

ALSTON & BIRD LLP

The Atlantic Building
950 F Street, NW
Washington, DC 20004-1404

202-239-3300
Fax: 202-654-4969
www.alston.com

Thomas A. Scully

Direct Dial: 202-239-3459

Email: thomas.scully@alston.com

June 18, 2012

The Honorable Max Baucus
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: Former CMS Administrator Roundtable on SGR

Dear Mr. Chairman:

Thank you for the opportunity to discuss the SGR and physician payment at the Committee Roundtable on May 10. It is a small group of folks who have had the honor of being confirmed for the post of HCFA or CMS Administrator. Thankfully it is a very friendly, constructive and bi-partisan group that includes Bruce, Mark and Gail-- as well as Nancy Ann Min DeParle, Leonard Schaefer and Bill Roper, who did not participate. Despite some policy differences, we have all remained friends and regularly communicate on health issues. It is a very nice tradition of civilized discourse that I am proud to be a part of, and I am pleased that the committee sought our collective opinion on physician payment.

Today we submitted a joint letter reflecting our communal thoughts on physician payment. Each of us has chosen to add some supplemental views, as I will do below. These views are solely my views as a former CMS Administrator and I have not discussed this subject with anyone, including clients at Alston and Bird, nor with any of my partners at Welsh Carson Anderson and Stowe, the NYC firm where I am a partner—nor any of the health care companies that we invest in. The opinions here are 100% my own and do not reflect input from any other source.

I will briefly cover 5 topics: a) bundling; b) options for smaller markets and rural physicians; c) physician payments across provider settings d) the RUC and CPT process; and e) continuing budget processes and fiscal constraints.

- A) Bundling. As wonderful as the Medicare program is for serving seniors and the disabled, it has a fundamental flaw that has driven much of the dysfunction of our health system the last 45 years—it fixes prices. When every professional is paid the same amount for services, regardless of quality, you inevitably get volume

explosions. That has been the problem since 1965—providers have incentives to produce more services, not better services. As a result, I believe that broader bundles of payment will drive the future of Medicare. In fact, I would suggest that Medicare should try: 1) pre acute bundling; 2) acute bundling and 3) post acute bundling—and bundle them into the ultimate bundle—Medicare Advantage—for everyone? Well regulated and competitively paid private insurers that have money at risk will always make better decisions—for patients and taxpayers—than will contractors writing checks where only the taxpayer is “at risk”. Price fixing has never worked in any economy in world history, and it certainly has not and will not work in the long run for the US health system.

So, whether it is ACOs, MA, the ACE program or CMS’ demos—every move in the direction of bundling more physician payments is a positive move for the program—and for sustaining the program for our seniors and the disabled.

- B) Rural Issues and Options. 75% of beneficiaries are still in Medicare FFS, and a majority likely will be for my lifetime. In rural areas it is especially hard to create the appropriate physician incentives and alternatives via capitation. There is very little rural managed care, and physician-based ACOs are not always easily organized or capitalized. Usually these areas have only one hospital, and it is virtually impossible for insurers to organize a “network” in these regions. The real goal of most ACO reformers is to give more economic and decision making power to doctors, and to provide more incentives to see patients often and to keep them OUT of hospitals. Today most rural ACOs or capitated plans have being organized by hospitals—not by physicians— which can be a fundamental problem if your goal is to reduce expensive hospital utilization?? The number of doctors employed by hospitals has doubled in the past five years-- not a healthy development if the policy goal is a more physician driven system?

One alternative may be to provide an option for partial capitation ONLY for Medicare Part B and Part D, passing through Part A costs to the trust funds, as in FFS. Medicare Cost plans have some component of this structure, as does the largely defunct Medicare Select program. But some hybrid of these approaches that provides capitation for all non facility services could speed the development of rural ACOs and other physician “risk” models. This could improve the economic incentives for health professionals in small markets and rural areas.

- C) FFS Payments Across Provider Settings. One of the crazy policies driving perverse incentives for physicians is the “site of service” differential for practice costs. A physician seeing, for example a wound care patient, gets paid the same for the “professional component” of a patient visit whether it is done in: a) an office; b) an ASC or c) a hospital. Often as much as half the payment is the “facility fee” or “practice expense” Illustratively, for that “facility cost” the reimbursement is often, on a relative basis, a) 1.0 in the office; b) 1.1 or 1.2 in an ASC; and c) 1.5-2.0 in a hospital outpatient department!? As a result, if a doctor

“sells” their practice to a hospital – the SAME office— they magically may get paid as much as 25% or more the next day?? Is it no wonder that so many doctors are selling practices to hospitals??

Moreover, only the physician office expense is subjected to the automatic cuts of the SGR? So when the SGR bites for a 27% automatic cut—it impacts the physician office visit “practice expense”—but NOT the hospital facility fee? This is bad policy. Most reformers are focused on giving doctors incentives to see patients for preventative care, and to REDUCE hospital use. Inadvertently encouraging doctors to work for hospitals is totally counterproductive, thus this “site differential” should be fixed in any physician payment reform.

- D) The Relative Value Update Committee (RUC) and the CPT process. As I mentioned in the Roundtable, it not the AMA’s fault that they were asked to take on this duty for the last 20 years. But the process effectively controls physician payment and is very political among physician specialty groups. This is not appropriate and should be changed. CMS could and should end the RUC as constituted today and assign these organizational duties to some independent authority or contractor. The GAO, IOM or even RTI, which has remained largely an independent CMS contractor, might oversee such a Committee. But the politics of the AMA and its specialty societies should not drive the allocation of over \$100 Billion a year of physician spending. So long as we have seniors in Medicare FFS, this should be an independent function. I also feel that CMS should similarly establish a CPT-like code system independent of the CPT system utilized today. Medicare payment drives this process, and independent Medicare evaluations should drive these decisions.
- E) Budget Targets. I was very involved in the creation of RBRVS. Clearly this process, and its SGR successor, has not worked. Still, it has been the ONLY structural budget restraint in Medicare for the past 35 years—and it has at least worked to draw attention and policy debate to exploding Part B Medicare costs. Instead of abolishing all budget restraints, maybe it is more appropriate to ask--should hospital spending have targets that initiate some policy changes? How about part B drugs? Outpatient services? SGR clearly did not work, and was inflexible and inappropriate. But with a 9% of GDP deficit, and Medicare being clearly the #1 fiscal issue for the next generation, is completely “punting” on structural fiscal discipline a good idea?

The annual debate around SGR is indeed unfortunate, ineffective and sometimes silly? But at least it generates debate about health costs—something that has been sadly missing in our public policy discussion. Some triggers for ALL Medicare categories of spending, and Medicaid as well, that would encourage action—or at least generate a debate—would be a policy advance.

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For the last 20 years only physicians were subjected to spending caps and triggers, and they were ineffective and unfair. Still, maybe we should be adding improved policy structure for ALL providers and suppliers, and not just surrendering to the behavioral whims of an open-ended entitlement?

Mr. Chairman, it has been a pleasure and an honor to be part of this process. I know I join Gail, Bruce, and mark in wishing you and the Committee the best in your reform efforts, and we hope we can all be helpful in the future.

Sincerely,

A handwritten signature in black ink, appearing to read "Tom Scully". The signature is fluid and cursive, with the first name "Tom" and last name "Scully" clearly distinguishable.

Thomas A. Scully

TAS:bc

Alston & Bird LLP