Prepared Statement for the Senate Finance Committee, Roundtable on Medicare Physician Payment

Medicare Physician Payments: Understanding the Past So We Can Envision the Future

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Thank you for the opportunity to participate in this roundtable on the critical issue of Medicare physician payment – how we got here, and where we can go from here. This is centrally important for real health care reform, because physicians and the health professionals who work with them are the linchpin of our health care system. The support they receive influences everything – how and how well they are able to meet patients' needs, the quality of care, and the overall costs of health care.

Two previous bipartisan legislative efforts form the foundation of the current SGR problem. The first, legislation creating the Resource Based Relative Value Scale (RBRVS), was enacted in 1989. It led to the development of "relative value units" for each of the physician-related services paid for in the traditional Medicare program. This in turn led to an extensive regulatory process, initially to develop RVU weights and subsequently to keep them up to date, for over ten thousand specific activities. The goal of this effort was for the (relative) payments made by Medicare to accurately reflect the value of services. Not surprisingly, this system has always been marked by differences in views about how different kinds of services should be valued (for example, "cognitive" services like spending time diagnosing and advising a patient, versus technical services like performing a procedure or a scan). It is also difficult to keep all these relative values up to date as medical technology advances and expands. Perhaps most importantly, new services such as email consultations and new approaches to care such as nurse-

or pharmacist-led care management teams may not be included at all in the list of covered services. Or services may not be paid in proportion to their value. For example, a new diagnostic procedure that enables a physician to determine which patients will benefit from a costly drug or major operation will be "valued" at the cost of tests with similar inputs or measured effort, even though the value of this test to the patient who receives it may be far higher. RBRVS also assigns the same value to a service regardless of whether it is of lifesaving value for a patient, or little or no value at all. This matters as we head into an era of more personalized medicine, where the right treatment at the right time for each patient is increasingly individualized- where some patients with heart disease may benefit from a certain imaging procedure but others may not, and where some patients with breast cancer may benefit from a combination of chemotherapy treatments and others may do much better with other regimens. So, it's not really a "relative value" system so much as a "relative estimated average cost" system.

With the goal of controlling costs more effectively, the 1997 Balanced Budget Act linked the conversion of the relative value units to actual physician payment each year based on a national target growth rate – the "sustainable growth rate" or SGR. The SGR was intended to keep the growth in Medicare physician-related spending per beneficiary in line with growth in the nation's gross domestic product (GDP). In the early years of the SGR, when spending growth was lower than the GDP growth target, payment rates for physician services increased. But starting with the recession in 2002, spending growth per beneficiary began to exceed GDP growth. In 2002, payment rates were reduced accordingly, by 4.8 percent.

Every year since then, the SGR payment rate reductions have not taken full effect. Instead, because of concerns about access to care and the sufficiency of payments, Congress has headed off the full payment reductions on a short-term basis. Typically, this has involved offsetting at

least some of the budgetary costs with payment reductions affecting other Medicare providers. And these short-term patches have not kept up with inflation: between 2000 and 2010, the total cumulative increase in physician payment rates in the Physician Fee Schedule was 8%, while the "market basket" for physician services (the Medicare Economic Index) rose 22%.

Setting aside the problems for access and quality of care, one might argue that so long as Congress offsets these short-term fixes, at least there is no adverse budgetary impact. But because so much legislative effort ends up being devoted year after year to these stopgap measures, both physician organizations and Congress have much less opportunity to focus on reforms that could support real, physician-led improvements in care that reduce long-term costs. With each patch, actual Medicare physician spending moves farther and farther from the SGR target. Prior to a series of patches in 2011, the SGR projected payment decrease was 25%. In 2012, the payment rate reduction would have been 27.4% and in 2013, it is projected to be 27%. It's taking more and more money and more and more effort to do the short-term patches.

Medicare spending accounts for roughly 3.5 percent of GDP. Even with the scheduled SGR reductions and reductions in market basket updates for other types of Medicare providers enacted in the Affordable Care Act, Medicare expenditures are projected to surpass 5% of GDP by 2030. Medicare physician spending is only 12% of these costs, yet physician decisions influence over 80% of health care spending. Instead of trying to achieve overall cost savings by disproportionately squeezing physician rates, or by increasingly trying to "spread the cuts" across other providers facing tighter and tighter payment rates, this legislative effort might be better devoted to identifying changes in how physicians are paid in Medicare – focusing on opportunities for improving care – that could lead to overall cost savings by promoting needed changes in how health care is delivered.

As you know, the goal of changing how physicians are paid in Medicare and getting out of the cycle of SGR patching has long been a bipartisan goal in Congress. I had the privilege of testifying on this topic six years ago, when I was CMS Administrator. I noted that if Medicare could implement physician payment reforms that better align payments with the care that physicians know can lead to better quality and lower overall costs, we could both relieve the financial pressure on physicians and get some of the savings needed to make the overall Medicare program more sustainable. Since then, two things have happened. The need to reform the SGR in a way that helps achieve overall Medicare cost savings has vastly increased. And the opportunities for doing so have become clearer. Thanks to the early attention and leadership from the Finance Committee and other members of Congress from both political parties, this year may be different; it may be the year when real alternatives to the SGR system emerge.

I believe that several steps are needed for that to happen. The first critical step is leadership from the physician community. Needed physician payment reform should support real health care reform, and no one knows better than physicians and other clinicians about how to answer the key question: where are the best opportunities to improve care and avoid unnecessary costs for their Medicare patients that are not well supported by Medicare's current payment systems? Every day, physicians and health care professionals see opportunities to improve the value of care, but the way that Medicare pays often works against them. They know best which services are reimbursed that may be of little value to particular patients; and they see the services that aren't reimbursed much if at all that may be tremendously valuable in preventing costly complications. Despite knowing this from their practices, clinicians can't implement the changes in care needed to improve quality while lowering costs, while still making ends meet in their practice. Or at the very least, it's becoming increasingly difficult to do so with tighter and tighter

regulated payments. So by saying that clinical leadership is needed to get out of this cycle, I mean physicians and other clinicians must identify ways that, in aggregate, could add up to meaningful system-wide savings.

The second step closely follows the first: translating the clinical opportunities for improving care into Medicare payment reforms that better support high-quality, patient-centered care. This means identifying the current payment rules in the fee-for-service/RBRVS system that, however well-meaning, don't do as much as they could to help promote the kind of efficient, high-quality care that physicians would like to provide – care that emphasizes prevention, getting the right treatment to the right patient the first time, and coordinating a patient's care more effectively.

As I noted, I think the opportunities for doing this are better than ever, thanks to the growing examples of clinical leadership that is using payment reform to support care improvements all over the country. At the Engelberg Center for Health Care Reform at Brookings, we have been working with a number of clinical groups and medical professional societies who are earnestly engaged in these types of real reform despite the obstacles.

For example, the American Society of Clinical Oncologists and many of their affiliated oncologists have been developing ideas on how to provide more time and resources for making sure that their cancer patients get the best care for their needs based on the latest medical evidence, and that complications leading to emergency room visits and hospitalizations are prevented, by shifting how they are reimbursed. Currently, oncologists treating Medicare patients have to cover a large part of practice costs using the margin between what it costs them to obtain chemotherapy drugs and what Medicare pays to administer them. At the same time, oncology practices get relatively little support for doing many of the things that their patients need, things

like spending time working out a treatment plan that meets each patient's individual needs; managing patient symptoms; and coordinating care across a diverse range of providers. The reform effort here involves identifying ways to shift some of the payments currently provided through the drug administration margin toward payments that are more directly tied to what the oncologists and their patients want – better evidenced-based care, more resources for managing individual patient needs and preventing complications. This might include extended nurse hours, greater availability to consult with patients who might otherwise progress to needing an emergency room or hospitalization, working out an individualized treatment plan with each patient, and many other areas. Several pilot payment reforms have been implemented, including bundled payments for chemotherapy episodes that are no longer tied to giving more intensive chemotherapy and increasing drug margins; instead, the bundled payment provides support for the treatment protocols that the physicians determine are most appropriate, and is tied to a set of quality measures that support oncologists in focusing more on getting their patients the care they most need.

As another example, cardiologists around the country and the American College of Cardiology are taking steps to identify and better support high-quality care for cardiovascular diseases. Clinically informed payment reforms involve both chronic conditions such as congestive heart failure, and aspects of care where cardiologists have identified unnecessary or inappropriate care. Payment reforms such as bundling a limited portion of the fee-for-service payments for these types of procedures could give cardiologists better financial support for setting up registries for tracking their patients, coordinating care, and avoiding the need for high-cost interventions as well as preventable complications. Cardiologists are also exploring care coordination models for patients with chronic cardiac conditions, where cardiologists and primary care doctors together

can share in the savings for coordinating the care, promoting shifts in care to lower-cost settings, the use of "tele-consults" and other electronically-supported consultations where appropriate, avoiding referrals that can be handled in primary care settings, avoiding unnecessary or redundant imaging, and promoting more rapid and efficient referral and treatment of higher-risk patients.

Many other medical specialties are also working on innovative approaches to payment reforms linked to opportunities to improve care in their clinical areas. Nephrology is actively working to build on bundled payments for ESRD, such as payment reforms that promote better vascular access with fewer complications, and exploring options for patients with chronic renal insufficiency. Surgeons are learning from and refining bundled payment reforms for common surgical procedures in ways that make it easier to implement reforms that prevent complications, improve transitions, and reduce readmissions. Radiologists and pathologists are working to better define their role in the provision of certain services in a range of clinical areas, doing much more than reading and interpreting tests, for example participating actively in coordinated-care teams to help patients get the right tests as quickly and efficiently as possible.

Along with these expanding efforts across a diverse and growing range of medical specialties, thanks to leadership in primary care, we also have a rapidly improving knowledge base for Medicare payment reforms affecting primary care services. Many "medical home" reforms have already started shifting primary care payments away from traditional fee-for-service payments, which have been squeezed to become less and less adequate to support managing each patient's needs. The medical homes are moving toward payments that are more related to higher-quality primary care and care coordination. For example, our Brookings-Dartmouth Accountable Care Organization Learning Network is working with a number of organizations who are linking

medical homes with accountability for achieving better population health and lower overall care costs. These reforms give primary care providers the kind of financial support that reflects their central role in achieving better outcomes for the population of patients that they serve; in these payment reforms, a one- or two- percentage-point savings in overall health care costs resulting from better primary care and care coordination translates into a much larger percentage improvement in the resources available to primary care providers to achieve the savings. That's the right kind of payment reform leverage: even limited changes in how physicians are paid can have a disproportionate impact on overall health care costs, because what physicians do is so important for overall health care costs.

Many of the most promising examples that we have seen in supporting better care with reformed physician payment share several common elements. First, they don't simply hope for savings to materialize: physicians involved in these payment reforms take some portion of payment out of the current fee-for-services structure and convert it to payments that they can more easily use to provide the care that their patients need. Within a clinical area, whether primary care or specialty care, this means moving at least a small piece of fee-for-service payments into a "case management" or per-patient payment related to the clinical goals of better quality and better outcomes. Case management payments allow flexibility for physicians to invest in clinical practices and infrastructure that maximizes their ability to treat patients in clinically appropriate ways while not reducing their income due to the reductions in billable procedures that would otherwise occur. Across different kinds of clinical care, some fee-for-service payments may also be moved into "care coordination" payments to better support the providers working together, for example primary care physicians and oncologists, or cardiologists and radiologists. Care coordination payments on the other hand allow for tighter collaboration and information sharing

between physicians and provider settings for complex patients with chronic and other complex conditions. Cancer patients, ESRD patients, CHF patients and patients with multiple chronic conditions require careful attention to coordination among the specialists providing their care in order to minimize costly complications, redundant or unnecessary tests, and other care breakdowns. A care coordination payment model that takes a portion of the existing fee-for-service payment to the different providers and redirects it to support this coordination makes it easier for providers to work together to improve care, and thus lower overall costs. By shifting physician payments in the directions that physicians have identified as having the most promise to improve care, both within their specialty and through better coordination across specialties, physicians can be protected financially while getting more support for doing what they think is most important for their patients.

Second, to the extent that these reforms in payment lead to improvements in care and resulting overall cost savings, total physician compensation can increase in an actuarially sound manner. Medicare and private payers are currently implementing many "shared savings" outside of the physician payment context that enable providers to get more financial support when they take steps that lower overall costs. Building on the work to date, the steps described here can give physicians the support they need to improve care. Under the fee-for-service SGR system today, physicians not only get little support for the improvements in care described here; instead, their payment rates get reduced no matter what they do. With these reforms, providers who take steps to improve care in conjunction with these payment reforms can get paid more.

I've been focusing on physician leadership in, first, identifying opportunities in their specialty and across specialties for improving care, and second, matching these opportunities to reforms in Medicare's physician payment system. That is the best foundation for improvements in care that

can help reduce cost pressures in Medicare. I want to conclude by thanking you for your leadership on addressing this challenge; this is also an essential step in reforming the SGR. By starting now, and by working on a bipartisan basis to avoid another cycle of short-term SGR patches, it is possible to turn these opportunities into real Medicare reform. Thank you for the opportunity to participate in today's roundtable, which is addressing one of the most important issues for effective health care reform.