APPENDIX B

Moving forward from the sustainable growth rate (SGR) system

MEDPAC Medicare Payment Advisory Commission

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October 14, 2011

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
104 Hart Senate Office Building
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The Honorable Dave Camp
Chairman, Committee on Ways and Means
U.S. House of Representatives
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The Honorable Sander M. Levin
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The Honorable Fred Upton
Chairman, Committee on Energy and Commerce
U.S. House of Representatives
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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 (SGR) system

Dear Chairmen and Ranking Members:

The sustainable growth rate (SGR) system—Medicare's formulaic payment method for services provided by physicians and other health professionals—is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. This system, which ties annual updates to cumulative expenditures since 1996, has failed to restrain volume growth and, in fact, may have exacerbated it. Although the pressure of the SGR likely minimized fee increases in the last decade, this effect disproportionately burdened physicians and health professionals in specialties with less ability to increase volume. Additionally, temporary, stop-gap "fixes" to override the SGR are undermining the credibility of Medicare because they engender uncertainty and anger among physicians and other health professionals, which may be causing anxiety among beneficiaries. The risks of retaining the SGR now clearly outweigh the benefits. Moreover, the cost of full repeal, as

well as the cost of temporary reprieves, grows inexorably. It will never be less expensive to repeal the SGR than it is right now.

With this assessment, the Commission recommends that the Congress repeal the SGR system and replace it with a 10-year schedule of specified updates for the physician fee schedule. The Commission drew on three governing principles to form our proposal. First, the link between cumulative fee-schedule expenditures and annual updates is unworkable and should be eliminated. Second, beneficiary access to care must be protected. Third, proposals to replace the SGR must be fiscally responsible.

From these principles, we recommend complete repeal of the SGR system and propose a series of updates that would no longer be based on an expenditure- or volume-control formula. These legislated updates would allow total Medicare expenditures for fee-schedule services to increase annually—roughly doubling over the next ten years. Approximately two-thirds of this increase would be attributable to growth in beneficiary enrollment and one-third would be attributable to growth in per beneficiary service use. Although our proposed updates reduce fees for most services, current law calls for far greater fee reductions and could lead to potential access problems under the SGR. The Commission finds it crucial to protect primary care from fee reductions, considering that the most recent data show that access risks are concentrated in primary care.

As is our charge, each year MedPAC will continue to review annually whether payments to physicians and other health professionals are adequate. To this end, we will continue to survey beneficiaries, conduct physician focus groups, track physician and practitioner participation in Medicare, and examine changes in volume and quality of ambulatory care. If, through these analyses, we determine that a future increase in fee-schedule rates is needed to ensure beneficiary access to care, then the Commission would submit such a recommendation to the Congress. Enacting our recommendation would eliminate the SGR and would alter the trajectory of fee-schedule spending in Medicare's baseline. Therefore, future fee increases relative to this new baseline would require new legislation and would carry a budgetary cost.

Our recommendation for repealing the SGR carries a high budgetary cost. The Congress, of course, may seek offsets for repealing the SGR inside or outside of the Medicare program. Because MedPAC was established to advise the Congress on Medicare policies, we are offering a set of savings options that are limited to the Medicare program. We do not necessarily

recommend that the Congress offset the repeal of the SGR entirely through Medicare. The steep price of this effort, and the constraint that we imposed on ourselves to offset it within Medicare, compels difficult choices, including fee-schedule reductions and offsets that we might not otherwise support.

The Commission is also proposing refinements to the accuracy of Medicare's physician fee schedule through targeted data collection and reducing payments for overpriced services. Even with improvements to the fee schedule's pricing, moreover, Medicare must implement payment policies that shift providers away from fee-for-service (FFS) and toward delivery models that reward improvements in quality, efficiency, and care coordination, particularly for chronic conditions. The Commission is also recommending incentives in Medicare's accountable care organization (ACO) program to accelerate this shift because new payment models—distinct from FFS and the SGR—have greater potential to slow volume growth while also improving care quality. Similarly, incentives for physicians and health professionals to participate in the newly established Medicare bundling pilot projects could also improve efficiency across sectors of care.

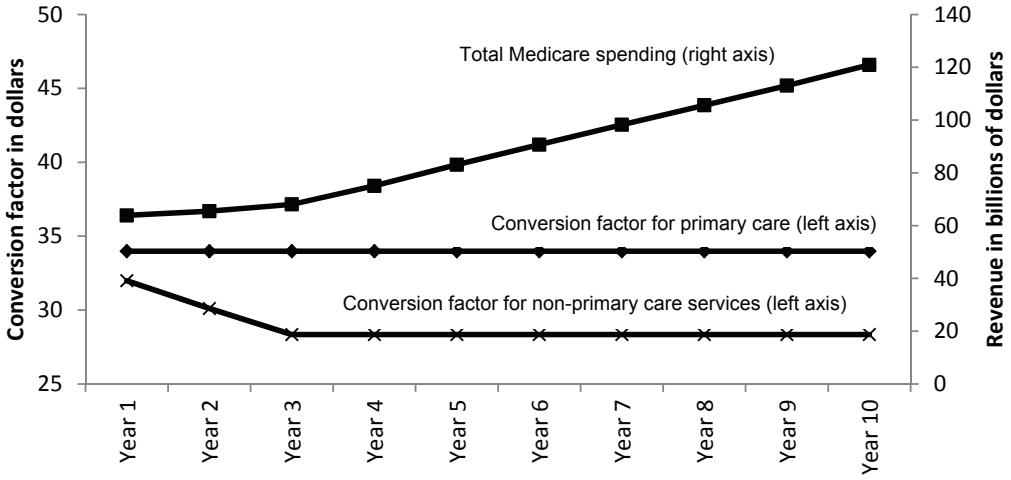
Respectfully, we submit the recommendations described below. Several of them are interrelated. Our willingness to recommend difficult measures underscores the urgency we attach to repealing the SGR. The cost of repealing the SGR, as well as the cost of any short-term reprieves, will only increase. Meanwhile, the opportunities for offsetting that cost by reducing Medicare expenditures will only shrink if Medicare savings are used for other purposes (such as, to help finance coverage for the currently uninsured or for deficit reduction). Our concern is that repealing the SGR will become increasingly difficult unless the Congress acts soon.

Repealing the SGR formula and realigning fee-schedule payments to maintain access to primary care

Repealing the SGR formula ultimately severs the link between future payment updates and cumulative expenditures for services provided by physicians and other health professionals. In place of the SGR, the Commission proposes a 10-year path of legislated updates (Figure 1). This path is consistent with the principles of an affordable repeal of the SGR, continued annual growth in Medicare spending for physician services, and maintaining access to care. For primary care, which we define more specifically later in this section, the Commission recommends that

payments rates be frozen at their current levels. For all other services, there would be reductions in the fee schedule's conversion factor in each of the first three years, and then a freeze in the conversion factor for the subsequent seven years.[1] While there would be decreases in payment rates for most services, projected growth in the volume of services—due to increases in both beneficiary enrollment in Medicare and per beneficiary service use—would lead to continued annual increases in total Medicare expenditures for fee-schedule services. We describe previous spending trends in Appendix Figure A-1.

Figure 1. Potential update path for fee schedule services



Source: MedPAC analysis of Part B fee-for-service spending per beneficiary, enrollment growth, and growth in the volume of fee-schedule services per beneficiary. See text for details.

The rationale for exempting primary care from fee-schedule cuts comes from recent research suggesting that the greatest threat to access over the next decade is concentrated in primary care services.[2] In both patient surveys and physician surveys, access to primary care providers is more

[1]Alternative update paths with the same approximate cost are possible. For example, fees for non-primary care services could receive smaller reductions over more years. Under this alternative, however, by year 10, the conversion factor for non-primary care services would be lower than that proposed in Figure 1.

[2]Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC; Friedberg, M. et al. 2010. Primary care: A critical review of the evidence on quality and costs of health care. *Health Affairs* 29, no. 5 (May): 766-772; Vaughn, B. et al. 2010. Can we close the income and wealth

problematic than access to specialists. These findings hold for both Medicare and privately insured patients, magnifying the vulnerability of access to primary care services.

One example of this research comes from MedPAC's annual patient survey that we use to obtain the most timely data possible for analyzing access to physician services. This survey interviews Medicare beneficiaries age 65 and over and privately insured individuals age 50 to 64. (For more details on the survey's methodology, please see Chapter 4 our March 2011 Report to the Congress.) Results from this annual survey consistently find that both Medicare beneficiaries and privately insured individuals are more likely to report problems finding a new primary care physician compared with finding a new specialist (Appendix Table A-2). For instance, in 2010, although only 7 percent of beneficiaries reported looking for a new primary care physician in the past year, among those looking, 79 percent stated that they experienced no problems finding one. In contrast 87 percent of the beneficiaries who were looking for a new specialist reported that they had no problems finding one. Among privately insured individuals looking for a new primary care physician, 69 percent reported no problems finding one compared with 82 percent of those looking for a new specialist.

Consistent with this patient survey, physician surveys have also found that primary care physicians are less likely than specialists to accept new patients. Again, this discrepancy holds for both Medicare and privately insured patients. For example, the 2008 National Ambulatory Medical Care Survey finds that 83 percent of primary care physicians accept new Medicare patients, compared with 95 percent of specialists (Appendix Table A-3). Acceptance rates are lower for patients with other insurance as well. Specifically, 76 percent of primary care physicians accepted new patients with private (non-capitated) insurance compared with 81 percent of specialists. In a 2008 survey conducted by the Center for Studying Health System Change, physicians who classified themselves in surgical or medical specialties were more likely

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gap between specialists and primary care physicians? *Health Affairs* 29, no. 5 (May): 933-940; Bodenheimer, T. et al. 2009. A lifeline for primary care. *New England Journal of Medicine* 360, no. 26 (June 25): 2693-2696; Grumbach, K. and J. Mold. 2009. A health care cooperative extension service. *Journal of the American Medical Association* 301 no. 24 (June 24): 2589-2591; Rittenhouse, D. et al. 2009. Primary care and accountable care—two essential elements of delivery-system reform. *New England Journal of Medicine* 361, no. 24 (December 10): 2301-2303; Colwill, J. et al. 2008. Will generalist physician supply meet demands of an increasing and aging population? *Health Affairs* 27, no. 3 (April 29): w232-w241.

than primary care physicians (classifying themselves as either in internal medicine or family/general practice) to accept all new Medicare, Medicaid, and privately insured patients.[3]

Exempting primary care from the reductions would mean that Medicare payments for those services would not be based entirely on resource-based relative values. Although resources used to furnish a service (e.g., the time and intensity of effort or practice expenses incurred) are appropriately considered in establishing the fee schedule, other considerations may also be important, including ensuring access or recognizing the value of the services in terms of improving health outcomes or avoiding more costly services in the future. Market prices for goods and services outside health care often reflect such factors. The Congress has demonstrated precedent for this approach in the Medicare fee schedule, such as through the primary care and general surgery bonuses included in the Patient Protection and Affordable Care Act of 2010 (PPACA), as well as floors established for work and practice expense values and bonuses for services provided in health professional services shortage areas.

Regarding the proposed updates included in our recommendation to repeal the SGR, we specify a definition of primary care that focuses on protecting the practitioners and services which make up the core of primary care. The Commission limits the primary care update path to physicians and other health professionals who meet both of the following criteria:

- *Practitioner specialty designation*: Physicians who—when enrolling to bill Medicare—designated their specialty as geriatrics, internal medicine, family medicine, or pediatrics. Eligible practitioners would also include nurse practitioners, clinical nurse specialists, and physician assistants.
- *Practice focused on primary care*: Physicians and practitioners who have annual allowed Medicare charges for selected primary care services equal to at least 60 percent of their total allowed charges for fee-schedule services. Primary care services used to determine eligibility are: office visits, home visits, and visits to patients in nursing facilities, domiciliaries, and rest homes.

Under our proposal, the legislated updates for primary care would apply to the following services when provided by eligible primary care practitioners: office visits, home visits, and visits to

[3]Boukus, E. et al. 2009. *A snapshot of U.S. physicians: Key findings from the 2008 Health Tracking Physician Survey.* Data bulletin no. 35. Washington, DC: HSC.

patients in hospitals, nursing facilities, domiciliaries, and rest homes.[4] MedPAC analysis of claims data finds that under these specifications, about 9 percent of fee-schedule spending would be protected from fee reductions each year. For eligible primary care practitioners, these protected services typically account for the vast majority of their Medicare billing. Payment rates for other services—such as laceration repairs and endoscopies—furnished by all fee-schedule providers, including primary care practitioners, would be subject to the fee reductions in the first three years.[5]

Table 1. Potential update path for fee-schedule services

	Primary care		Other services		Annual
Year	Payment rate change	Conversion factor	Payment rate change	Conversion factor	payments (billion)
Y1	0.0%	$33.98	−5.9%	$31.99	$64
Y2	0.0	33.98	−5.9	30.11	66
Y3	0.0	33.98	−5.9	28.34	68
Y4	0.0	33.98	0.0	28.34	75
Y5	0.0	33.98	0.0	28.34	83
Y6	0.0	33.98	0.0	28.34	91
Y7	0.0	33.98	0.0	28.34	98
Y8	0.0	33.98	0.0	28.34	106
Y9	0.0	33.98	0.0	28.34	113
Y10	0.0	33.98	0.0	28.34	121

Note: The current (2011) conversion factor is $33.98.
Source: MedPAC analysis of Part B fee-for-service spending per beneficiary, enrollment growth, and growth in the volume of fee-schedule services per beneficiary 2004-2009.

Medicare fees for non-primary care services would be reduced by 5.9 percent each year for 3 years (Table 1). We arrive at this path after satisfying two requirements: protecting core primary care services that are furnished by primary care providers from payment reductions, and

[4]Expanded definitions of primary care are possible. For example, the range of specialties could be expanded. However, protecting more services from the fee reduction will result in either a higher cost (and the need for more offsets) or a deeper fee reduction for the non-primary care services. Alternative definitions of protected services are also possible, such as using the number of unique diagnosis codes that a provider sees over the course of a year to distinguish between highly specialized providers and those that provide a more comprehensive range of care.
[5]The freeze on payment rates for primary care could be implemented either with a separate conversion factor, or with a claims-based payment modifier. If the freeze is implemented with a claims-based payment modifier, a single, reduced conversion factor would apply to all services; but, for eligible primary care services, the payment modifier would increase the fee and effectively reverse the conversion factor reduction.

achieving a total estimated 10-year cost that is no more than $200 billion. If the update paths depicted in Figure 1 were implemented in 2012, the conversion factor for non-primary care would decrease over a period of three years from the current level of $33.98 to about $28.34. It would then stay at that level for the remaining seven years of the budget window. By contrast, under current law, the conversion factor would be $24.27 at the end of the budget window. Taking into account the increase in the number of Medicare beneficiaries over the next 10 years and growth in the volume of services provided per beneficiary, total practitioner payments from Medicare would rise from $64 billion to $121 billion. On a per beneficiary basis, practitioner payments would continue to rise at an average rate of 2.2 percent per year. The $200 billion estimated cost of this proposed update path accounts for the cost of eliminating the significantly larger SGR cuts and replacing them with the updates specified in Table 1.

A freeze in payment levels for primary care is not sufficient to support a robust system of primary care. Payment approaches that recognize the benefits of non-face-to-face care coordination between visits and among providers may be more appropriate for primary care, particularly for patients with chronic conditions. The Centers for Medicare & Medicaid Services (CMS) is embarking on several projects to examine the results (patient health and total spending outcomes) of monthly per-patient payments to primary care providers for their care coordination activities. These include the Comprehensive Primary Care Initiative, the Multipayer Advanced Primary Care Initiative, and the Federally Qualified Health Center Advanced Primary Care Practice Demonstration. Issues that this work will help to inform include patient involvement in selecting these providers and effective ways for attributing one eligible provider per patient.

Recommendation 1:

The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three years, followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program.

Collecting data to improve payment accuracy

In addition to a conversion factor, the physician fee schedule includes relative value units (RVUs). These RVUs account for the amount of work required to provide each service, the expenses that practitioners incur related to maintaining a practice, and malpractice insurance costs. To arrive at the payment amount for a given service, its RVUs are adjusted for variations in the input prices in different markets, and then the total of the adjusted RVUs is multiplied by the conversion factor.

The Secretary lacks current, objective data needed to set the fee schedule's RVUs for practitioner work and practice expenses.[6] The fee schedule's time estimates are an example. The RVUs for practitioner work are largely a function of estimates of the time it takes a practitioner to perform each service. However, research for CMS and for the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services has shown that the time estimates are likely too high for some services. In addition, anecdotal evidence and the experience of clinicians on the Commission suggest problems with the accuracy of the time estimates. Furthermore, under CMS's recent potentially misvalued services initiative, time estimates for a number of services have been revised downward after consultation with the Relative Value Scale Update Committee (RUC). These revisions suggest that current time estimates—which rely primarily on surveys conducted by physician specialty societies that have a financial stake in the process—are subject to bias.

Reliable, objective data are also needed for the fee schedule's practice expense RVUs. CMS's methodology for determining these RVUs relies on various types of data: time estimates for clinical employees who work in practitioners' offices, prices for equipment and supplies used in practitioners' offices, and total practice costs for each physician specialty. The Commission questions the accuracy and timeliness of these data.[7]

The Commission evaluated sources of data the Secretary could consider. Surveys might be an alternative, but they are costly and response rates are likely to be low. Time and motion studies

[6]Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[7]Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

would be costly, too, and they are subject to bias. And mandatory data reporting—analogous to the cost reports submitted by institutional providers—would raise issues of administrative burden on practitioners.

Instead of these approaches, the Secretary could collect data on a recurring basis from a cohort of practitioner offices and other settings where practitioners work. Participating practices and other settings could be recruited through a process that would require participation in data reporting among those selected. The cohort would consist of practices with a range of specialties, practitioner types, patient populations, and furnished services. Further, the cohort should consist of practices with features that make them efficient (e.g., economies of scale, reorganized delivery systems). If necessary, practices could be paid to participate. The Commission is working with contractors to assess the potential of using electronic health records, patient scheduling systems, cost accounting, and other systems as sources of data in physician practices and integrated delivery systems.

Recommendation 2:

The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

Identifying overpriced services

Moving forward from the SGR could also include a change in the process for identifying overpriced services in the physician fee schedule. The current process for identifying potentially misvalued services is time consuming, occurring over several years. In addition, the process has inherent conflicts. The process relies on surveys conducted by physician specialty societies. Those societies and their members have a financial stake in the RVUs assigned to services.

To accelerate the review process, the Secretary should be directed to analyze the data collected under recommendation 2, identify overpriced services, and adjust the RVUs of those services. Further, the Congress should direct the Secretary to achieve an annual numeric goal equivalent to

a percentage of fee-schedule spending. This would be a goal for reducing the RVUs of overpriced services. These adjustments should be implemented in a budget neutral manner. Therefore, while payments could decrease considerably for any given overpriced service, they would increase slightly for all other services.

As mentioned earlier, the RUC and CMS have started a potentially misvalued services initiative, and there is some evidence that this effort has drawn attention to inaccurate pricing. As an example, for fee schedule payments in 2011, CMS received work RVU recommendations from the RUC for 291 billing codes and made decisions after considering all of those recommendations.[8] In some cases, comprehensive billing codes were established that bundled component services, thereby recognizing that efficiencies can arise when multiple services are furnished during a single patient encounter. Other recommendations did not include a change in billing codes. Instead, the RUC had addressed the question of whether current RVUs are too high or too low for certain services because of a change in technology or other factors. The net effect of the increases and decreases in work RVUs—had the changes not been budget neutral, as required by statute—would have been a reduction in spending under the fee schedule of 0.4 percent. Previously, the net effects of work RVU changes had been smaller: 0.1 percent per year in both 2009 and 2010.

The American Medical Association's (AMA's) position is that the process for identifying potentially misvalued services has been broader in scope than that suggested by these budget neutrality adjustments.[9] The AMA reports that in addition to about $400 million that was redistributed for 2011 due to changes in work RVUs, another $40 million was redistributed due to changes in the RVUs for professional liability insurance, and $565 million was redistributed due to changes in practice expense RVUs.

An annual numeric goal for RVU reductions—stated in terms of a percentage of spending for practitioner services—could foster further collaboration between the RUC and CMS in improving

[8]Centers for Medicare and Medicaid Services, Department of Health and Human Services. 2010. Medicare program; payment policies under the physician fee schedule and other revisions to Part B for CY 2011. Final rule. Federal Register 75, no. 228 (November 29): 73169-73860.

[9]American Medical Association. undated. The RUC Relativity Assessment Workgroup Progress Report. http://www.ama-assn.org/resources/doc/rbrvs/five-year-progress.pdf.

payment accuracy. For example, such a goal should focus the effort on high-expenditure services, thereby making a time-consuming and resource-intensive review process more efficient. In addition, collecting objective data to improve payment accuracy—the data collection addressed by recommendation 2—will make the process more effective. As to the level of the numeric goal, judgment is required. If the AMA's estimates are accurate, RVU changes for 2011 led to a redistribution of payments equaling almost 1.2 percent of total allowed charges.

Recommendation 3:

The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2. These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending.

Accelerate delivery system changes to emphasize accountability and value over volume

Even with more accurate RVU assignments, the FFS payment system inherently encourages volume over quality and efficiency. Indeed, rapid volume growth in the last decade is due, in large part, to the underlying volume incentives in FFS reimbursement. New payment models, such as the ACO program and new bundled payment initiatives, present an opportunity to correct some of the undesirable incentives in FFS and reward providers who are doing their part to control costs and improve quality.

Repealing the SGR provides an opportunity for Medicare to implement policies that encourage physicians and other health professionals to move toward delivery models with better accountability for quality and value. With this shift, we should see a greater focus on population health and care coordination—thereby improving patient experience and aligning incentives for beneficiaries to become more engaged with their own care management. Through the ACO program and bundled payment approaches, Medicare is taking important steps in this direction—embarking on new payment models that can encourage providers to work together across sectors to maximize quality and efficiency.

Within the ACO program, incentives for these improvements are strongest for ACOs which bear financial risk, often called two-sided risk ACOs. These ACOs are eligible for both rewards and penalties based on their performance on quality and spending measures. In contrast, bonus-only ACOs are not subject to performance-based penalties. Therefore, the Commission recommends aligning policies related to Medicare's fee schedule with incentives for physicians and health professionals to join or lead two-sided risk ACOs.

Specifically, the Commission recommends that physicians and health professionals who join or lead two-sided risk ACOs should be afforded a greater opportunity for shared savings compared to those in bonus-only ACOs and those who do not join any ACO. The greater opportunity for shared savings would come from calculating the two-sided risk ACO's spending benchmark using higher-than-actual fee-schedule growth rates.

More precisely, assuming the initial reduction in fee-schedule rates outlined in our first recommendation, the Commission recommends that the spending benchmarks for assessing the performance of two-sided risk ACOs be calculated using a freeze in fee-schedule rates, rather than the actual fee reductions. Under this circumstance, two-sided risk ACOs would have a greater opportunity to produce spending that is below their benchmark, and thus be more likely to enjoy shared-savings payments from Medicare.[10]

This recommendation might increase the willingness of physicians and other health professionals to join or lead two-sided risk ACOs. In doing so, it would accelerate delivery system reform toward models with greater accountability for health care quality and spending. As ACO models develop and make strides in improving quality and efficiency, the volume-based FFS environment should be made increasingly less attractive for Medicare providers. Accordingly, the advantage offered to the two-sided risk ACOs would increase in the second and third year that the fee-schedule reductions are in place.

[10]One issue to examine under this policy would be to monitor the effect of differential payments for services provided by ACO and non-ACO providers. The differential shared savings opportunities are intended to hasten improvements in our delivery system and shift payments away from FFS. The incentives should be revisited as enrollment increases to ensure that ACOs are having the desired effect of encouraging more organized care delivery and lowering overall spending growth.

Final regulations on the ACO program are not yet completed. Therefore, it is difficult to determine the effects of this recommendation, relative to current law. Theoretically, by offering providers a greater opportunity to share in Medicare savings, the Commission's recommendation could reduce total Medicare savings. However, more importantly, if more providers decided to join two-sided risk ACOs as a result of greater shared savings opportunities in this recommendation, total Medicare savings could increase over the long term.

Recommendation 4:

Under the 10-year update path specified in recommendation 1, the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates.

The Secretary could also consider developing analogous pricing incentives in Medicare's new bundled payment initiatives. That is, in the context of fee-reductions, bundled pricing would assume a rate freeze across all fee-schedule services. In testing this approach for improvements in quality and efficiency, the Secretary could, at the same time, assess the effect that bundled payments have on growth in the total number of episodes.

Offsetting the cost of the SGR package

The Commission describes a budget-neutral package for repealing the SGR, offsetting the cost within the Medicare program (Appendix Table A-4). Under current law, the SGR calls for a very large fee reduction (30 percent on January 1, 2012) and the budget score associated with repealing the SGR has grown exponentially. Given the high cost of repealing the SGR and the current economic environment, the Commission's proposal must be fiscally responsible.

The list of options offered by the Commission spreads the cost of repealing the SGR across physicians and other practitioners, as well as other providers and Medicare beneficiaries. Under the Commission's approach, physicians and other practitioners who provide non-primary care services will experience a series of Medicare fee reductions, followed by a freeze in payment

rates. Primary care physicians and other primary care practitioners would experience a freeze in rates for the primary care services they provide. Through these reductions and freezes, physicians and other health professionals are shouldering a large part of the cost of repealing the SGR. The cost of repealing the SGR and replacing it with a complete freeze in fee-schedule payment rates would be approximately $300 billion over ten years, but the Commission's approach would cost approximately $200 billion, with most physicians and practitioners absorbing $100 billion in the form of lower payments than they would receive under a freeze.

To offset this $200 billion in higher Medicare spending relative to current law (which applies the SGR fee cuts), the Congress may seek offsets inside or outside of the Medicare program. Because MedPAC was established to advise the Congress on Medicare policies, we are offering a set of savings options that are limited to the Medicare program. We do not necessarily recommend that the Congress offset the repeal of the SGR entirely through Medicare. Also, we offer this set of options with the express purpose of assisting the Congress in evaluating ways to repeal the SGR. The steep price of this effort, and the constraint that we are under to offset it within Medicare, compels difficult choices, including fee-schedule payment reductions and offsets that we might not otherwise support.

The offset options listed in Appendix Table A-4 would spread the impact of the reductions across other providers and Medicare beneficiaries. They are grouped in two categories. Those in Tier I— about $50 billion— are MedPAC recommendations not yet enacted by the Congress. Those in Tier II—about $168 billion—are informed by analyses done by MedPAC, other commissions, and government agencies. Several of the options in Tier II are designed to make changes to Medicare payments to encourage the use of more cost effective care. The estimates of savings are preliminary staff estimates and do not represent official scores.

The Commission has not voted on each individual item in the Tier II list, and their inclusion should not be construed as a recommendation. Tier II does not include all of the proposals that have been offered for reducing long-term Medicare spending—e.g., increasing the age of eligibility, or requiring higher contributions from beneficiaries with higher-than-average incomes, or premium support. The exclusion of such policies should not be construed as a

statement of MedPAC's position on these policies. Such policies raise complex issues that are beyond the scope of Tier II offsets.

To reiterate, we offer the list of offset options to assist the Congress in its deliberations on resolving the SGR problem. The Congress could choose different directions to offset the related cost—for example, other spending or revenue offsets, even from outside the Medicare program.

In closing, given the urgency of the need to resolve the SGR policy, the Commission is submitting this letter to the Congress in advance of our usual March and June publication schedule. At a minimum our proposal underscores the exigency of the matter, the complexity of deriving any solution, and the degree of sacrifice a resolution entails. If you have further questions or otherwise wish to discuss this important issue, please feel free to contact me or Mark E. Miller, MedPAC's Executive Director.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

Appendix

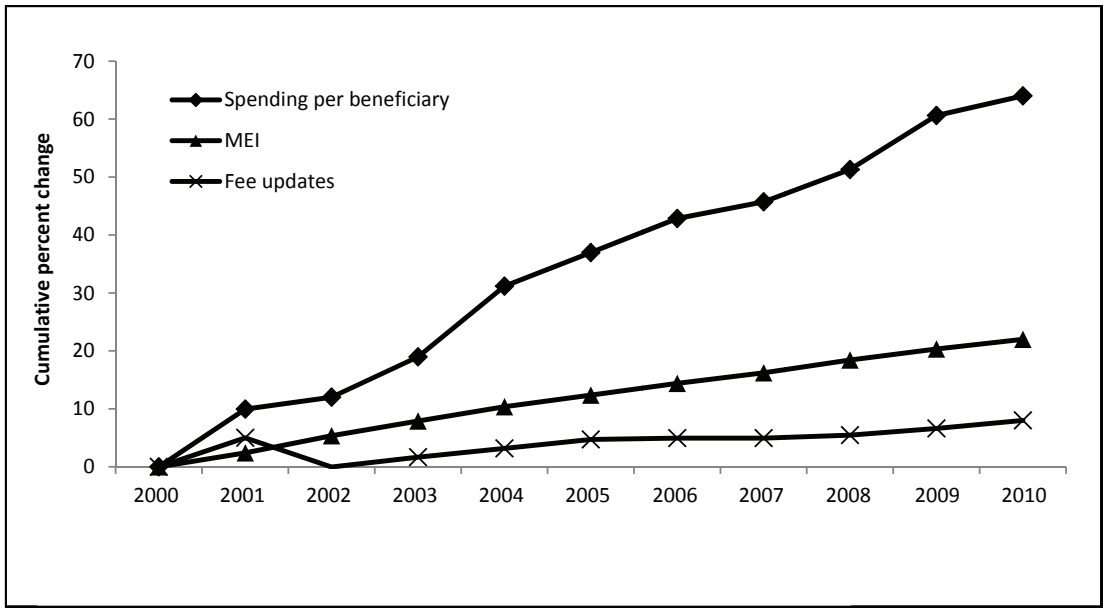
TABLE A–1

Commissioners' voting on recommendations

1	The Congress should repeal the sustainable growth rate (SGR) system and replace it with a 10-year path of statutory fee-schedule updates. This path is comprised of a freeze in current payment levels for primary care and, for all other services, annual payment reductions of 5.9 percent for three years, followed by a freeze. The Commission is offering a list of options for the Congress to consider if it decides to offset the cost of repealing the SGR system within the Medicare program. *Yes: Armstrong, Baicker, Behroozi, Berenson, Butler, Chernew, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello* *No: Borman, Castellanos*
2	The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years. *Yes: Armstrong, Baicker, Behroozi, Berenson, Borman, Butler, Castellanos, Chernew, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello*
3	The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2. These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending. *Yes: Armstrong, Baicker, Behroozi, Berenson, Butler, Castellanos, Chernew, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello* *No: Borman*
4	Under the 10-year update path specified in recommendation 1, the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates. *Yes: Armstrong, Baicker, Behroozi, Berenson, Butler, Castellanos, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello* *No: Borman* *Not voting: Chernew*

FIGURE A–1

Growth in spending for fee-schedule services, 2000–2010



- Spending for fee-schedule services grew from $37 billion in 2000 to $64 billion in 2010—an increase of 72 percent.
- On a per beneficiary basis, spending grew over this period from $1,200 to $2,000—an increase of 64 percent. This increase amounts to an average annual spending increase of 5 percent per beneficiary, per year.
- Medicare spending on fee-schedule services grew much more rapidly over this period than both the payment rate updates and the Medicare Economic Index (MEI). The cumulative increase in fee-schedule updates from 2000 to 2010 was 8 percent. The comparable cumulative increase in the MEI was 22 percent.
- The growth in spending per beneficiary was due more to growth in the volume and intensity of services provided than to fee increases. The volume of imaging, tests, and "other procedures" (procedures other than major procedures) grew more rapidly than the volume of major procedures and evaluation and management services.

TABLE A–2

Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2007–2010

	Medicare (age 65 or older)				Private insurance (age 50–64)			
Survey question	**2007**	**2008**	**2009**	**2010**	**2007**	**2008**	**2009**	**2010**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"								
For routine care								
Never	75%*	76%*	77%*	75%*	67%*	69%*	71%*	72%*
Sometimes	18*	17*	17*	17*	24*	24*	22*	21*
Usually	3	3*	2*	3*	4	5*	3*	4*
Always	3	2	2	2	3	2	3	3
For illness or injury								
Never	82*	84*	85*	83*	76*	79*	79*	80*
Sometimes	13*	12*	11*	13*	17*	16*	17*	15*
Usually	3	1	2	2	3	2	2	2
Always	2	1*	1	1*	3	2*	2	2*
Looking for a new primary care physician: "In the past 12 months, have you tried to get a new primary care doctor?"								
Yes	9	6	6	7	10	7	8	7
No	91	93	93	93	90	93	92	93
Looking for a new specialist: "In the past 12 months, have you tried to get a new specialist?"								
Yes	14	14*	14*	13*	15	19*	19*	15*
No	86	85*	86*	87*	84	81*	81*	84*
Getting a new physician: Among those who tried to get an appointment with a new primary care physician or a specialist in the past 12 months, "How much of a problem was it finding a primary care doctor / specialist who would treat you? Was it…"								
Primary care physician								
No problem	70*	71	78	79*	82*	72	71	69*
Small problem	12	10	10	8	7	13	8	12
Big problem	17	18	12*	12	10	13	21*	19
Specialist								
No problem	85	88	88	87*	79	83	84	82*
Small problem	6	7	7	6*	11	9	9	11*
Big problem	9	4	5	5	10	7	7	6
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Percent answering "Yes")	10*	8*	7*	8*	12*	12*	11*	12*

Note: Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in 2007, 3,000 in 2008, and 4,000 in 2009 and 2010. Sample sizes for individual questions varied.
*Statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone survey conducted in 2007, 2008, 2009, and 2010.

TABLE A–3

Acceptance of new patients is lower among primary care physicians, across most insurers

Accepting new patients, type of insurance	Primary care specialties	All other specialties
Any new patients	89.5%	97.8%
Medicare	83.0	95.2
Medicaid	55.1	68.7
Capitated private insurance	58.3	43.7
Non-capitated private insurance	76.4	81.3
Workers' compensation	53.4	61.2
Self-pay	85.7	95.1
No charge	39.7	52.2

Note: Results include office-based physicians with at least 10 percent of practice revenue coming from Medicare.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey (2008).

TABLE A–4 **Potential Medicare offset options for repealing the SGR system**

- Along with the recommendations included in this letter, the Commission is offering a set of savings options for the purpose of assisting the Congress in offsetting the budgetary cost of repealing the SGR system. The projected savings amounts are unofficial, based on MedPAC staff estimates, and subject to change.

- The options are divided into two tiers. Tier I—about $50 billion—contains proposals that have been recommended by the Commission in previous reports or comment letters. Tier II—about $170 billion—contains options informed by outside (e.g., the Office of Inspector General, Department of Health and Human Services; Congressional Budget Office options) and MedPAC staff analysis. The Commission has not voted on or recommended the items on the Tier II list. The exclusion of policies from this list should not be construed as a statement of MedPAC's position on such policies.

- In the statute creating MedPAC, the Congress charges the Commission with reviewing Medicare policies, including their relationship to access and quality of care for Medicare beneficiaries. Therefore, all of the offset options on this list are Medicare policies; the Congress could choose to employ other savings or revenue offsets including those from outside of Medicare.

Note: *The availability and scoring of these options may have changed based on legislative or regulatory action since October 2011.*

TABLE A–4 **Potential Medicare offset options for repealing the SGR system**

	Tier I: MedPAC work	5-year savings ($ in billions)	10-year savings ($ in billions)	Reference
1	Copayment for home health episode	2	4	MedPAC March 2011
2	Hospital update of 1 percent for 2012 and DCI recovery	7	14	MedPAC March 2011
3	Dialysis update of 1 percent for 2012	0	1	MedPAC March 2011
4	Hospice update of 1 percent for 2012	1	2	MedPAC March 2011
5	Apply the competitive bidding offset to all competition-eligible DME categories starting in 2013	1	1	MedPAC June 2003
6	Apply the competitive bidding offset to the DME categories never subject to competitive bidding starting in 2013	2	7	MedPAC June 2003
7	Repeal MA quality bonus demonstration	6	6	MedPAC comment letter, 2011
8	Rebase HH in 2013 and no update in 2012	5	10	MedPAC March 2011
9	No IRF update in 2012	0	1	MedPAC March 2011
10	No LTCH update for 2012	0	1	MedPAC March 2011
11	Raise the compliance threshold for IRFs to 75 percent	1	3	MedPAC comment letter, 2003
12	ASC update of 0.5 percent for 2012 and report on cost and quality	0.1	0.1	MedPAC March 2011
13	Program integrity: prior authorization for imaging by outlier physicians	0	0.1	MedPAC June 2011
Subtotal, MedPAC work		***25***	***50***	

	Tier II: Other Medicare	5-year savings ($ in billions)	10-year savings ($ in billions)	Reference
14	Part D LIS cost-sharing policy to encourage substitution	6	17	Staff
15	Apply an excise tax to medigap plans (5 percent)	5	12	CBO: Budget Options 2008
16	Program integrity: pre-payment review of power wheelchairs	0.1	0.2	PB 2012, HHS OIG
17	Require manufacturers to provide Medicaid-level rebates for dual eligibles	25	75	CBO: Budget Options 2011
18	Bundled payment for hospital and physician during the admission	0	1	CBO: Budget Options 2008
19	Pay E&M visits in hospital outpatient departments at physician fee schedule rates	5	10	Staff
20	Reduce payments by 10 percent for clinical lab services	4	10	Staff
21	Risk-adjustment validation audits in the MA program	2	3	PB 2012
22	Bring employer group plan bids closer to other MA plan bids	0	1	Staff
23	Hold the trust funds harmless for MA advance capitation payments	2	3	HHS OIG
24	Restore the Secretary's authority to apply a least costly alternative policy	0	1	Staff
25	Additional reductions through competitive bidding or fee schedule reductions to payments for home oxygen	3	5	HHS OIG
26	Rebase payments to SNFs	10	23	Staff
27	Apply readmissions policy to SNFs, HH, LTCHs, and IRFs	1	4	Staff
28	Targeted 3 percent reduction for hospice care provided in nursing homes for hospices with a significant volume of nursing home patients	0.5	1	HHS OIG
29	Program integrity: validate physician orders for high-cost services	0	2	PB 2012
Subtotal, Other Medicare		***64***	***168***	
Total, Tier I and Tier II		***89***	***219***	

Note: ASC (ambulatory surgical centers), CBO (Congressional Budget Office), DCI (documentation and coding improvements), DME (durable medical equipment), E&M (evaluation and management), HH (home health), HHS (Department of Health and Human Services), IRF (inpatient rehabilitation facilities), LTCH (long-term care hospitals), LIS (low-income subsidy), MA (Medicare Advantage),OIG (Office of Inspector General), PB (provider bulletin), SNF (skilled nursing facility).The Commission is offering a set of savings options for the purpose of assisting the Congress in offsetting the budgetary cost of repealing the SGR. The projected savings amounts are unofficial, based on MedPAC staff estimates, and subject to change.