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April 30, 2011

Sent Via Electronic Mail

The Honorable Joe Barton
Chairman Emeritus
Committee on Energy and Commerce
2109 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Barton:

The North American Spine Society (NASS) is a multidisciplinary medical organization dedicated to fostering the highest quality, evidence-based and value-based, ethical spine care by promoting education, research and advocacy. NASS is comprised of more than 6,200 spine care providers from several disciplines including orthopedic surgery, neurosurgery, physiatry, neurology, radiology, anesthesiology, research and physical therapy. As patient and physician advocates, NASS welcomes the Energy and Commerce Committee's request for ideas and proposals to reform the physician payment system in a way that provides fair and value-based payment for physicians and at the same time reduces Medicare spending. NASS believes these are essential building blocks to establishing a truly sustainable system that accurately covers the costs of health care services delivered to Medicare patients while promoting access to high quality health care.

Executive Summary

The goal of any Medicare payment policy with physicians, hospitals, nursing homes, drug coverage and other providers is to obtain good value for the program's expenditures. This includes high-quality health care, efficient use of resources and maintaining continued beneficiary access to these high-quality services. A program that does not consider all of these aspects or the longer term implications of any policy changes may do a disservice to its beneficiaries and to the nation.

Broad consensus exists amongst the medical profession, Congress and various other stakeholders that the current Sustainable Growth Rate (SGR) formula used to determine annual physician payment updates is an unfeasible long-term solution that does not reflect the true costs of providing care to Medicare beneficiaries. Any system used to replace the flawed SGR formula should look into all aspects of Medicare outlays, including Medicare expenditures to non-physician providers such as hospitals, nursing homes, DME providers, Medicare Advantage as well as technical costs for imaging services. Disproportionate annual updates to various stakeholders within Medicare should be avoided. Identification of the value associated with specific elements of care is crucial, and stakeholders need to broaden the data infrastructure to optimize this process. In order to achieve meaningful incorporation of value parameters into the reimbursement system, a short-term (3-5 years) transitional system between the current SGR formula and a future value-based payment system, similar to other transitional systems that have been used in the physician fee schedule when a methodological change was made, may be necessary. Increasing the value and cost-efficiencies of health care delivery will require integration of efforts between multiple stakeholders, including the Centers for Medicare and Medicaid Services (CMS), clinicians and specialty societies.

We present our thoughts on a system that will allow us to continue to provide appropriate and patient-centered care for our patients in the following pages. The topics covered in the following pages include facts on Medicare expenditure growth, Part B expenditures, the current SGR formula and concepts that ought to be considered in any replacement system.

Topics Covered

- Medicare Expenditure Growth
- Physician Component of Part B Expenditures and Growth

- Physician Payments in the United States: Development of Fair Value for Codes
- Reducing National Health Care Expenditures: Bearing Our Share of the Load
- Broad Agreement of SGR Failure
- Options for Replacing the SGR
- Incorporating Value into Physician Payment Systems
- Specific Value-Based Model Proposals

Medicare Expenditure Growth

Total Medicare expenditures have increased by approximately 7.5 percent per year between 1997 and 2007.[1] In fiscal year 2010, overall Medicare spending accounted for 20 percent of national health expenditures and 15 percent of the federal budget. Medicare expenditures paid for more than 30 percent of the nation's total hospital spending, 24 percent of prescription drug costs and 20 percent of physician services covered under Medicare Part B. In addition to physician fees, Part B covers Medicare beneficiary charges for the following: hospital outpatient services, end-stage renal disease management, laboratory services, durable medical equipment and certain home health services.

Growth in spending can be attributed to both an increase in the fees Medicare pays for each service, which have risen by an average of about 2 percent annually since 2002, and the addition of covered services and increases in volume and intensity of services, which have risen by about 4.5 percent annually over this same time period.[2] An aging population, increasing life expectancy, advances in medical technology, advanced medical imaging and other changes in the practice of medicine have increased the average volume and intensity of the services provided to Medicare beneficiaries. Other policy changes, including the Part D prescription drug benefit added in 2006 and rising Medicare beneficiary enrollment into Medicare Advantage plans, have significantly contributed to overall Medicare expenditure and projections.

Medicare enrollment is expected to grow by more than 1.6 million beneficiaries annually between 2010 and 2030, expanding the number of people on Medicare from 47 million to 79 million.[3] Increased program enrollment from the "baby boom" generation will continue to act as a major driver of Medicare expenditures.

Physician Component of Part B Expenditures and Growth

Physician and other health professional services (including diagnostic imaging, laboratory testing, office-administered drugs and various other "high-ticket" items) are covered by Medicare Part B. Increases in combined Part B expenditures are often inaccurately used to imply higher physician expenditures. Physician payment within Part B is updated on an annual basis via the SGR formula. The conglomeration of services that constitute Medicare Part B is assigned an annual target, and if expenditures exceed this target, a formulaic decrease in the annual physician update is required. The combined Medicare Part B services have exceeded their spending target every year since 2002, and are projected to increase annually by 8 percent over the next decade.[4] Based on the SGR formula, physician payments were decreased by 4.8 percent in 2002.[5] The target-driven process has mandated further cuts in each subsequent year; however, these cuts have been averted by congressional intervention, creating an even greater difference between target and expenditures annually. Despite exceeding annual targets, combined Part B expenditures have not increased as a proportion of total Medicare spending, remaining steady at around 20 percent of overall Medicare expenditures since 2000.[6]

Increases in total Part B expenditures should not be attributed to increased payments for physician services. Medicare physician expenditures as a percentage of Medicare outlays have decreased significantly since 2008—from 12.9% in 2008 to 9.6% in 2011 (Figure 1). Medicare outlays for the professional component of Part B are currently in line with 2007 expenditures, which is the first year the Health and Human Services budget distinguished physicians alone (as opposed to

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[1] Centers for Medicare and Medicaid Services. National Health Expenditure Data. www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf

[2] Medicare's Physician Payment Rates and the Sustainable Growth Rate. *CBO TESTIMONY Statement of Donald B. Marron, Acting Director*. July 25, 2006.

[3] Kaiser Family Foundation. Financing Medicare an Issue Brief. Prepared by Lisa Potetz, Health Policy Alternatives, Inc. January 2008.

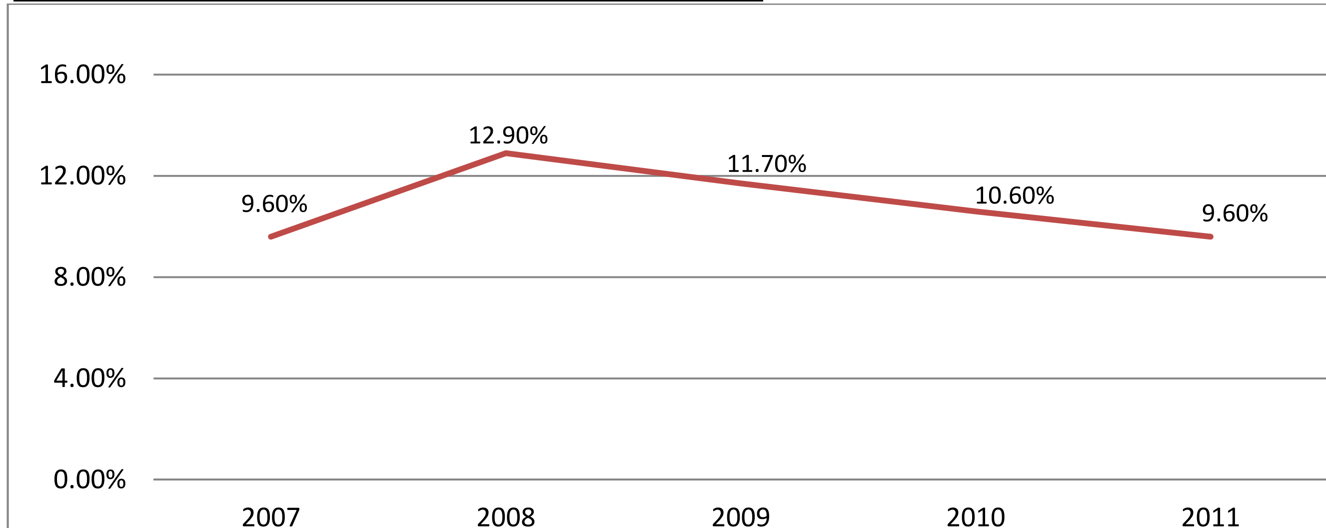
[4] Id. at two.

[5] Id. at two.

[6] Id. at one.

combining physicians payments with other suppliers) as a separate service area within their budget documents.[7] The SGR formula, however, penalizes and holds physicians liable for costs over which they have no control.

Figure 1. Physician Expenditures as a Percentage of Medicare Outlays



Source: Department of Health and Human Services. Historical Medicare benefits by Service Data. CMS Budget in Brief Documents 2005-2011.

In its 2011 Report to Congress on Medicare Payment Policy, the Medicare Payment Advisory Commission (MedPAC) segregated services provided under Part B and highlighted volume growth patterns for each service category within Medicare Part B. The average growth rate for all services provided under Part B between 2000 and 2009 was approximately 4.4 percent. Physician evaluation and management services and physician payments for major procedures showed a modest 3.3 percent average annual volume growth rate, while the volume of imaging and test services grew by almost 9 percent on average annually.[8] Given faster rising costs for other components within Part B expenditures, the SGR formula will continue to project negative updates for physician payments despite decreasing expenditures on the professional component since 2007.

Physician Payments in the United States: Development of Fair Value for Codes

Health care in the United States has, for many decades, been a beacon to the rest of the world. A substantial component of the United States' high-quality health care has been provided by specialists in their fields. Maintaining the excellence of that care by attracting individuals to specialty care must remain an integral part of health care policy as many surgical and specialty medicine disciplines have current or projected workforce shortfalls.

Physician payment in the United States is based on the submission of codes for services provided. Codes are valued through a process undertaken by the American Medicare Association (AMA) Relative Value Update Committee (RUC), which is a panel of 29 volunteer representatives from both primary and specialty care. The RUC has, in the last few years, recommended substantial increases to values for primary care services, preventive services, emergency services, home visits and nursing home visits while values for surgical procedures have decreased significantly. Between 1993 and 2002, Medicare payment for new office visits increased 73 percent and established visits increased 67 percent. During that same time period, payment for major procedures decreased an average of 8 percent, with some procedures such as cataract surgery, coronary artery bypass graft surgery and joint replacement surgery decreasing 43 percent.

While overall physician payment through Medicare has declined over the past few years, significant steps have been taken over this same time period to improve payment for primary care. In its March 2009 report, MedPAC noted that Medicare payments for primary care have increased 10.6 percent between 2006 and 2009, which can be attributed

[7] The Department of Health and Human Services. Historical Medicare benefits by Service Data. CMS Budget in Brief Documents 2005-2011.

[8] MedPAC. Report to Congress: Medicare Payment Policy. March 2011.

largely to the work of the physician community through the RUC process. The RUC's most recent five-year review (2007), approved by CMS, resulted in more than $4 billion in the fee schedule being shifted to evaluation and management codes from other services, including specialty care. Payment for many surgical services were cut again in 2008 because of an additional reduction in work values.

Specialists continue to lose ground in the fees they receive for serving Medicare beneficiaries while their practice costs steadily rise. Specialists go through longer training periods, accumulate more educational debt, experience more complex and higher stress of practice, work longer hours, and realize higher practice expense and liability costs. Further, several studies demonstrate looming workforce shortages for specialty care physicians, not dissimilar to that projected for primary care physicians. Any system attempting to replace or improve the current SGR should equally adjust payments for all physicians in an effort to maintain and promote access to high quality specialty care, accommodate the needs of all Medicare patients, and foster continued high quality care in the United States.[9]

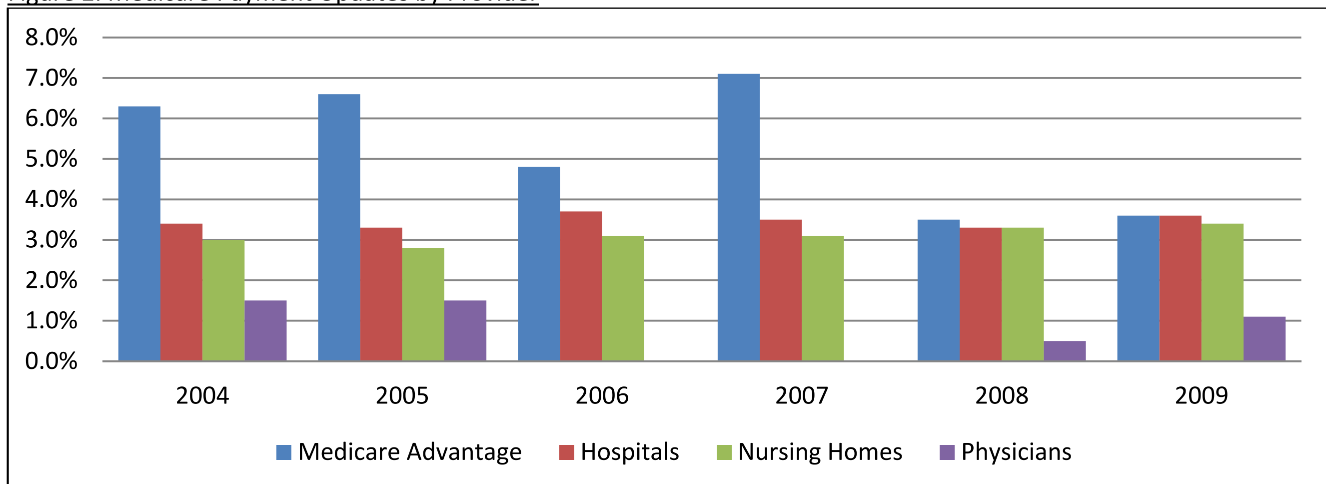
Reducing National Health Care Expenditures: Bearing Our Share of the Load

The patients' welfare is the primary driver of individuals who choose a career in medicine. Physicians are also cognizant of the current strains on the economy and wish to contribute to the effort in reducing national expenditures. It pains physicians to point out that Congress has, over the years, consistently provided significantly greater payment updates to Medicare Advantage plans, hospitals, and nursing homes than to those on the frontlines providing care to Medicare patients. On average, physician updates are less than half of those of other providers. These discrepancies have resulted in increasing payment inequities that negatively affect physicians' ability to continue providing high-quality services to Medicare beneficiaries.

From 2004-2009, physician updates averaged an annual 0.77% increase. Over the same time period, Medicare Advantage payments increased an average of 5.32%, while hospitals increased an average of 3.47% and nursing homes increased an average of 3.12%. In 2006 and 2007, when physicians received no payment update, Medicare Advantage plans, hospitals and nursing homes received updates of at least 3% per year (Figure 2). This lack of payment consistency across providers and settings is illogical, , inequitable and unsustainable.

Hospital spending constitutes approximately 33% of the total Medicare budget. Hospital payments have escaped the formulaic approach to payment, resulting in continued positive annual payment updates. Combined Part B Medicare expenditures constituted 13% of total Medicare expenditures in 2009. Any attempt at reducing health care expenditures should take into consideration all Medicare providers and in particular, identify expenditures that constitute higher proportions of overall expenditure and expenditures that have received generous updates.

Figure 2. Medicare Payment Updates by Provider



Source: American Medical Association. Analysis of Medicare Provider Payment Updates 2004-2009.

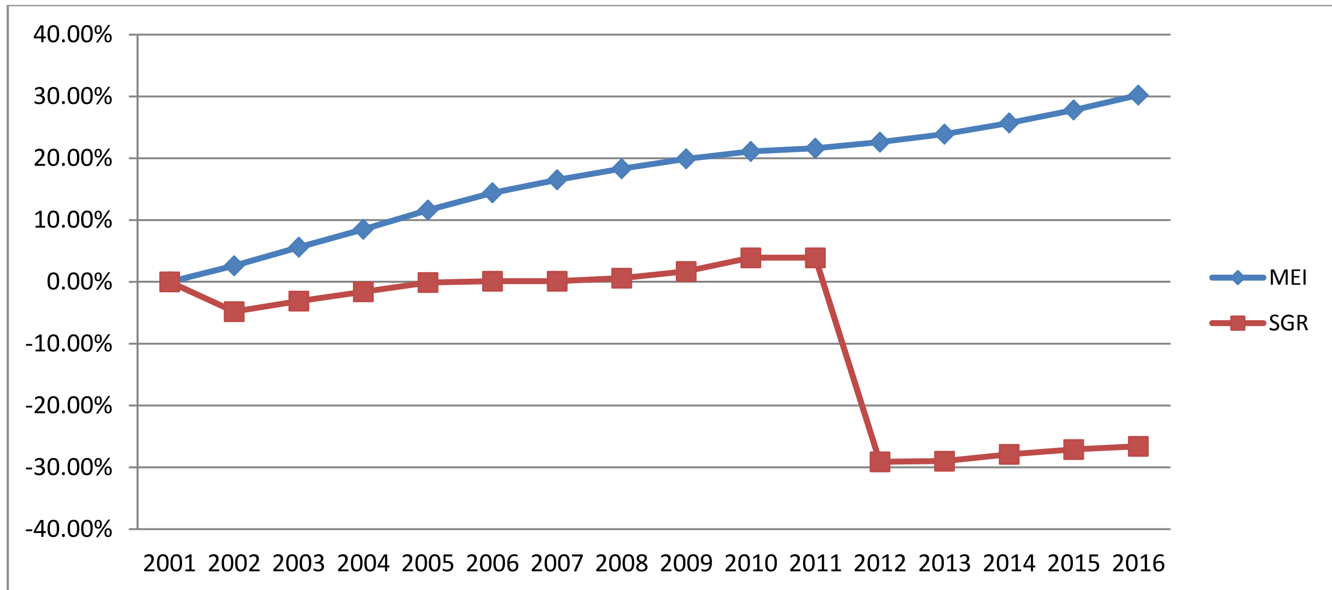
[9] Council on Graduate Medicare Education. New Paradigms for Physician Training for Improving Access to Health Care. September 2007.

Broad Agreement of SGR Failure

A general consensus among physician groups, policymakers and health care experts that Medicare's current physician payment formula is flawed. While this system attempts to monitor and stabilize Part B expenditures, it fails to accurately and fairly reimbursing physicians for the services they provide to Medicare beneficiaries. Expert analysis provided by physician groups, including the AMA and Alliance of Specialty Medicine, demonstrates that as Congress continues to provide temporary relief from payment cuts, the gap between the cost of services provided and their payment is increasing. The SGR formula requires a 29.5% cut to physician payments beginning January 1, 2012. According to the 2010 Medicare Trustees Report, further cuts of more than 20% will be mandated through 2016, while practice costs will increase more than 30% over the same period (Figure 3). Physicians cannot continue to treat Medicare patients if payments fail to even cover the costs associated with treating these patients.

MedPAC communicated its concerns with the SGR formula in its 2011 Report to Congress. The report highlights the disadvantages in the formula's across-the-board cuts to Medicare's physician fee schedule, the inability to reward or penalize individual providers who limit or contribute to unnecessary volume growth respectively, and its failure to provide a mechanism to counter the volume incentives inherent in a fee-for-service payment scheme.

Figure 3. Cumulative Update: Medical Inflation vs. SGR



Source: 2010 Medicare Trustees Report Updated to Reflect Medicare and Medicaid Extenders Act of 2010

Options for Replacing the SGR

NASS proposes that as Medicare physician payment transitions into a value-based system (3-5 years), the SGR formula be replaced by a formula based on the Medicare Economic Index (MEI). The CBO projects that the MEI will remain relatively stable from 2012 through 2019 and range from 1.0 to 2.7% (Figure 3). Replacing the SGR with a system that updates physician payments based on changes in costs as reflected by MEI would reimburse physicians in a manner that more accurately represents the cost of providing care. An alternate proposal would update physician payments based on changes in Gross Domestic Product (GDP), with the addition of a fixed percentage increase to ensure payment fairness. For example, President Obama recently proposed GDP plus 0.5% as a reasonable target for growth of total Medicare expenditure.

NASS also proposes that a target that uses combined Part B expenditures is too crude an instrument to develop any meaningful information on costs. This crude instrument precludes policymakers from accurately assessing the contributions of various expensive items with different annual growth rates within Medicare Part B, such as diagnostic imaging, laboratory and outpatient hospital expenditures. A combined target for all expenditures within Part B also eventually results in mandatory reductions in formulaic physician payment, without regard to the cause of increased expenditure within Part B. NASS proposes that if a target for expenditure were to be used, this target should be strictly limited to the immediate prior year professional physician payment expenditures. This more restricted target will provide a more accurate accounting of physician expenditures on an annual basis. Creating a set of more granular and increasingly sensitive targets may also lead to more careful analysis on various subgroups within the physician workforce when attempting to determine the best value for Medicare expenditures.

Incorporating Value into Physician Payment Systems

Despite vigorous efforts on the part of medical providers and researchers to develop an evidence-based approach to care, substantial gaps remain in quantifying the “value” of individual treatments, comparing the relative value of differing treatments, and the extrapolation of such values in the treatment of any individual patient. Therefore, attempting to develop a value-based system with the limited information currently available on what actually constitutes value is likely to result in an inaccurate and unsuccessful replacement of our current flawed system.

Identifying effective components of treatment and delivering high value care to Medicare beneficiaries will require an expanded pool of data. The development of registry databases, increased research on the effectiveness of treatments, the study of existing outcomes data through CMS or other organizations, and defining appropriate pathways of care will all allow for more reliable and consistent determinations regarding the value of specific services. Collaboration among specialty societies, CMS and other governmental agencies will be the most effective means of identifying crucial areas for study, appropriate individuals or groups to champion specific projects, and funding patterns that will facilitate the production of critical information necessary to transition to value-based payment. With government funding, specialty societies across medicine could develop a series of registries to track outcomes on important medical interventions.

Specific Value-Based Model Proposals

Developing integrated systems to deliver care in a manner that emphasizes value for the beneficiary and Medicare will require substantial cost outlays and risk assumptions. Identifying specific care pathways and components of delivery systems will be crucial to the success of these structures. In order to maintain a competitive balance that will allow for innovation, patient choice and economic efficiency, it is necessary to have a reimbursement environment that permits the development of smaller scale care groups that can maintain system viability. This will require some degree of economic protection or safety for groups that may be vulnerable to advancements of much larger groups which, if unopposed, may ultimately reduce patient choice and value. Additionally, there should be transparency in payment to ensure fair competition and to allow progress in cost containment to be shared. The parallel development of multiple delivery mechanisms will require the joint efforts of CMS, private payers, clinicians/specialty societies and patient advocates.

Value-based changes in care delivery that have been previously proposed include Accountable Care Organizations (ACOs), value-based payments and coordinated delivery of care. An ideal system may well involve a combination of these mechanisms of payment, particularly while transitioning from the current model. ACOs offer advantages by centralizing patient information and services, but have difficulties of scale, particularly for low population density areas, lower frequency treatments and highly complex patients requiring very specialized care. Ensuring adequate reimbursement for specialty care within these organizational structures is essential to reflect the high level of skill and training necessary to provide these services, to maintain an adequate specialty workforce, and to preserve the high quality of the nation’s health care.

Value-based reimbursement could also be linked to the development of a value modifier for services provided. Transitioning to such a value-based payment system will require the development of specific outcomes information on various health care diagnoses. Registry databases, large scale clinical trials and appropriate care guidelines will be required to develop and refine this type of system. This form of payment would, however, allow for more independent forms of health care delivery than an ACO model, enabling clinicians to serve those who would be particularly difficult to treat in larger systems, such as those in rural areas. Coordinated delivery of episodes of care, or “bundling” of related

services, offers another potential delivery method. As with the other possibilities, identifying those components of care necessary to maintaining the value of the service is critical to the success of this model.

Because there are a variety of options without a clearly superior choice, Congressional support of demonstration projects may provide the best opportunity to explore and identify the best method or methods to achieve a successful transition to a payment system that focuses on value. For example, NASS includes primary care and specialty physicians, chiropractors and physical therapists who treat patients with spinal disorders. Neck and back disorders are a common malady representing a significant proportion of health care services. However, the care of patients with these common problems remains fragmented under our current delivery system, with inadequate and inefficient coordination among the various providers. Similar to the concept of the "medical home," which was evaluated with a CMS demonstration project, a model of interdisciplinary care that includes the integration and participation of a group of providers treating a disease process with a bundled payment reflective of the costs of managing the disease rather than costs reflecting each individual service would serve as an excellent demonstration project.

All of these alternative payment models offer the potential for increasing the quality of care while controlling costs. They also pose significant potential risks for Medicare beneficiaries while health care providers and systems try to deliver high quality care in a changing and uncertain marketplace. Financial safeguards for those developing these models will cultivate an innovative care environment and allow smaller provider groups to explore ways to improve value. Financial penalties associated with site-of-service or excessive documentation requirements will particularly disadvantage smaller groups and promote excessive consolidation of delivery by large hospital systems or coordinated groups, having a negative long-term effect on both cost and quality. Additionally, any value-based system developed should recognize efficiencies created by site-of-service changes and establish a mechanism to identify situations in which changing health care patterns result in cost shifting from Medicare Part A to Part B and vice versa. The implementation of this system should include policies to facilitate the movement of related funds across Medicare cost centers to improve budget and payment accuracy. Changes in the tort system that decrease the defensive practice of medicine and provide liability protection for physicians in these altered delivery environments will further enhance the capabilities of physicians to develop an effective value-based system.

As you consider the next steps for Medicare payment reform, NASS hopes that you will take into account these comments and concepts, as well as the unique role of specialty medicine. In closing, NASS would like to offer itself as a resource to the Energy and Commerce Committee as this discussion continues, and would be willing to provide expert testimony on any of the concepts offered. If you have any questions or comments please contact Nicholas A. Schilligo, MS, Director of Advocacy, at nschilligo@spine.org or (630) 230-3600. Thank you for your commitment to and leadership on this issue.

Sincerely,

Greg Przybylski, MD
President

cc: The Honorable Fred Upton, Chairman
The Honorable Henry A. Waxman, Ranking Member
The Honorable Joseph R. Pitts, Chairman Subcommittee on Health
The Honorable Michael C. Burgess, MD, Vice Chairman Subcommittee on Health
The Honorable John D. Dingell, Chairman Emeritus
The Honorable Frank Pallone, Jr., Ranking Member Subcommittee on Health