boards of Trustees and CMS Office of the Actuary *(as cited in J. Farb's February 2013 presentation at the National Health Policy Forum)*
Notes: Beginning with 2008, required updates are a result of both the SGR formula and legislative changes. The physician updates for 2010 and 2011 reflect the impact of the two different updates that were effective during parts of 2010. For January through May 2010, the physician update was 0 percent. For June through December 2010, the physician update was 2.2 percent.

The SGR appeared to work as intended at first but, because MFS spending exceeded the SGR target, fees were reduced by about 5 percent in 2002, and the SGR would have required further reductions in subsequent years. Since 2003, not wanting to jeopardize beneficiary access to physician services, which overall has been excellent, Congress has acted to prevent the SGR from further reducing Medicare fees in every year up to and including 2013. This annual ritual of kicking the can down the road has been a major annoyance for both the Congress and doctors who participate in the Medicare program.

While we can all agree that the SGR has not worked as intended, it is worth reviewing why this policy was adopted as a cost containment measure in the first place. Chart 2 shows the trends in spending increases attributable to increases in the volume and intensity (or complexity) of physician services furnished to Medicare beneficiaries over the 1980 to 2011 period.[ii]

Chart 2: Growth in Volume and Intensity of Medicare Physician Services Per FFS Beneficiary, 1980-2011




Source: Data from the Medicare Boards of Trustees *(as cited in J. Farb's February 2013 presentation at the National Health Policy Forum)*

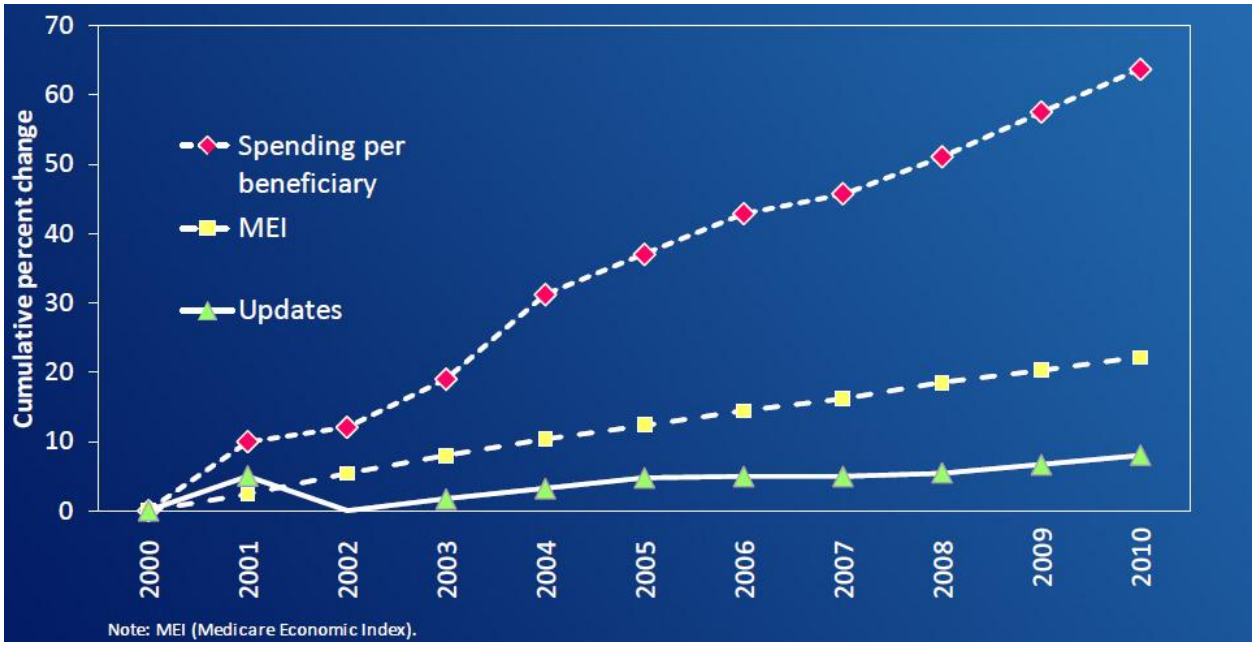
During the 1980s and early 1990s, when Medicare used a "Customary-Prevailing – Reasonable" method of setting physician fees, volume and associated spending increased rapidly. Clearly, something needed to be done, and it was. When the resource-based relative value Medicare fee schedule was installed in 1992, along with the SGR predecessor target system to control spending increases, the Medicare Volume Performance Standards (MVPS), the problem appeared to be licked – for a while. Throughout the remainder of the 1990s volume growth was moderate. Indeed, although it is hard to believe in the present, one of the reasons that SGR replaced MVPS was to provide physicians more upside in fee increases as a reward for limiting volume increases.

At the beginning of the 21st century, spending increases associated with rising volume began trending upward again – not as much as in the 1980s, but still

enough to trigger payment decreases under the SGR formula. The allowance above inflation in the cost of running a medical practice was set at real growth in Gross Domestic Product.[iii] Thus, whenever volume growth generated spending increases exceeding about 2.4 percent, SGR was bound to put the squeeze on fees. As you can see, while volume growth did not exceed this threshold in every year, the average growth exceeded real GDP growth substantially during this period.

My final chart, from MedPAC, shows the relationship between Medicare fee updates, inflation in the cost of running a medical practice, and Medicare spending per fee-for-service per beneficiary during the first decade of this century. Looking at Chart 3, one can certainly sympathize with physicians whose practices provided a constant flow of services, because the very modest increase in fee levels during this period was not enough to keep up with inflation in input prices physicians paid, on average, to run their practices.

Chart 3: Increased Volume Growth has Impacted Physician Spending More than Input Prices and Payment Updates, 2000-2010




Source: MedPAC, June 2012 Databook

However, there are many other physicians who have prospered from increasing the volume and complexity of services, generating additional income even when fees were constant. In my view, the greatest defect of SGR has been its treatment of all physicians the same, regardless of their individual contributions to Medicare's spending problem.

LOOKING AHEAD

While there have been many calls for repealing SGR since 2002, and many Congressional hearings oriented to this outcome, circumstances today may be more favorable for finally doing away with SGR than they have been in the past. I leave it to others to delineate the specific characteristics of Medicare payment policy without the looming specter of SGR, but here are a few observations of current conditions that appear to favor reform in physician payment.

*Widespread acceptance of the need to replace volume incentives with value incentives*—For decades there has been a reluctance to accept cost as a legitimate concern in coverage and payment policy. While Medicare has a long way to go to incorporate this concern, the policy world at least seems to recognize that open-ended fee-for-service reimbursement is a major impediment to achieving value objectives.

*Involvement of the medical profession in reforming physician payment* –For many years the medical profession has been staunchly in favor of repeal of SGR without being willing, in my view, to offer a *quid pro quo*.[iv] This appears to be changing as many medical organizations have shown leadership in encouraging physicians to adopt value-based criteria. I am especially impressed, for example, in the voluntary participation of specialty societies to encourage limitation of certain inappropriate and unnecessary procedures as indicated by the Choosing Wisely Campaign.

*Growing capability to make data-driven decisions on coverage and payment* – For decades health policy analysts have lamented the fact that airlines and other industries have used information technology to improve safety and efficiency in their industries, but not health care. Now, largely driven by federal policy, there has been a substantial increase in investment in the data infrastructure at the

individual provider level (e.g., electronic health records) and national level (e.g., Patient-Centered Outcomes Research Institute). Medicare coverage and payment policy may need to be adjusted to take full advantage of this growing capability.

*Activity on the reform front* – While there is never a shortage of reform proposals, this appears to be an especially fertile period of both experimentation in the health care delivery system, much (but not all) financed through federal research dollars, and in serious proposals to restructure Medicare. The SGR "doc-fix" problem has become so prominent that it is included in Simpson-Bowles and all major budget reform proposals.

*Lower score* – No Medicare reforms can be implemented without observance of the net cost to the federal government, the "score" estimated by the Congressional Budget Office (CBO), over a 10-year budget window, which is a major reason why SGR has not been eliminated already. Unexpectedly, the estimated 10-year cost of repealing SGR and replacing it with a fee freeze was reduced by CBO from $243.7 B in November 2012 to $138.0 B in February 2013. It is uncertain whether the cost of repealing SGR will be "on sale" indefinitely, but the lower score makes repeal more attractive (or, at least, less unattractive) from the federal budget perspective.

## A POST-SGR MEDICARE WORLD

What will, or should, Medicare physician payment look like if SGR is repealed. When I was at GAO, I was often the "skunk at the picnic" in discussions of SGR's repeal. While I agree that SGR is problematic, to say the least, I also believe that Medicare fee-for-service spending would have been greater without SGR. Therefore, I was an opponent of repealing SGR without putting substitute controls in place. Here are three "shoulds" that I believe need to be incorporated in any strategy to accompany SGR's demise.

*The movement toward global payment systems should be encouraged to occur naturally for beneficiaries and physicians* – Several integrated delivery systems exist in all parts of the U.S., serving urban, suburban, and rural populations. At the same time, Accountable Care Organizations and other "hybrid" forms of health care delivery and financing are growing with support from federal

subsidies. These organizations have the capability of replacing or modifying the volume incentives of fee-for-service payment, which is a good thing. However, we don't want to repeat the mistakes of the 1980's managed care movement wherein many providers and beneficiaries believed they were being forced into systems they didn't choose voluntarily.[v] A reformed delivery and financing system that focuses on population health and value in service delivery should be attractive to beneficiaries and providers alike.

*The Medicare fee schedule, along with Medicare coverage policy, should be fine-tuned to reward value and discourage unnecessary utilization* – With the blunt instrument of SGR out of the way, Medicare could have greater opportunity to use its extensive data to make distinctions between high-value and low-value care. Some of these opportunities can be accomplished under current law, such as more bundling of services together for payment and profiling physicians' utilization patterns and providing feedback when utilization (suitably adjusted for patient risk) appears excessive. Others may require new legislation, such as requiring prior authorization for expensive diagnostic procedures or tiering beneficiary copayments according to service value (both of which are used extensively in the private sector). The Medicare fee schedule is likely to be with us for years, perhaps indefinitely in some areas. It needs to be, and can be, improved.

*Policy makers should never underestimate the incentives of fee-for-service payment to generate more volume and spending* – Because spending increases in health care generally have been at low levels for the past few years, it is tempting to conclude that the "pressure is off" to limit spending.[vi] I remind you that this was the situation during the 1990s when the SGR was born. It would be a supreme irony if SGR died during a similar low-spending period, only to have physician spending ramp up again in the absence of effective controls. In addition to making sure there are attractive alternative systems for physicians to go to that, for example, offer salaried employment, there is nothing wrong with ensuring that fee-for-service practice is attractive to leave.

In conclusion, I believe the post-SGR world should be one of decreasing reliance on fee-for-service payment but with effective controls in place to ensure that

value, not volume, is rewarded by the Medicare fee schedule. This may encourage some physicians to seek alternative delivery settings, thereby providing a boost to the reform movement.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or Committee members may have.

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[i] See, for example B. Steinwald, "Medicare's Sustainable Growth Rate," National Health Policy Forum, The Basics, June 21, 2011.

[ii] Volume refers to the number of services and intensity or complexity refers to the resources required to perform a particular service. For example, the number of imaging studies performed per 1000 beneficiaries has increased, and the proportion of such studies using advanced imaging technology, such as Magnetic Resonance Imaging, has also increased. Thus, in this case both the volume and complexity of services have increased.

[iii] The law actually uses a 10-year moving average of real GDP growth to minimize year-to-year fluctuations.

[iv] I realize this is a gross oversimplification and I apologize to the many individual physicians and medical organizations that have advocated fundamental reforms for many years.

[v] Another gross oversimplification -- for an analysis of the failure of the managed care movement, see, for example, JC Robinson, "The End of Managed Care," *JAMA* 285:20, May 23/30, 2001.

[vi] See, for example, DM Cutler and NR Sahni, "If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off By $770 Billion," *Health Affairs* 32:5, May 2013.