TESTIMONY

# Medicare payments to physicians

February 10, 2005

Statement of
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Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

DRAFT February 7, 2005 (3:57pm)

Chairman Johnson, Congressman Stark, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss payments for physician services in the Medicare program.

Medicare expenditures for physician services are the product of the number of services provided, the type of service, and the price per unit of service. The number and type of services provided we refer to as service volume. The sustainable growth rate (SGR) system was meant to control the volume of physician services and hence total expenditures for physician services by setting the update (change in unit payment for the year) for physician services. The SGR is based on changes in: the number of beneficiaries in the Medicare fee-for-service program; input prices; law and regulation; and gross domestic product (GDP). The GDP, the measure of goods and services produced in the United States, is used as a benchmark of how much growth in volume society can afford. The basic SGR mechanism is to compare actual spending to target spending and adjust the update when there is a mismatch.

The SGR approach has three basic problems.

- It disconnects payment from the cost of producing services. The formula produces updates that can be unrelated to changes in the cost of producing physician services and other factors that should inform the update. If left alone, negative updates would provide a budget control but in so doing would produce fees that in the long run could threaten beneficiaries' access.
- It is a flawed volume control mechanism. Because it is a national target, there is no incentive for individual physicians to control volume. There has been no consistent relationship between updates and volume growth, and the volume of services and level of spending are still increasing rapidly.
- It is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume influencing behavior.
- It treats all volume increases the same, whether they are desirable or not.

The SGR formula has produced updates that in some years have been too high and in others too low. MedPAC has consistently raised concerns about the SGR—when it has set updates both above and below the change in input prices. The current projection, according to the trustees of the Medicare trust funds, is that annual updates of negative five percent will occur for seven consecutive years. The trustees characterize this series of updates as "unrealistically low" and in terms of budget scoring, these projections make legislative alternatives to the SGR very expensive.

Instead of relying on a formula, MedPAC recommends a different course—one that involves explicit consideration of Medicare program objectives and differentiating among physicians. Updates should be considered each year to ensure that payments for physician services are adequate to maintain Medicare beneficiaries' access to necessary high quality care. At the same time, the growth in the volume of physician services should be addressed directly. Volume and volume growth differs across geographic areas and by service and ultimately is the result of individual physician's practice decisions. Is all the care being provided necessary? Dartmouth

researchers and others have shown that often high quality care is not correlated with more services. We know the private sector is taking steps to control volume in services such as imaging with very high growth rates. Volume growth must be addressed by determining its root causes and specifying policy solutions. A formula such as the SGR that attempts to control volume through global payment changes treating all services and physicians alike will produce inequitable results.

In this testimony we will first review how the SGR came about and explain the problems with it. Then we will discuss our recommendations. First, a year-to-year evaluation of payment adequacy to determine the update. Second, approaches that would allow Medicare to differentiate among providers when making payments as a way to reduce inappropriate volume of services and improve the quality of care. Currently, Medicare pays providers the same regardless of their quality or use of resources. We recommend Medicare should pay more to physicians with higher quality performance and less to those with lower quality performance. With regard to imaging, a rapidly growing sector of physician services, the Commission recommends that providers who perform imaging studies and physicians who interpret them meet quality standards as a condition of Medicare payment. Further, the Commission recommends measuring physicians' use of Medicare resources when serving beneficiaries and providing information about practice patterns confidentially to physicians. This recognizes the unique role of physicians—who order tests, imaging studies, surgery, drugs—as gatekeepers of the health care system. These are all important steps to improve quality for beneficiaries and to lay the groundwork for obtaining better value in the Medicare program.

**Historical concerns about physician payment**

The Congress established the fee schedule that sets Medicare's payments for physician services as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89). As a replacement for the so-called customary, prevailing, and reasonable (CPR) payment method that existed previously, it was designed to achieve several goals. First, the fee schedule decoupled Medicare's payment rates and physicians' charges for services. This was intended to end an inflationary bias that was believed to exist under the CPR method because it gave physicians an incentive to raise their charges.

Second, the fee schedule corrected distortions in payments that had developed under the CPR method. Evidence of those distortions came from William Hsiao and his colleagues at Harvard University who found that payments were lower, relative to resource costs, for evaluation and management services but higher for imaging and laboratory services. Further evidence came from analyses, conducted by one of MedPAC's predecessor commissions, the Physician Payment Review Commission, that revealed wide variation in CPR-method payment rates by geographic area, that could not be explained by differences in practice costs.

A third element of the OBRA89 reforms is central to our testimony today. The legislation established a formula based on achievement of an expenditure target—the volume performance standard (VPS). This approach to payment updates was a response to rapid growth in Medicare spending for physician services driven by growth in the volume of those services. From 1980 through 1989, annual growth in spending per beneficiary, adjusted for inflation, ranged widely,

from a low of 1.3 percent to a high of 15.2 percent. The average annual growth rate was 8.0 percent.

Because of physicians' unique role in the health care system, the hope was that the VPS would give them a collective incentive to control the volume of services. Physicians order tests, imaging studies, surgery, drugs, and otherwise serve as gatekeepers of the health care system. In addition, the unit of payment in the fee schedule is quite small—over 7,000 discrete services.

Experience with the VPS formula showed that it had several methodological flaws that prevented it from operating as intended. Those problems prompted the Congress to replace it as part of the Balanced Budget Act of 1997. Under the SGR, the expenditure target is not a function of historical growth in the volume of services. Instead, the SGR target is based on growth in real GDP per capita and other factors—inflation in physicians' practice costs, changes in enrollment in fee-for-service Medicare, and changes in spending due to law and regulation. As noted, the real GDP factor was included in the SGR to link the expenditure target to growth in the national economy. This linkage was thought appropriate because volume growth for physician services is theoretically as unlimited as the demand for health care. Congress decided to link growth to GDP as a benchmark of what the U.S. economy could afford.

**The problem with the current update system**

The underlying assumption of an expenditure target approach, such as the SGR, is that increasing updates if overall volume is controlled, and decreasing updates if overall volume is not controlled, provides physicians nationally a collective incentive to control the volume of services. However, this assumption is incorrect because physicians do not respond to collective incentives but individual incentives. An efficient physician who reduces volume does not realize a proportional increase in payments. In fact, an individual physician has an incentive to increase volume under a fee for service system: moreover, there is evidence that physicians have increased volume in response to reductions in fees. The sum of those individual incentives will result in an increase in volume overall, if fees are reduced, and trigger an eventual further reduction in fees under an expenditure target.

Compounding the problem with the conceptual basis of the system, the SGR system has produced volatile updates. Updates went from increases in 2000 and 2001 of 5.4 percent and 4.5 percent, respectively, much larger than the increases in practice costs, to an unexpected large reduction in 2002 of 5.4 percent. This volatility illustrates the problem of trying to control spending with an update formula.

In the MMA, the Congress attempted to reduce the volatility problem. The GDP factor in the SGR is now a 10-year rolling average, which dampens the effects of yearly changes in GDP growth. However, there is another source of volatility which has not been controlled—estimating changes in enrollment in traditional fee-for-service Medicare. CMS may need to reestimate enrollment growth as it gains experience with shifts in enrollment from traditional Medicare to Medicare Advantage. Under the SGR, this could lead to continued volatility in spending targets and updates.

**A different approach to updating payments**
To address these problems, in our March 2002 report we recommended that the Congress replace the SGR system for calculating an annual update with one based on factors influencing the unit costs of efficiently providing physician services. Replacing the SGR system could allow updates more consistent with efficiency and quality care and would also uncouple payment updates from spending control. If total spending for physician services needs to be controlled, it is necessary to look not only at adjusting payment updates, but at controlling volume growth directly—as discussed in the next section.

A new system should update payments for physician services based on an analysis of payment adequacy which would include the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity. Updates would not be automatic (required in statute) but be informed by changes in beneficiaries' access to physician services, the quality of services being provided, the appropriateness of cost increases, and other factors, similar to those MedPAC takes into account when considering updates for other Medicare payment systems. Furthermore, the reality is that in any given year Medicare might need to exercise budget restraints and MedPAC's analysis would serve as one input to Congress's decision making process.

For example, we use this approach in our recommendation on the physician payment update in our March report to the Congress. Our assessment is that Medicare beneficiaries' access to physician care, the supply of physicians, and the ratio of private payment rates to Medicare payment rates for physician services, are all stable. Surveys on beneficiary access to physicians continue to show that the large majority of beneficiaries are able to obtain physician care and nearly all physicians are willing to serve Medicare beneficiaries. In the fall of 2004, MedPAC found that among beneficiaries looking for a new doctor, 88 percent reported little or no problems obtaining a new primary care physician. Access to specialists was even better—94 percent reported little or no problems. Further, Medicare beneficiaries and privately insured individuals age 55-64 report very similar experiences accessing physicians. Indeed, Medicare beneficiaries' reported as good as or better access than their privately insured counterparts. (These findings are consistent with earlier work done by the Center for Studying Health Systems Change.) A large national survey found that among office-based physicians who commonly saw Medicare patients, 94 percent were accepting new Medicare patients in 2003. This figure is up 1 percentage point from 2002.

We have also found that the supply of physicians furnishing services to Medicare beneficiaries has kept pace with the growth in the beneficiary population, and the volume of physician services used by Medicare beneficiaries is still increasing. In consideration of expected growth in physicians' costs and our payment adequacy analysis, the Commission recommends that payments for physician services be updated by the projected change in input prices, less an adjustment of 0.8 percent for productivity growth.

This update should be thought of in the context of the entire package of our physician payment recommendations. The update, coupled with pay for performance and our imaging recommendations discussed below, will provide an adequate increase in physician payment

overall while starting to reward better quality and dampen growth in a rapidly growing service. Over the next few years, as quality performance is rewarded, as physicians are made aware of their practice patterns and increase efficiency, and as specific volume problems are targeted, Medicare can improve the value of the physician services it buys.

**A different approach to controlling volume**

If payment rates are adequate and updated to account for changes in efficient physicians' cost, the remaining issue is controlling volume, which is important for both beneficiaries and taxpayers. For beneficiaries, increases in volume lead to higher out-of-pocket costs—copayments, the Medicare Part B premium, and any premiums they pay for supplemental coverage. For taxpayers, increases in volume lead to higher Part B expenditures supported with the general revenues of the Treasury. The MMA has established a trigger for legislative action if general revenues exceed 45 percent of total outlays for the Medicare program.

For beneficiaries, volume growth increases the monthly Part B premium. Because it is determined by average Part B spending for aged beneficiaries, an increase in the volume of services affects the premium directly. From 1999 to 2002 the premium went up by an average of 5.8 percent per year. By contrast, cost-of-living increases for Social Security benefits averaged only 2.5 percent per year during that period. Since 2002 the Part B premium has gone up faster still—by 8.7 percent in 2003, 13.5 percent in 2004, and 17.3 percent in 2005.

Volume growth also has implications for the federal budget. The Committee is aware of the growth of Medicare relative to the nation's output of goods and services as discussed in the Medicare trustees report. Increases in Medicare spending per beneficiary is an important reason for that growth, cited by the Congressional Budget Office and the General Accounting Office among others.

However, some of the root causes of volume growth may be amenable to policy action and some growth may be desirable. For example, growth arising from technology that produces meaningful gains to patients, or growth where there is currently underutilization of services may be beneficial. But one indicator that not all growth is good may be its variation. Among broad categories of services, growth in volume per beneficiary ranged from about 15 percent to almost 45 percent, based on our analysis of data comparing 2003 with 1999 (Figure 1). Within these broad categories, growth rates were higher for services which researchers have characterized as discretionary (e.g. , imaging and diagnostic tests). In imaging, for example, growth rates were over 15 percent a year for such services as magnetic resonance imaging, computed tomography, and nuclear medicine.

In addition, volume varies across geographic areas. As detailed in our June 2003 report to the Congress, the variation is widest for certain services, including imaging and tests. Researchers (e.g. Wennberg and Fisher) have reached several conclusions about such findings:

- Differences in volume among geographic areas is primarily due to greater use of discretionary services sensitive to the supply of physicians and hospital resources.
- On measures of quality, care is often worse in areas with high volume than in areas with lower volume. The high-volume areas tend to have a physician workforce composed of relatively high proportions of specialists and lower proportions of generalists.

- Areas with high levels of volume have slightly worse access to care on some measures, suggesting patients may be delaying entry into the health care system because of patient discomfort with the level of specialization.

All this suggests that service volume may be too high in some geographic areas.

In our March report to the Congress we make several recommendations that taken together will help control volume and increase quality of Medicare physician services. Our basic approach is to differentiate among physicians and pay those who provide high quality services in a resource efficient way more, and pay those who do not, less—or in some cases not at all. As a first step, we make recommendations concerning: pay for performance and information technology (IT), measuring physician resource use, and managing the use of imaging services.

**Pay for performance and information technology**

Medicare uses a variety of strategies to improve quality for beneficiaries including the quality improvement organization (QIO) program, and a variety of demonstration projects, such as the group practice demonstration, aimed at tying payment to quality. MedPAC supports these efforts and believes that CMS, along with its accreditor and provider partners, has acted as an important catalyst in creating the ability to measure and improve quality nationally. CMS's prior quality investments provide a foundation for initiatives tying payment to quality and encouraging the diffusion of information technology.

However, for the most part, Medicare, the largest single payer in the system, still pays its health care providers without differentiating on quality. Providers who improve quality are not rewarded for their efforts. In fact, Medicare often pays more when poor care results in unnecessary complications. The incentives of this system are neutral or negative toward improving the quality of care.

To begin to address these issues, the Congress should adopt budget neutral pay-for-performance programs, starting with a small share of payment and increasing over time. For physicians, this would initially include use of a set of measures related to the use and functions of IT, and over time a broader set of measures.

IT measures should describe evidence-based quality- or safety-enhancing functions performed with the help of IT. Functions might include, for example, tracking patients with diabetes and sending them reminders about preventive services, or providing educational support for patients with chronic illnesses. This approach focuses the incentive on quality-improving activities, rather than on the tool used. It also allows providers to achieve performance in the early stages without necessarily investing in IT, although it would be easier if they did so. The potential additional payment may also increase the return on IT investments.

Because physicians play a central role in directing patient care, their adoption and use of IT should be a part of physician pay-for-performance initiatives from the start. Physician use of electronic health records promises to lead to better care management, reduced errors, improved efficiency, and can facilitate reporting of meaningful quality indicators that may not otherwise available.

However, few providers use IT for clinical (as opposed to administrative) functions perhaps because it is difficult to demonstrate an adequate return on investment.

Some suggest that Medicare could reward IT adoption alone. However, not all IT applications have the same capabilities and owning a product does not necessarily translate into using it or guarantee the desired outcome of improving quality.

Process measures for physicians, such as monitoring and maintaining glucose levels for diabetics, should be added to the pay-for-performance program as they become more widely available from administrative data. Using administrative data minimizes the burden on physicians. We recommend improving the administrative data available for assessing physician quality, including submission of laboratory values using common vocabulary standards, and of prescription claims data from the Part D program. The laboratory values and prescription data could be combined with physician claims to provide a more complete picture of patient care. As clinical use of IT becomes more widespread, even more measures could become available.

**Measuring physician resource use**

Medicare beneficiaries living in regions of the country where physicians and hospitals deliver many more health care services do not experience better quality of care or outcomes. Moreover, they do not report greater satisfaction with care than beneficiaries living in other regions. This finding, and others by researchers such as Wennberg and Fisher are provocative. They suggest that the nation could spend less on health care, without sacrificing quality, if physicians whose practice styles are more resource intensive moderated the intensity of their practice; that is if they provided fewer diagnostic services, used fewer subspecialists, referred patients less frequently to hospitals and intensive care units (ICUs), and did fewer minor procedures.

MedPAC recommends that Medicare measure physicians' resource use over time, and feed back the results to physicians. Physicians would then be able to assess their practice styles, evaluate whether they tend to use more resources than either their peers or what evidence-based research (when available) recommends, and revise their practice style as appropriate. Moreover, when physicians are able to use this information in tandem with information on their quality of care, it will provide a foundation for them to improve the efficiency of the care they and others provide to beneficiaries. Once greater experience and confidence in this information is gained, Medicare might use the results in payment, for example as a component of a pay-for-performance program.

Although comprehensively measuring resource use and quality may be difficult, we must ask ourselves what the cost is of doing nothing. Right now, we know there are wide disparities in practice patterns, all of which are paid for by Medicare and many of which do not appear to be improving care. Yet many physicians have few opportunities to learn about how their practice patterns compare to others or how they can improve. This recommendation would inform physicians and is crucial to starting the process of improvement.

**Managing the use of imaging services**

The last several years have seen rapid growth in the volume of diagnostic imaging services when compared to other services paid under Medicare's physician fee schedule (Figure 1). This increase

has been driven by technological innovations that have improved physicians' ability to diagnose disease and made it more feasible to provide imaging procedures in physician offices. Other factors include:

- possible misalignment of fee schedule payment rates and costs,
- physicians' interest in supplementing their professional fees with revenues from ancillary services, and
- patients' desire to receive diagnostic tests in more convenient settings.

These factors have contributed to an ongoing migration of imaging services from hospitals, where institutional standards govern the performance and interpretation of studies, to physician offices, where there is less quality oversight. These variations in oversight, coupled with rapid volume growth, create an urgent need for Medicare to develop standards for all providers that receive payment for performing and interpreting imaging studies. These standards should improve the accuracy of diagnostic tests and reduce the need to repeat studies, thus enhancing quality of care and helping to control spending.

Requiring physicians to meet quality standards as a condition of payment for imaging services provided in their offices represents a major change in Medicare's payment policy. Traditionally, Medicare has paid for services provided by physicians operating within the scope of practice defined by the state in which they are licensed. The Commission concludes that requiring standards is warranted because of the growth of imaging studies provided in physician offices and the lack of comprehensive standards for this setting. According to GAO, the Mammography Quality Standards Act has increased mammography facilities' compliance with quality standards and led to improvements in image quality. After the Act took effect, the share of facilities that were unable to pass image quality tests dropped from 11 percent to 2 percent.

In addition to setting quality standards for facilities and physicians, CMS should through administrative action:

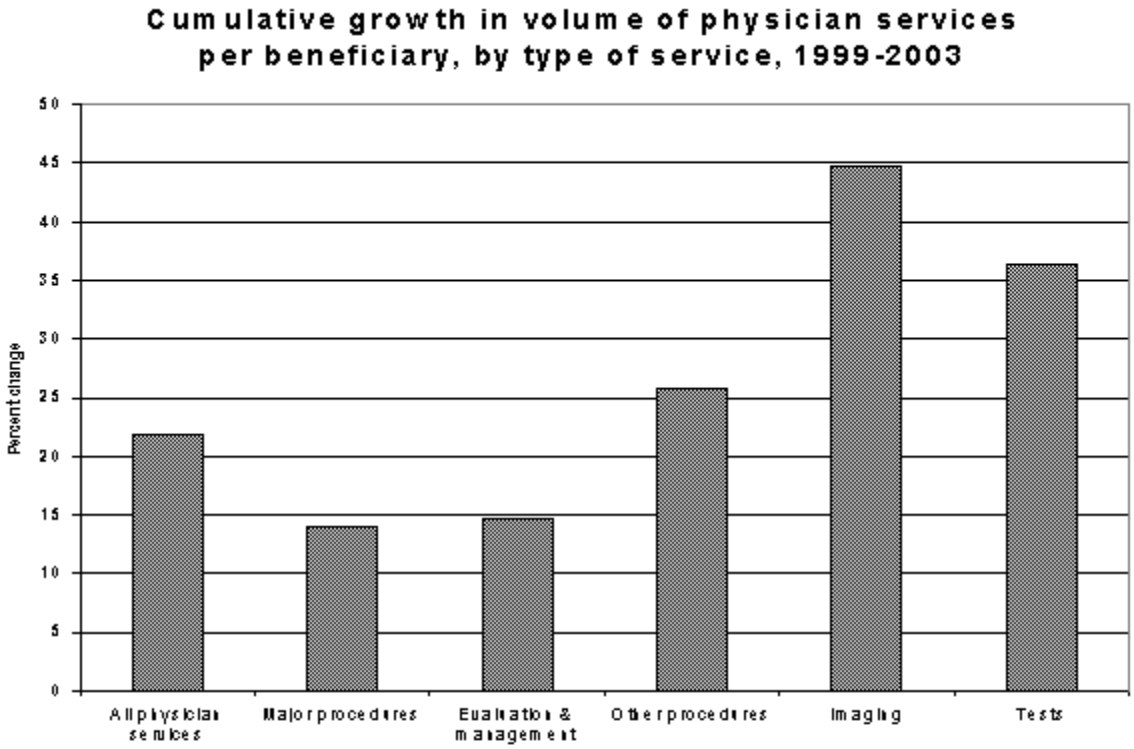
- measure physicians' use of imaging services so that physicians can compare their practice patterns with those of their peers,
- expand and improve Medicare's coding edits for imaging studies, and
- strengthen the rules that restrict physician investment in imaging centers to which they refer patients.

CMS should improve their coding edits that detect improper imaging claims, such as claims for unbundled and mutually exclusive services. Medicare also should discount payments for multiple imaging studies of the same modality that are performed on contiguous body parts. Medicare payments should reflect the efficiencies that are often gained when studies are performed in tandem.

**Creating new incentives in the physician payment system**

MedPAC has consistently raised concerns about the SGR as a volume control mechanism and recommended its elimination. We believe that the other changes discussed previously—pay for performance, IT, measuring resource use, and reform of payments for imaging service —can help Medicare beneficiaries receive high-quality, appropriate services while also controlling volume growth. Although the Commission's preference is to address issues of inappropriate volume increases directly as discussed in the previous section on imaging, we recognize that the Congress

may wish to have some form of limit on aggregate volume as well; but it needs to be one that will more closely match physician's incentives to their individual performance. In our March report to the Congress, we will discuss potential ideas for creating incentives for more effective volume control methods that encourage more collaborative and cost effective delivery of physician services in accordance with clinical standards of care.


Cumulative growth in volume of physician services per beneficiary, by type of service, 1999-2003
Percent change
50
45
40
35
30
25
20
15
10
5
0
All physician services
Major procedures
Evaluation & management
Other procedures
Imaging
Tests
Source: MedPAC analysis of claims data for 100 percent of beneficiaries.