

Gail R. Wilensky



physician spending revisited ... once again

Congress is again struggling with physician payment under Medicare.

It has been slightly more than four years since I have written a column focused on physician payments and the challenge that the resource-based relative-value scale (RBRVS) and sustainable growth rate (SGR) present to the Congress. Once again, Congress has been holding hearings discussing the problems posed by the existing payment system and searching for ideas on how to reform the current approach to physician payment and, more important, what to do about the accumulated cost of moving away from the SGR—now estimated to have a 10-year cost of more than \$270 billion.

Two Camps

Based on the Senate Finance Committee roundtable on Medicare physician payments held in May, where I was a participant along with three other former administrators of Medicare (Bruce Vladeck, Tom Scully, and Mark McClellan), there appear to be two camps developing regarding the RBRVS with very different views.

One camp is focused on improving the RBRVS calculations, including to better reflect the increased productivity that certain specialties have experienced over the past decade, to correct for distortions that may have been introduced by the RUC process, and to make use of better data and larger data samples.^a The rationale is that fee for service is likely to be a part of how physicians

are paid for the foreseeable future and that these corrections would improve the accuracy of the payments.

The other camp is focused primarily on developing alternatives to the RBRVS—payment systems in which payment covers larger units of treatments or episodes of care. This camp believes moving away from compensating physicians for individual units of inputs—as Medicare has done for hospital care with DRGs and for home care with payments per 60-day episode of care—is critical to effectively reforming how physicians are paid, although they recognize that an improved RBRVS has advantages as long as it is in use.

Congress needs to resolve quickly the question of which direction the nation will pursue or whether it will pursue both simultaneously, not only because refining the RBRVS or devising credible alternatives to it will take time, but also because the approach taken will determine whether a spending limit, such as the SGR, will be needed in the future. The rationale for introducing a spending limit in the 1989 legislation that enacted the RBRVS was that spending increases more rapidly under a disaggregated billing

a. The American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) is an advisory group of physicians, established by the AMA, that makes recommendations to CMS regarding relative values assigned to physician services. In addition to its annual recommendations regarding new and revised physician services, the RUC performs a more comprehensive review of the RBRVS every five years.

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system, such as one that bills according to several thousands of CPT codes, than it does under a more aggregated billing system, such as had been developed for hospitals and home care. The SGR was established as part of the 1997 Balanced Budget Act to fix volatility problems associated with the previous volume performance standard, which had been established in the 1989 legislation, and to tie the growth in overall spending on physician services in Medicare to the rate of growth in the economy as a budget-saving measure, even though there had been no historical precedence for believing such a relationship was sustainable.

Options

If Congress decides to retain an RBRVS type payment system—refined or otherwise—it will need to consider whether it wants to modify the SGR in some way rather than remove it entirely, given the history of what is otherwise likely to happen to spending. Examples of the various suggestions on how to improve the SGR include:

- > Using separate targets for multispecialty group practices to encourage their formation
- > Having the SGR apply differentially according to the “value of services provided,” with greater value being assigned to services that are oriented to evaluation and management
- > Using a number of different SGRs (as outlined in legislation passed by the House in 2007)

I think a better alternative is to set the SGR at the level of the practice, which would link the updates to the behavior of the physicians in the practice, correcting what to my mind is now the most serious problem with the SGR: Nothing a physician now does (or doesn't do) affects what happens to

the SGR, because no single physician or physician practice can affect total spending on Medicare physician services. For those of us who believe incentives matter, this lack of a linked relationship is very problematic.

It is easy to conceive of a practice-level SGR being used for practices of some size. It's harder to imagine one being used for small groups or individual physician practices because of the adjustments that would be required to correct for substantially atypical patients. Perhaps a default SGR could be established for very small physician groups, reflecting the experience of small to mid-size groups in the geographic area.

The other option is to begin developing more aggregated or bundled payment strategies. Although this effort would not be easy (or quick), some initiatives are under way that either are already moving or could be moved in this direction. The patient-centered medical home (PCMH), for example, is a concept being piloted both by the Centers for Medicare & Medicaid Services and by private payers. The PCMH concept could be transformed into an integrated bundled payment approach if payment for care coordination were integrated with the average fee-for-service payments for the treatment of specific chronic diseases, some payments were made for infrastructure development, and payments were tied to some extent to performance measures.

It's hard to imagine Congress allowing Medicare physician fees to be reduced by 27 percent come January 2013, as current law now requires. I assume that Congress will once again do what Congress has done each year since 2003—find some way to pay for at least a short-term extension. The question is whether Congress can begin to get something in return for these expenditures. Thus far, it has not. ●

Gail R. Wilensky, PhD, is a senior fellow at Project HOPE; a former administrator of HCFA, now CMS; and a former chair of the Medicare Payment Advisory Commission (gwilensky@projecthope.org).