Medicare Payment Advisory Commission’s June 2011 Report to the Congress: Medicare and the Health Care Delivery System

The compensation policy for physicians under the Medicare program is established through Federal legislation. Legislators are influenced by a variety of reports as well as invited testimony in committee hearings. These reports include policy recommendations from the Institute of Medicine, program flaws identified by the Office of Inspector General, strategy recommendations from the Medicare Payment Advisory Commission and the financial report from the Trustees of the Medicare Program. The clearly stated goal pursued by policy advisors and legislators over the last five years is to establish physician payment parameters in clinically coherent, vertically integrated systems and elimination of the fee for service program.

As we look forward to the release of the proposed Medicare Physician Fee Schedule for 2012 (next month’s Watchline will focus on the proposed fee schedule for 2012), it is worth reviewing the recent reports and Congressional testimony that will influence evolving Federal health policy.

On May 13, the Medicare Trustees released their annual Report to Congress. The Hospital Insurance Trust Fund (Part A) is now estimated to be exhausted in 2024, five years earlier than was shown in last year’s report. In 2010, $32.3 billion in trust fund assets were redeemed to cover the shortfall of income relative to expenditures. The Supplementary Medical Insurance Trust Fund (Parts B and D) is adequately financed over the next 10 years. However, Part B costs have been increasing rapidly, having averaged 6.9 percent annual growth over the last 5 years. Transfers from the general U.S. treasury are an important source of financing for Parts B and D. These transfers represent a large and growing addition to the federal deficit and are attracting substantial attention in the current Washington climate. In a June 22 meeting of the Health Subcommittee of the Committee on Ways and Means, it was suggested that the financial burden on the treasury could be addressed by immediately increasing the payroll tax by 24 percent or by an immediate 17 percent cut in expenditures by reducing Medicare benefits or cutting provider payments.
MedPAC released its report on June 15. This report appears to be designed to both educate the freshman class of legislators and reinforce previous recommendations to longer term legislators with more specific detail. The commissioners emphasize previously expressed concerns with the ineffectiveness of both the Sustainable Growth Rate (SGR) formula and the Medicare sanctioned Quality Improvement Organizations (QIOs) as well as the inequities of the Resources Based Relative Value System (RBRVS) system.

Physicians who have been in practice for several decades have experienced the legislatively imposed transition from free market fee-for-service through a variety of spending target measures to the current SGR/RBRVS system with oversight by QIOs. The current health care framework is a mixture of free market and central control with the worst of both worlds. The economics of medical practice are governed, in part, by the laws of supply and demand. Demand for services must be recognized as a significant component of rising expenditures. Directly addressing demand, however, is considered political suicide in the current highly charged partisan climate of Washington. For this reason legislative emphasis has tried to control the supply side.

The Sustainable Growth Rate

The supply of physician services is influenced by payment policy. The primary attempt by the government to control supply has been through the SGR formula. The MedPAC report highlights two fundamental problems with the SGR system. The first is its design as a strict budgetary tool, with no mechanism for influencing individual provider performance. The second is a “passive devaluation” problem for specialties that are highly dependent on evaluation and management (E&M) services. That is, procedural specialties can more readily compensate for fee restrictions by generating greater service volume. As businesses that must meet an annual escalation in the cost of operating a practice, the nature of services provided is influenced by the government’s control of compensation for those services. As a result, as E&M services have experienced a relative devaluation, many physicians have expanded their practices to add profitable ancillary services such as diagnostic imaging, clinical laboratory testing, physical therapy, and radiation therapy.

These services now account for a significant share of Part B revenue for certain specialties. A survey of physicians conducted in 2008 found that 29 percent of physicians were in practices that owned or leased equipment for noninvasive testing procedures such as echocardiograms and nuclear medicine studies, 25 percent were in practices that owned or leased clinical lab testing equipment, 23 percent owned or leased X-ray equipment, and 17 percent owned or leased MRI or computed tomography machines. This has led to a shift of profitable diagnostic and procedural services from the hospital (Part A) to office and physician owned facilities (Part B). MedPAC reports that physician investments in diagnostic testing equipment have contributed to rapid growth services under Part B but does not address a possible decrease in utilization under Part A. The report recommends that the Congress direct the Secretary to establish a prior notification and prior authorization program for practitioners who order substantially more advanced diagnostic imaging services than their peers.

The Resource Based Relative Value Scale

The RBRVS was developed and implemented to make reimbursement for the wide variety of physician services equal to the cost and effort of providing the service. The reality has not met the premise of this system. The values assigned to each service are composed of three categories: the work of the practitioner, practice expense, and professional liability insurance. Practitioner work accounts for about 48 percent of fee schedule payments and practice expense accounts for another 47 percent of fee schedule payments. Resource-based payments generally ascribe higher values to performing procedures than to conducting E&M services. MedPAC has previously raised concerns about the increasing inequities in this system. They point out that paying based on effort rather than outcome skews incentives, leading to overuse of procedures without consideration for outcomes.

As an example, the assigned RVUs for a service may become too high over time when practitioners and staff gain the ability to furnish the service more quickly and routinely than when it was first introduced into practice. Practitioners can increase their service volume, and payments received from Medicare, with little change in the number of hours they work — think about colonoscopy. The higher relative values and the greater ability to generate volume result in significantly higher cumulative reimbursements for specialties that perform more procedures than for those that do not. The assignment of payment values to CPT codes are “budget neutral,” requiring that every additional dollar allocated to a given service, there is a dollar less for those who do not use a given code.
The RBRVS values are revisited every five years, or at the request of a professional society, by the AMA Relative Value Update Committee (RUC). Some societies, primarily procedure based societies, have been more aggressive than others in requesting adjustments to their codes. Each increase in value of a given code results in devaluation of the population of codes within the same sphere. The RUC meetings are closed to the public. The committee composition is closely controlled by the sitting members, who are predominately from procedure oriented societies. The RUC data are copyrighted by the AMA, but its use is required by statute. This allows the AMA to charge a license fee to anyone who wishes to associate RVU values with CPT codes. The AMA receives approximately $70 million annually from these fees.

MedPAC points out that the fee schedule’s time estimates explain much of the perceived discrepancy in the relative values for physician work. Overstated time estimates can cause a service to be overvalued and, because changes in fee schedule payment rates are budget neutral, other services can be undervalued. The process for developing time estimates relies on surveys conducted by physician specialty societies whose members have a financial stake in the process. Research findings have led the Commission to conclude that the current time data are flawed. MedPAC recommends:

1) The Congress could require that the Secretary identify and reduce payments for overpriced services, in a non-budget-neutral manner. More specifically, the Congress could make future, across-the-board fee schedule updates contingent on the Secretary identifying and reducing relative values for overpriced services.

2) Future payment policies should be designed to move toward alternative payment models that focus on population health and coordination of care—such as ACOs, medical homes, bundling, and similar payment models.

Quality Improvement Organizations

Medicare sanctioned Quality Improvement Organizations (QIOs), were in place prior to the landmark Institute Of Medicine report on medical errors in 1999. The subsequent record of these QIOs has been “uneven.” The MedPAC report states “given the pronounced need for quality improvement, Medicare must try a new approach.”

The Commission recommends fundamental changes to the current QIO program to:

- Give providers and communities the choice of who assists them and flexibility in how they use quality improvement resources.
- Increase the number and variety of technical assistance entities that can assist providers and communities to introduce a greater range of choices for assistance in quality improvement.
- Make technical assistance to low-performing providers and community initiatives a high priority as a strategy to complement payment policy and address persistent health care disparities.
- Updating the conditions of participation so that the requirements incorporate and emphasize evidence based measures of quality care.
- Increasing accountability of providers by expanding CMS’s use of interventions that promote system-wide remediation of quality problems among persistently low-performing providers.
- Increasing public recognition of high-performing providers that participate in learning networks to assist low-performing providers.

Demand for Services

The MedPAC report does briefly address the demand side of the equation. Based on information obtained through interviews of both public and private payers, four strategies were identified: lowering cost sharing for high-value services, raising cost sharing for low-value services, creating financial incentives for enrollees to see high-performing or low-cost providers, and providing incentives for enrollees to adopt healthier behaviors. The Commission will continue to consider the need to move toward benefit designs that give individuals incentives to use higher value care and discourage them from using lower value care.

From the larger political perspective, payment reform is not a single event but a multipart process and pursuing an SGR replacement policy should not depend on resolution of all policy issues. SGR termination could be contingent on a set of trade-offs to improve the payment system.
The Commission is considering a range of policy ideas for reform:

- **Set limited future updates in law, across all fee schedule services.**
- **Enhance efforts to continuously improve the accuracy of fee schedule payments, with particular attention to estimates of the time required to provide services.**
- **Realign payments for physician and other health professionals to help ensure an adequate supply of practitioners in cognitive (nonprocedural) specialties who focus on managing patients with chronic conditions.**
- **Reform delivery systems to shift payment away from the fee schedule’s disproportionate emphasis on procedures and tests and toward payment models focused more on care coordination and population health.**

## The Next Steps

The MedPAC report has been submitted to Congress. The usual venues for Medicare policy discussion and development include the Health Subcommittee of the House Committee on Energy and Commerce, the Health Subcommittee of the Committee on Ways and Means and the Senate Finance Committee. Committee recommendations are shaped by committee members and the opinions of those invited to testify. At the same time, invitations may be issued to those individuals known to support the goals of the legislators.

Under the leadership of Chairman Thomas Bliley nearly two decades ago, the Committee on Energy and Commerce was of invaluable help to the pulmonary and critical care community; however, the current committee hearings have been focused on dismantling the Affordable Care Act. The recent physician related activity has been in the House Ways and Means Health Subcommittee. On May 12, Chairman Wally Herger held a hearing, “Reforming Medicare Physician Payments.” In introductory statements, Chairman Herger stated his belief that that the future of Medicare depends on a transition away from the fee-for-service system. Invited speakers were Keith Wilson, M.D., Chair, Governing Board and Executive Committee, California Association of Physician Groups; Lisa Dulskey Watkins, MD, Associate Director, Vermont Blueprint for Health; Dana Gelb Safran, Sc.D Senior Vice President Blue Cross Blue Shield of Massachusetts and Stuart Guterman, Vice President, Payment and System Reform, The Commonwealth Fund. Notably absent from this hearing were representative of the community of practicing physicians.

The most telling testimony was by Dr. Wilson who stated, “Nearly a third of California’s population, including employer based plans, Medicare, and Medicaid, are covered under capitated arrangements. We believe that our capitated payment system can serve as a model for the rest of the country.”
Pharmaxis received this testimonial from an allergist in Connecticut who has been doing the mannitol test in his office.

June 16, 2011

Dear Pharmaxis,

I have been using the Aridol (mannitol inhalation powder) Bronchial Challenge test in my practice since it became available in February 2011. The test is simple to use and does not require expensive equipment such as a treadmill and dry air setup as for exercise or a dosimeter for a methacholine challenge. Aridol requires only a spirometer, nose clips, and the Aridol test kit. The test is time effective, requiring less than 30 minutes to perform a negative test, with even less time for a positive test. There is very little test preparation and little clean up after completion of the test. I am very happy with the Aridol; it is office friendly and allows me to better serve my patients.

Sincerely,

Christopher Randolph, M.D.
Clinical Professor of Pediatrics, Yale Affiliated Programs, Waterbury Hospital, Center For Allergy, Asthma and Immunology, Waterbury, Connecticut
A Bout NAMDRC:

Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.

http://www.namdrc.org/coding.html

One of NAMDRC’s primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation’s health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of NAMDRC’s key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRC members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

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