# Testimony Before the Senate Finance Committee

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

Tom Scully, HCFA/CMS Administrator May 2001-January 2004

The Medicare Volume Performance Standards (MVPS) and its successor the Sustainable Growth Rate (SGR) have been: (a) a success in that it is the only legislative and regulatory attempt in the last 40 years to track and react to growing Part B physician related services; and (b) a disaster in that its worthy goals have proven unworkable for both Congress and CMS, and created an unfair burden for individual physicians who are subjected (unlike any other part of Medicare) to global caps driven by nationwide physician behavior that they have no ability to impact or control.

In the Administration of President George HW Bush I was intensely involved in the effort to pass the initial RBRVS/MVPS legislation in 1989. I still believe it was a worthy, but flawed, effort that was done with the best of policy intentions. I have attempted to give a brief historical overview before getting into policy issues.

## Historical Points

1989- Passage of the Resource Based Relative Value Scale (RBRVS) was a very bipartisan affair. Medicare Part B spending was projected to grow at 15% a year (under the old "cost" payment system) as President George HW Bush began his Presidency, with a Congress that had large Democratic majorities in both the House and Senate. Part B reform topped the health care agenda, with a proposal from Harvard Professor William Hsiao (RBRVS) leading the debate around reforming and restricting physician payment.

In the House, Ways and Means Chairman Rostenkowski, and Health Subcommittee Chair Stark were in favor of reform, but wary. Subcommittee Ranking Member Gradison was a supporter, but the bulk of Republicans initially supported the AMA in opposing the RBRVS reforms.

In the Senate Democrats, including Finance Committee Chairman Bentsen, were also warily supportive, as were Minority Leader Dole, and Ranking Finance Republican Packwood. But the Senate bipartisan effort was really led by Finance Committee members Senator Rockefeller and Senator Durenberger.

The Administration team was Dr. Bill Roper (now Dean of the UNC Health System), also a former HCFA Administrator under President Reagan, and at that time Deputy Assistant to the President for Domestic Policy; and me -- then the Associate Director of OMB for

Human Resources, Veterans and Labor. Nick Calio, then in WH Legislative affairs, was also very involved in the Congressional effort.

The AMA and most other specialty groups aggressively opposed RBRVS from the start—deeming them "Expenditure Targets" and flooded the Capitol with "No ET" buttons—and consistent opposition all through the Spring. In March, Democrats were wary and most Republicans were fundamentally opposed. President Bush had good relations with the Democratic Congress—especially Chairman Rostenkowski, and they both wanted physician payment reform. The White House was told that Democrats would support RBRVS—if at least half the GOP members on each of Finance and Ways and Means supported it. We worked through months of hearings and markups, garnering the needed Republican support in both Committees. It passed, with considerable effort by leaders in both parties, over the very agitated opposition of America's doctors, in the summer of 1989. It was a model of legislative cooperation and compromise. If only the policy had been sound!

Still it was a considerable improvement over the prior, even more flawed system.

1992- Implementation. It was a complex piece of regulation, and HCFA at the time did not have the staff resources to evaluate and assign weights to various services and practice expenses. Additionally, the very capable HCFA Administrator—Gail Wilensky-- left HCFA in February 1992 to join the White House staff. As I remember it, the then Acting Administrator, a career HCFA regional director, understandably concerned about the complex assignment facing the agency, turned to the AMA for help.

As a result, from the beginning AMA's Resource Value Update Committee (RUC) took a central role from the start in assigning weights and making recommendations on payments in Medicare. Bruce Vladeck and Gail may remember it differently-- but by the time Bruce came to HCFA a year later, in 1993, the RUC was firmly imbedded in the process.

You can't blame the AMA. They were doing a good job for their members by taking over the process. But it was a fundamental error for HCFA to delegate that authority—because the RUC quickly became very powerful, very political and very responsive to the stronger specialty groups, and many believe it limited the ability of the RBRVS/SGR system to make appropriate changes.

1992-97- The MVPS system had its flaws, and relatively few teeth. From 1992-97 it worked reasonably well, and spending and performance generally stayed within the parameters of the system. Still the deficit grew, and pressure mounted for Medicare spending reductions.

1997- In another bipartisan budget deal, President Clinton and Congress made large "cuts" in Medicare spending. Hospitals, nursing homes and home health were hit particularly hard-- causing chaos in each sector. Congress spent much of the next 4 years

adding back funding to each of these sectors—and the ’97 budget bill was the hardest in this generation on providers.

The AMA and physician groups, early in that process, offered to Congress that their “contribution” to deficit reduction would be tightening the RBRVS system (the resulting new formula was the Sustainable Growth Rate). They swapped long term reform—giving the SGR teeth—for avoiding the immediate cuts that hammered other providers. It looked like a great call at the time, but it directly caused the messy situation of the last 15 years. Of course service volume growth and GDP growth contributed mightily—but only physician spending was subject to the “spending target and automatic cut” mechanism.

2002- The SGR hits for the first time. Unfortunately, I was the Administrator at the time. There were many efforts to fix the formula in Congress, but none proceeded—so there actually was a 4.8% reduction in payments in 2002, as dictated by the SGR formula. The unhappiness created by that cut generated the pressure to defer all subsequent SGR cuts—and the budgetary hole the system now faces.

2010- Part B drug spending was taken out of the SGR administratively. It helped relieve the pressure a bit, but not much. I was always amazed at the structure HCFA adopted in 1992, that RBRVS/SGR measured drug spend—but penalized only physicians when the drug spend accelerated? Instead of removing drugs, one could argue that Part B drugs should have been subjected to some other restraint mechanism.

Regulatory Structure—AMA and the RUC

From its inception, HCFA delegated most of the relative value discussion to the RUC. Traditionally, 95% plus of the RUC suggestions were followed, simply because HCFA did not have the staff resources to replicate what the RUC process could do, and because the AMA and specialty groups became so vested in it. The RUC became far more than advisory. It has become very political, and the AMA’s role has given it far too much leverage in the medical professions, and the power it wields has made any significant change difficult.

In a 2010 New England Journal article, Paul Ginsburg stated that:

> in the 2002 five year review, 900 codes were identified [of about 6500] as improperly valued. 750 were reviewed – and 477 went up, and only 28 went down.

This outcome is not shocking, in fact it is understandable. Doctors were stuck in a finite, budget neutral “shark tank.” Every new code added, or procedure that was increased had

to come from the hide of another procedure or specialty. So increasing primary care values had to be offset from surgeons or radiologists, etc—not an easy thing to do in the UN of Medicare physician payment.

Changing or dropping the SGR is essential. Still, removing the structure of the SGR may also relieve any sense of Part B discipline if it is not replaced with some other structure. Unless the system is well designed, is every new code and procedure a new expense that is not offset? If a value goes up, must another go down? Retaining some sense of budget discipline in the system is critical, or inevitably there will be bigger and less surgical cuts to restrain volume and spending.

The RUC serves an essential purpose in evaluating services. But in any reformed system it should be removed from the AMA and operate as an independent body, likely through a contractor reporting to CMS directly. The current structure is far too political and the existing structure makes objective assessment and reallocation almost impossible.

Under the current administration, it appears that CMS is asserting itself more, especially through Jon Blum, the Deputy Administrator for Medicare, to make the RUC truly "advisory", and they should be congratulated for that effort. CMS and objectivity should be driving valuations, not physician politics.

Other Policy Suggestions

MedPAC recommendations here are hard to disagree with, though obviously any "fix" is painful to physicians due to future freezes and cuts—and costly due to the needed "offsets". As MedPAC itself said (March 2012. Pg 87):

> the Commission stressed that Medicare must ultimately implement payment policies that shift providers away from FFS and toward payment policies… that reward improvements in quality, efficiency and care coordination- particularly for chronic conditions. Accordingly the Commission recommended incentives in Medicare's accountable care organization program to accelerate this shift because new payment models- distinct from FFS and SGR- may have greater potential to slow volume growth while also improving care quality. Similarly, incentives for physicians and health professionals to participate in the newly established Medicare bundling pilot projects could also improve efficiency across sectors of care.

AMEN!

Clearly "bundling" of services is the future. Pure fee for service reimbursement simply can't be expected to change behavior or to drive better results. There are a few obvious courses to take that should be accelerated:

- Accountable Care Organizations, ACOs. Are a great idea, if designed properly, and they are already changing the market and the way physicians look at care delivery. Not just in Medicare, but in commercial markets, physicians are again organizing to take risk—and to look at comprehensive patient care. It may be a small step—but a good one. The model has been there in California and elsewhere for years—and it is the only obvious answer: get physicians invested in the entire care system.

- Acute Care Episode (ACE) program. This demo combines hospital and physician services in the acute care setting, bundling doctor and hospital payments. It clearly works, saves money for Medicare while increasing compensation for the doctors and margin for the hospitals. It should be rapidly expanded.

- Post-Acute Bundling. It is evolving with CMS demos, and it is inevitable that global capitation, or a post-acute DRGs are coming in the near future. For doctors, this must include folding Part B reimbursement into these bundles. This will align their incentives with their post-acute provider partners. These costs are predictable, and CMS should move away from physician FFS in these settings and toward global post-acute capitation.

- ESRD Bundling. Dialysis patients see a provider 3 times a week—for 3-4 hours. No other patients encounter providers as often. Bundling ALL services an ESRD patient gets, including physicians, into a capitated plan, makes complete sense, and it is the most readily available bundle there is.

Medicare Advantage—The Ultimate Bundle. If you: (a) bundle pre-acute care; (b) bundle acute care and (c) bundle post-acute care; and combine them all into one bundle—you get Medicare Advantage? This bundle travels under other names-- The Federal Employee Health Benefits Plan (FEHB) and TRICARE. Medicare Advantage has its flaws, but private insurers and systems, when (1) appropriately paid and (2) well regulated can coordinate care to reduce volume and drive better behavior and performance. As Senator Wyden has discussed, a well-structured Medicare exchange that assures appropriate benefits can indeed provide better value.

From a Medicare budgeting perspective, the essential concept is to provide the right incentives to deliver more efficient care at reduced costs. Medicare Part D has accomplished this—and it can also be done in the broader program.

Medicare FFS: Today only 25% of beneficiaries are in Medicare Advantage, and I know I will be long gone before Medicare FFS is? So, we must make Medicare FFS work as effectively as possible as the program modernizes. Thus, redesigning a new RBRVS/SGR system to "make the trains run on time" as we gradually move to bundling and capitation, is one the critical challenges facing Congress—and the doctors and patients you represent.

As a die-hard capitalist, I honestly believe that well regulated private plans and systems will deliver these benefits most efficiently. Yet, I care deeply about the Medicare program and the vulnerable beneficiaries that it protects. Therefore I am also concerned that the next generation of Medicare FFS be well designed to maximize the level of services available to the majority of beneficiaries that will remain in the traditional program for years to come.