Health Affairs | Robert Wood Johnson Foundation

Health Policy Brief

JUNE 25, 2010

Paying Physicians For Medicare Services.

It is widely agreed that the existing payment system is broken. Congress has again enacted a short-term fix to a long-term problem that it will have to revisit.

WHAT'S THE ISSUE?

Congress has voted to halt and delay for six months a scheduled 21.5 percent cut for physician fees under Medicare that had gone into effect in June 2010. The change gives physicians a 2.2 percent rate increase retroactive to June 1. But unless a longer-term solution is found, this short-term "doc fix" will expire November 30, 2010, at which point the previously scheduled reduction will kick in.

This latest episode represents the fourth time this year that scheduled Medicare fee cuts to physicians have been averted at the last moment—or even later. A longer-term repair is needed, but will be costly for U.S. taxpayers.

A BROKEN SYSTEM: There is widespread agreement that the existing system for paying for physician services under the Medicare program is broken. Under current Medicare rules, intended to restrain growth in spending, payments to physicians have been subject to supposedly "automatic" cuts for a number of years. However, Congress has consistently postponed those cuts and instead raised physician fees or held them constant.

The latest scheduled cut for physician fees was the 21.5 percent reduction that took effect in June. In May, the House passed a proposal to provide rate increases in 2011 and 2012, followed by an even sharper 35 percent rate cut in 2012. But the Senate was unable to pass similar legislation, contained within a long-stalled bill to extend unemployment benefits and provide Medicaid assistance to the states. Instead, the Senate approved the six-month, 2.2 percent rate increase in late June.

The Centers for Medicare and Medicaid Services (CMS) was for a time holding June bills, pending possible congressional action, but as of June 18 it had begun paying doctors' bills at the reduced rates required by current law. When it became clear that the Senate would not be able to approve the longer-term House bill, members in the House voted on June 24 to adopt the shorter Senate version, and President Obama signed it on June 25.

THE PROBLEM IS MONEY: A permanent "doc fix" that would override both pending and expected automatic cuts in future years could add as much as $276 billion to federal spending over the next decade. There is no agreement in Congress on how best to make the fix or on how to pay for it, whether by raising taxes, cutting other federal spending, or simply adding the amount to the federal deficit. This brief describes the likely options for congressional action in the months and years ahead.

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10.1377/hpb2010.5

WHAT'S THE BACKGROUND?

Medicare pays physicians using what is called a fee schedule, or list of prices. This list sets a fixed maximum price for each type of service, such as an office visit, a particular surgical procedure, or a specific diagnostic test. Current law requires CMS to update these prices each year.

In computing the annual update, CMS starts with an estimate of inflation but then adjusts this amount upward or downward, depending on how rapidly overall spending for physician services has been growing. If spending has stayed within set targets, physicians get a bonus—a price increase greater than inflation. But if spending has exceeded the targets, the updated prices may rise more slowly than inflation or even be reduced.

The current system of spending targets was put into place by the Balanced Budget Act of 1997. The aim was to give physicians an incentive to restrain the growth in the number of services they furnished to patients, and to discourage them from providing higher-price services in place of lower-price ones.

The spending targets are set using a "sustainable growth rate" formula, often referred to as the SGR. The formula is complicated, but its basic goal is to keep spending for each beneficiary from growing faster than the per capita increase in the gross domestic product (GDP). GDP growth is included in the formula on the theory that it is not sustainable for Medicare physician spending to grow faster than the national economy.

HOPE NOT REALIZED: The expectation that this payment system would control spending was not realized. In the first few years under the 1997 rules, physician spending did stay within the targets, and physicians were rewarded with price increases greater than inflation. For 2002, however, the update formula in the law required a reduction in physician fees of almost 5 percent. Congress allowed the reduction to take effect. But when the formula dictated a further reduction for 2003, Congress overrode the Balanced Budget Act rules and approved a small fee increase.

That action set a precedent that has continued to this day. In each year since 2003, although the statutory formula would have led to a fee cut, Congress has instead granted an increase or at least frozen the rates and prevented a decrease.

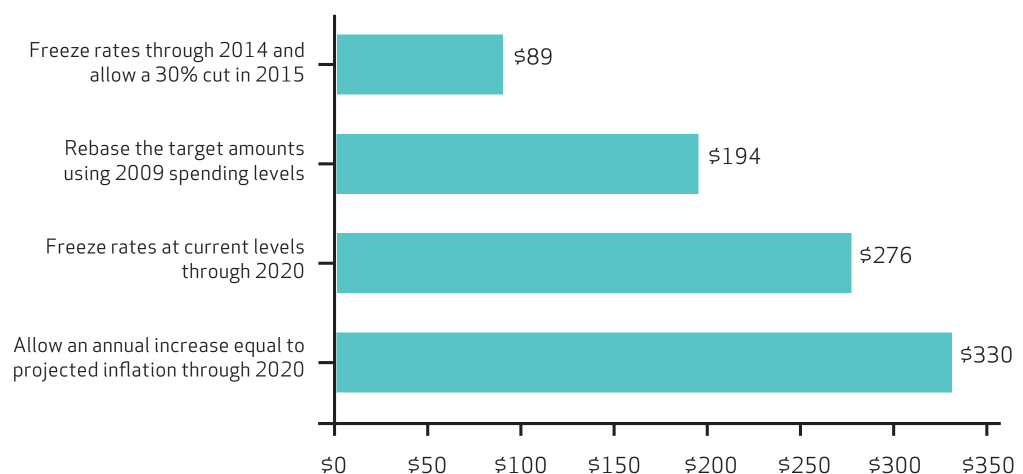
Although Congress has repeatedly intervened to prevent rate cuts, it has never changed the formulas that dictate these cuts. Each time it has set the fee increase, Congress has specified that fee updates for later years should be computed as if it had not acted. What's more, Congress has never modified the SGR targets themselves.

Meanwhile, the number of services that physicians provide has been growing steadily, and the services are increasingly costly and complicated. That means that there has been a widening gap between actual spending each year and the amount allowed by the targets. Under the law, this ballooning deficit is supposed to be recouped by even steeper automatic rate cuts in the future.

"A permanent 'doc fix' that would override both pending and expected automatic cuts in future years could add as much as $276 billion to federal spending over the next decade."

EXHIBIT 1

Increase In Net Federal Outlays Under Different Proposed Changes In Medicare Physician Payment



SOURCE Congressional Budget Office, April 30, 2010. **NOTE** $=Billions of dollars.

$89 billion

Federal deficit increase

The estimated increase to the federal deficit if Medicare rates were frozen through 2014.

"The expectation that this payment system would control spending was not realized."

PAYMENT CUTS KICK IN: In November 2009, CMS announced that under the formula, physician fees for 2010 would be 21.5 percent less than 2009 levels. The cut would have been even larger except for two factors. First, CMS on its own made some changes in the methods used for setting the targets. Second, the law limits how much fees can be reduced in any one year. However, cuts not made in 2010 would simply carry over into future years. Unless the law is changed, by 2014, rates could be about 40 percent less than 2009 levels.

Why has Congress consistently acted in this "Perils of Pauline" fashion, overriding automatic cuts on a short-term basis nine times so far? The answer is that a longer-range fix could greatly increase the federal deficit. Congress relies on the Congressional Budget Office (CBO) to measure the budgetary impact of proposed legislation. The CBO establishes a "baseline," projections of future spending and revenues that assume all current laws will be enforced. The baseline includes all of the physician cuts scheduled to take effect in future years, which will produce substantial savings for Medicare.

As a result, legislation that overrides future cuts would be "scored" by the CBO as increasing the deficit, in contrast with the current baseline. Eliminating the SGR targets and permanently freezing Medicare physician fees at the 2009 level would cost $276 billion between 2011 and 2020.

Postponing the cuts month by month or year by year, as Congress has done, has a smaller apparent budgetary impact. Yet even the six-month rate increase most recently passed by the House and Senate was scored as costing more than $6 billion, although the bill included savings provisions to offset that amount. Unless something is done before the end of this year, Congress will, once again, encounter pressure to avoid even bigger rate cuts in 2011 and later years.

FIXING THE "DOC FIX": Few members of Congress wish to see physician payments slashed, and many would prefer to see some permanent "fix" so that they would not have to revisit the issue. Yet there are also mounting concerns about the overall size of the future federal deficit. In this context, many members on both sides of the aisle are reluctant to enact a costly fix without finding some way of paying for it.

WHAT ARE THE LONGER-RANGE OPTIONS?

Now that another short-term fix has been passed, Congress has several longer-range options. It could do nothing and let future cuts take effect. It could drop the SGR system and simply freeze future rates or let them rise with inflation. It could keep the current system but adopt various proposed modifications. It could adopt other fee schedule changes that might help slow spending growth. Or it could develop entirely new ways of paying for physician services.

DO NOTHING: Congress could simply allow scheduled fee reductions to take effect. Without a fix, physician payments would drop as much as 40 percent from 2009 levels over the next several years. Although the government would save money, there are concerns about the potential impact that such large cuts would have on Medicare beneficiaries' access to health care. If Medicare rates fall too far behind those paid by private insurers, physicians might turn away current Medicare patients or stop accepting new ones. That would be more likely to happen if physicians have enough non-Medicare patients to make up for the income losses. The best guess is that physicians' ability to replace Medicare patients with those who have private insurance is likely to vary by geographic area and physician specialty.

Another possibility is that physicians would make up for lower Medicare fees by increasing the volume or intensity of services furnished to Medicare beneficiaries. However, it is unlikely that such "behavioral" changes could offset a 40 percent fee cut.

Whatever the potential effects of rate cuts might be, some people contend that the entire SGR approach has proved unworkable. The SGR system was supposed to give physicians incentives to practice more efficiently and thus gain higher fee increases, or at least avoid decreases. But the incentives don't work for individual physicians.

The problem is that if some doctors provide extra services, they will make more money in the short term than those who don't—yet the resulting penalties fall on everyone. Because of these perverse incentives, critics contend, aggregate spending targets may never be workable and should be replaced by more-focused cost containment methods.

-40%

Medicare rate reduction
The scheduled reduction in Medicare rates by 2014, unless the law is changed.

"There is general agreement that long-range savings will require other reforms in the current payment system."

ABANDON THE SUSTAINABLE GROWTH RATE SYSTEM: Congress could decide to eliminate the formula that ties fee updates to trends in spending growth. Those who favor this step argue that since Congress is unlikely ever to allow the full scheduled rate cuts, it would be better and arguably more honest to take the full budgetary hit at once, instead of year by year. With no system in place for updating the fee schedule, Congress might at some point come up with a better approach.

A contrary view is that repeated short-term fixes to the SGR system are actually preferable. If the threat of rate cuts were permanently removed, Congress would never get around to fixing the system.

Others have suggested shelving the problem for some years, rather than a few months at a time, in the hope that additional breathing room would make it possible to develop a consensus around more comprehensive reforms in the system. But even that kind of half-measure would cost a great deal. For example, the CBO estimates that freezing the rates through 2014 would raise the deficit by $89 billion.

MAKE LONG-TERM MODIFICATIONS TO THE SGR SYSTEM: There are numerous proposals on the table to continue the current system of SGR targets, but with various modifications. CMS could simply wipe the slate clean and base future targets on actual current spending levels. In effect, past overspending would be forgiven, offering physicians a new chance to restrain spending but threatening them with penalties in the future if they failed to do so.

This approach, known as "rebasing," would be almost as costly as getting rid of the targets altogether. And rebasing would not correct the distorted incentives in the current system. Over time, physicians might once again ramp up service delivery until the formula dictated rate reductions.

Other options include setting separate spending targets for different services, different geographic areas, or even specific providers or groups of providers. For example, Congress could allow more spending growth in services such as primary and preventive care, while clamping down on such fast-growing areas as x-rays and other imaging services.

Another approach might be to establish separate targets for areas with lower and higher average per capita spending. Physicians in some areas deliver or order far more services for Medicare beneficiaries than do physicians in other areas, and there is little evidence that patients in high-volume areas have better health outcomes. Geographically based targets would arguably focus on constraining spending in high-cost areas.

Although these options are more focused than the current system, there is still a risk that they would penalize some efficient providers or reward some inefficient ones. To prevent this, updates or targets could be set for specific providers.

Under one proposal, CMS could identify physicians who provide or order an unusually high number of services and could reduce fee updates for those who fail to change their behavior. Any such option would be controversial. It would require extensive data collection and some consensus on how to distinguish inefficient providers from those who are treating difficult cases.

Finally, payment targets could be broadened to include a wider scope of services. The Medicare Payment Advisory Commission (MedPAC) has suggested that if payment targets are retained, they should apply to all health care sectors. MedPAC notes: "Medicare has a total cost problem, not just a physician cost problem." In this view, systemwide targets could pressure physicians, hospitals, and other actors to collaborate in order to reduce unnecessary or duplicative services.

MAKE OTHER PAYMENT REFORMS: Whatever happens to the SGR targets, there is general agreement that long-range savings will require other reforms in the current payment system. Incentives for physicians are driven not just by the overall level of Medicare prices, but also by the prices for specific services. MedPAC and others have contended that certain services are "overvalued": The price is too high relative to the difficulty of providing the service or the physician's overhead costs.

Because overvalued services can be profitable, physicians have incentives to furnish more of them, while the system discourages the delivery of primary care and other undervalued services. Over time, misaligned incentives can even affect career choices, driving physicians into specialties with the most profitable services. CMS has been taking action on its own to correct some of these pricing problems, and further changes are mandated in the new health reform law.

Many observers argue that Medicare needs to move beyond the basic idea of paying physicians for each service that they provide to each patient. Paying service by service may encourage the fragmentation of care and the delivery of unnecessary services.

There are numerous proposals for payment changes that would promote integrated care delivery and encourage cost-effective medical treatment. One option is the bundled payment, a single payment to a provider for all services related to a specific disease or condition during some fixed period. Another is to encourage the development of accountable care organizations (ACOs), networks of physicians and other providers that would accept responsibility for the overall care of a population of Medicare patients, perhaps in return for a fixed per capita payment.

Many people think these approaches could eventually yield real savings. Still, it could take many years for CMS to develop new payment systems and for providers to form the organizations that can receive the payments. In the interim, most Medicare physician services will still be paid on a fee-for-service basis. And Congress will still face the task of balancing budgetary concerns with the goal of maintaining access to quality care for Medicare beneficiaries.

WHAT'S NEXT?

Because the six-month fix has now been signed into law, Congress will have to revisit the issue before December 1, 2010. Senate leaders are still hoping to negotiate a longer-term fix that would be part of a larger jobs and Medicaid assistance package for the states. The coming days and weeks will determine whether Congress is likely to consider more-permanent payment reforms, or take other steps to thwart a looming, major doctors' fee cut in an election year. ■

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Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:
"Health Policy Brief: Paying Physicians for Medicare Services," *Health Affairs*, June 25, 2010.

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