MEDPAC Medicare Payment Advisory Commission

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Glenn M. Hackbarth, J.D., Chairman
Michael Chernew, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

April 10, 2013

The Honorable Max Baucus
Chairman, Committee on Finance
U.S. Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member, Committee on Finance
U.S. Senate
203 Hart Senate Office Building
Washington, DC 20510

The Honorable Dave Camp
Chairman, Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sander M. Levin
Ranking Member, Committee on Ways and Means
U.S. House of Representatives
1106 Longworth House Office Building
Washington, DC 20515

The Honorable Fred Upton
Chairman, Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Henry A. Waxman
Ranking Member, Committee on Energy and Commerce
U.S. House of Representatives
2322A Rayburn House Office Building
Washington, DC 20515

RE: Moving forward from the sustainable growth rate system

Dear Chairmen and Ranking Members:

Having been asked at recent hearings about MedPAC's view on the sustainable growth rate (SGR) formula, I am writing to provide some updated information.

The time to repeal SGR is now. Further delay would expose beneficiaries to an increasing risk of impaired access, especially access to primary care. Although we do not yet see evidence of a nationwide problem in access to care for Medicare beneficiaries, access is strained in some markets. Those problems could spread to more markets due to increases in the Medicare population, a large cohort of physicians reaching retirement age, and newly insured patients seeking care in 2014. Growing "SGR fatigue" among physicians, resulting from annual crises prompted by pending Medicare payment cuts, can only aggravate any access problems that might develop.

In October 2011, MedPAC made four distinct recommendations. First, the link between cumulative fee-schedule expenditures and annual conversion factor updates is unworkable and should be eliminated. In place of the SGR, the Commission outlined a 10-year path of legislated updates, including updates for primary care services that are different from those for other services. Second, CMS should collect data to improve payment equity within the fee schedule. Third, CMS should identify overpriced services and adjust the RVUs of those services. And fourth, the Medicare program should encourage physician movement from fee-for-service into risk-bearing accountable care organizations (ACOs) by creating greater opportunities for shared savings. With these recommendations, we offered a list of possible offsets if the Congress were to decide to offset the cost of repeal from within the Medicare program.

Our basic position has not changed, but the Congressional Budget Office's (CBO's) estimate of the cost of repeal has changed. In October 2011, CBO's estimate of a 10-year freeze was about $300 billion over 10 years. Their current estimate of a 10-year freeze is $138 billion. We urge the Congress to act now to take advantage of this lower estimate; if history is any guide, the cost of repeal could increase again.

Providing higher payment updates for primary care compared with other fee schedule services would counter inequities in the physician and other health professionals fee schedule and contain the cost of the repeal. Further, given that the cost of repeal has decreased, the 10-year path of legislated updates described in our October 2011 letter could be revised. The October 2011 updates would have resulted in physicians and other health professionals bearing about one-third of the fiscal burden of repeal while the remaining two-thirds would have been spread across all of the other participants in Medicare (other providers and suppliers, health plans, and beneficiaries). If those same proportions were maintained, the fee schedule conversion factors could be higher as a result of the new CBO score. To be clear, we still believe it is necessary to have a differential between primary care services and other services. However, while our 2011 recommendations included reductions for services other than primary care of 5.9 percent each year for three years, our preliminary estimate is that each of those reductions could now be 3 percent or less. This estimate assumes that primary care fees are held constant throughout the 10-year period and that one-third of the fiscal burden of repeal is borne by physicians and other health professionals paid under the fee schedule.

While a specific sequence of legislated updates would establish a new budgetary baseline, they would not be immutable. Each year MedPAC will continue to review whether payments to physicians and other health professionals are adequate—through surveying beneficiaries, conducting physician and beneficiary focus groups, tracking practitioner participation in Medicare, and examining changes in volume and quality of ambulatory care. If, through these analyses, the Commission determines that a change in payment rates is needed to ensure adequate access, the Commission would make such a recommendation to the Congress.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman