DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

February 29, 2008

Mr. Glenn M. Hackbarth
Chair
Medicare Payment Advisory Commission
601 New Jersey Avenue, NW, Suite 9000
Washington, DC 20001

Dear Mr. Hackbarth:

Pursuant to section 1848(d)(1)(E)(ii) of the Social Security Act (the Act), I am writing to provide the Medicare Payment Advisory Commission (MedPAC) with the Centers for Medicare & Medicaid Services' (CMS) estimates of the 2009 physician fee schedule conversion factor update, conversion factor, and sustainable growth rate (SGR), together with the data used in making these estimates. In addition, I am providing information regarding national health expenditure projections and the Medicare funding warning, which support the need for payment reforms. This letter also provides a summary of CMS efforts to ensure that Medicare payments encourage providers to render high quality care to our nation's seniors.

Current estimate of the physician update and conversion factor for 2009

In general, the physician fee schedule update is determined by a formula specified in section 1848(d)(4) of the Act. Section 101(a)(1)(B) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) amended the statute to replace the scheduled 10.1 percent reduction to the Medicare physician fee schedule conversion factor that would have applied in 2008 with a 0.5 percent increase from January 1, 2008 through June 30, 2008. Section 101(a)(1)(B) of MMSEA contained a provision similar to the one in section 101(a) of the Tax Relief and Health Care Act of 2006 (TRHCA) regarding updates after the applicable period. Section 101(a)(1)(B) of MMSEA specified that the conversion factor for the remainder of 2008 and 2009 and subsequent years must be computed as if the legislated increase for the first half of 2008 had never applied. Therefore, in the absence of additional legislation, the physician fee schedule conversion factor effective from July 1, 2008 through December 31, 2008 will be the conversion factor that would have applied for all of 2008 if MMSEA had not been enacted ($34.0682). This conversion factor is 10.1 percent lower than the 2007 conversion factor ($37.8975). Compared to payment levels in effect for the first six months of 2008 and as a result of the 0.5 percent increase provided for in MMSEA, payment levels beginning on July 1, 2008 will be 10.6 percent lower than current levels (i.e., combining the -10.1 percent that would have occurred on January 1, 2008 without the MMSEA legislation and removal of the 0.5 percent increase required in MMSEA).

The physician fee schedule update for 2009 is set under the statutory formula in section 1848(d)(4) of the Act. We currently estimate that this statutory formula will result in a 2009 physician fee schedule conversion factor update of -5.4 percent which, applied to the conversion factor applicable for the second half of 2008, would result in an estimated 2009 physician fee schedule conversion factor of $32.2285. Therefore, under current law, the 2009 physician fee schedule conversion factor is estimated to be 15.4 percent lower than the current $38.0870 conversion factor in effect for the first half of 2008, and 15.0 percent lower than the $37.8975 conversion factor that was in effect for 2007. (The 10.6 percent reduction effective July 1, 2008, and an estimated additional reduction of 5.4 percent effective January 1, 2009 multiplicatively combine to result in a reduction of 15.4 percent in the conversion factor for 2009 compared to payment levels in effect for January to July 2008. That is, 0.894 times 0.946 = 0.846, which is a 15.4 percent reduction).

Attachment 1 shows our estimate of the update adjustment factor and Attachment 2 shows the calculation of the estimated change in the conversion factor for 2009.

Current estimate of the SGR for 2009

Section 1848(d)(l)(E)(ii) also requires that we provide an estimate of the following year's SGR. Our current estimate of the SGR for calendar year 2009 is 0.7 percent. The SGR is the product of the Secretary's estimate of four factors. We have provided more detail on our estimates of the factors included in the SGR for 2009 in Attachment 3. These estimates are based on the best data available to us at this time and may be revised later.

We will be providing a more detailed explanation of the SGR and physician fee schedule updates on the CMS Web site (http://www.cms.hhs.gov/SustainableGRatesConFact/). SGR-related data and other information are available to the public in the Web site document.

National Health Expenditure Projections

The CMS's Office of the Actuary released its annual short-term report on projected national health expenditures on February 26. Overall health care spending in the United States is projected to grow 6.7 percent in 2007 and total just over $2.1 trillion. Over the full projection period (2007-2017), total health spending growth is expected to average 6.7 percent annually with $4.3 trillion in total health spending estimated for 2017.

As we have reported in previous letters, physician spending under the Medicare program historically has grown at a rapid pace, at times reaching double digit increases. Of particular concern has been the increase in the volume and intensity of services and the great variation in care patterns by physicians. The latter point is an issue that MedPAC has opined on several times over the past few years and was reinforced in a report issued earlier this month by the Congressional Budget Office (CBO). These reports continue to raise important policy concerns on which changes in utilization are likely to be associated with important health improvements and which ones have health benefits that may be more questionable.

These spending trends for physicians become ever more important for beneficiaries because they factor into the Part B premium and beneficiary cost sharing. Over the past several years there has been a succession of rapid increases in the Medicare Part B premium, now set at $96.40 for most beneficiaries. These increases strain both beneficiaries' incomes and the Federal budget.

In the 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (also known informally as the Trustees Report), the difference between Medicare's total outlays and its "dedicated financing sources" was estimated to reach 45 percent of outlays in fiscal year 2013. As a result, under section 801 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the Board of Trustees issued a determination of projected "excess general revenue Medicare funding." Since this was the second consecutive such finding, a "Medicare funding warning" was triggered, which calls for the President to submit to Congress, within 15 days after the release of the Fiscal Year 2009 Budget, proposed legislation to respond to the warning. The Secretary transmitted to Congress a legislative proposal on Friday, February 15, 2008. This legislation provides for a three-step approach to strengthen Medicare. Details on the "trigger legislation" transmitted to Congress are available at:
http://www.hhs.gov/asl/medicarefundingwarningsummary.pdf (summary) and
http://www.hhs.gov/asl/medicarefundingwarninglegislation.pdf (legislation)

One provision to this proposal is the authority to implement value-based health care into Medicare. This legislation follows the principles that were contained in the President's Executive Order of August 22, 2006. The specific components of that Executive Order include:

- Improved health information technology, including electronic medical records;
- Transparency of pricing information;
- Transparency of quality information; and
- Incentives for providers to deliver, and beneficiaries to choose, high-quality, low-cost health care.

Details on the President's Executive Order are available at:
http://www.hhs.gov/valuedriven/fourcornerstones/

Transforming Medicare to become an active purchaser of high quality care

As many have pointed out over the past several years, the answer to the question of whether to transform Medicare into an active purchaser of high quality health care is an emphatic "yes." The real issue is how Medicare can rapidly transform itself from a passive payer for services into an active purchaser of higher quality care by linking payment to the value of care provided. This transformation will shift Medicare away from reimbursing providers based solely on volume of services and create appropriate incentives to encourage health care providers to deliver high quality care. CMS is working in many areas to achieve this goal and the balance of this letter highlights some of those activities.

First, the Physician Quality Reporting Initiative (PQRI) is an important first step toward establishing a value-based purchasing program for physicians. The Medicare PQRI program is consistent with several of the four cornerstones identified in the President's Executive Order on value driven health care.

As authorized by section 101(b) of the TRHCA, the PQRI is a quality reporting system based on measures for physicians and other eligible professionals. Building upon provisions in TRHCA, CMS utilized 74 measures for the 2007 PQRI program that had been developed by or with input from the physician community, and with the benefit of a consensus process. The measures were posted on the CMS Web site at: http://www.cms.hhs.gov/PQRI, and were widely available to eligible professionals.

Eligible professionals who satisfactorily submitted data on certain applicable quality measures during the 2007 PQRI reporting period will receive an incentive payment of 1.5 percent of CMS's estimate of the Medicare physician fee schedule allowed charges for all covered professional services furnished during the reporting period, subject to a cap. Eligible professionals include physicians, non-physician practitioners, and therapists. TRHCA established a reporting period of July 1, 2007 through December 31, 2007 for the 2007 PQRI.

The TRHCA also required the establishment, through notice and comment rulemaking, of a set of quality measures that would be appropriate for eligible professionals to use for quality reporting during 2008. The quality measures for 2008 were required to be measures that were endorsed or adopted by a consensus organization (such as the NQF or AQA), that include measures that have been submitted by a physician specialty, and that CMS identifies as having used a consensus-based process for developing such measures. TRHCA also required that the quality measures include structural measures such as use of electronic health records (EHR) and electronic prescribing technology.

The 2008 PQRI measure set is composed of 119 measures which are available at: http://www.cms.hhs.gov/PQRI. The 2008 measures include 117 clinical quality measures and two structural measures. The clinical quality measure set significantly expanded the conditions and types of practitioners to which the PQRI measures apply. In establishing the 2008 set of measures, CMS worked with the American Medical Association's (AMA) Physician Consortium, the NQF, the AQA Alliance and other stakeholders. For 2008, measures exist for specialties accounting for more than 95 percent of Medicare physician spending. We are considering using some of these measures in the medical home demonstration project.

The CMS is actively working, within existing legal authorities, to build incentives into the payment system to encourage physicians to use electronic health records (EHR) to improve the quality of care they deliver. Starting January 1, 2008, a new measure is included in the set that enables physicians to report not simply that they bought an EHR, but that they use it on an ongoing basis when they see patients. The structural measures are an important step towards the

President's goal of ensuring that all Americans have access to an EHR by 2014 and promote the use of e-prescribing.

We would note that CMS is also implementing an EHR demonstration that will provide financial incentives to physicians who adopt and use EHRs to improve quality of care. It will allow the Medicare program to develop a better understanding of the effect of incentives on adoption and the level of use of EHRs and how EHRs change physician practice and improve quality of patient care. More specifically, over a 5 year period, the demonstration will provide financial incentives to as many as 1,200 small and medium-sized primary-care physician practices in 12 communities across the country that use certified EHRs to improve quality as measured by their performance on specific clinical quality measures. Additional bonus payments will be available, based on a standardized survey measuring the number of EHR functionalities a physician practice has incorporated into their practice. To further amplify the effect of this demonstration project, CMS is encouraging private and public payers to offer similar financial incentives consistent with applicable law.

We are encouraged by the preliminary success of the 2007 PQRI program, particularly since the TRHCA payment incentives applied for only 6 months and physicians have reported that uncertainty about continuation of payment incentives after 2007 adversely affected participation. Preliminary PQRI participation data through November 2007 indicates that 99,000 professionals (16 percent of the eligible professionals who could have reported quality data) submitted PQRI quality data at least once during the 2007 reporting period. This number includes professionals from all 50 states and the District of Columbia. In the CMS regions with the highest participation, reporting rates are approaching 20 percent. Three specialties in particular, anesthesiology, ophthalmology and emergency medicine, had above average rates of participation. Participation rates have trended upwards during the reporting period. Over half of those professionals who reported are on track to satisfy the statutory requirements for successful reporting and thereby earn the incentive payments.

We anticipate that the initial PQRI participation rates would increase over time, much like participation rates for the Medicare participating physician program, which began in 1984. Participating physicians voluntarily sign agreements to accept assignment for all Medicare services furnished during the following year. Physicians who sign participation agreements receive a 5 percent payment differential. Initially about 30 percent of physicians signed participation agreements, but the participation rate has increased to about 90 percent by the mid-1990s and 95 percent for 2007. We are optimistic that the improvements for 2008 PQRI, enacted in MMSEA, will enhance the program.

Given the continued rapid growth in physician spending, we have intensified our efforts over the past year to develop meaningful, actionable, and fair measures of physician resource use to initially be used for confidential feedback reporting to physicians about the comparative costs of their care. This is particularly relevant given the earlier referenced concern over the extensive

variation in physician use of resources to treat a given condition. Further, greater volume of services does not appear to correlate with higher quality care or improved outcomes.

Our efforts to develop physician resource use measures are currently focused on:

- Identification and resolution of attribution, benchmarking, risk adjustment, small numbers, and episode definition issues, among other challenges inherent in resource use measurement;
- In-depth evaluation of episode grouper technology using Medicare claims data;
- Assessment of the clinical validity of the episode grouper technology; and
- Design and testing of physician resource use reports.

While more research needs to be done to understand all the challenges and issues that must be addressed before any episode grouping system can be used for resource use measurement and reporting, the ultimate goal of such a system would be to link physician resource use measures to quality measures for a comprehensive assessment of physician efficiency. These performance assessment measures could be used for physician value-based purchasing, which would tie the measurement results to payment and public reporting. We have closely coordinated our physician resource use measure development activities with MedPAC, the Government Accountability Office (GAO), the NQF, the Quality Alliance Steering Committee, and the AQA Alliance, among others.

For certain clinical categories, particularly in-hospital services, including surgical infection and prevention, the physician clinical quality measures overlap with hospital quality measures. Because both hospitals and physicians are reporting on the same processes of care in which both parties have a role, these parallel measures create aligned incentives for improved quality.

The CMS is also testing new payment methodologies that link payment to quality and efficiency. The Physician Group Practice (PGP) Demonstration presents yet another alternative for rewarding physicians who improve the quality and cost-efficiency of health care furnished to Medicare beneficiaries and generates savings for the program. Participating groups report, using a statistical sampling model, on 32 ambulatory care quality measures that focus on high-cost chronic conditions and preventive care. The measures are phased-in under the demonstration, and the groups submit clinical data using a performance assessment tool on a sample population.

First year results are encouraging; we found that all groups improved the clinical management of diabetes patients by redesigning care processes and incorporating health information technology, in many cases, to provide actionable feedback to physicians at the point of care. All 10 of the groups achieved benchmark or target performance levels on at least 7 of the 10 diabetes clinical quality measures, and 8 groups increased their scores on 6 or more diabetes quality measures. In addition, two groups earned $7.3 million as their share of the total savings of $9.5 million generated for the Medicare Trust Funds, and six additional physician groups had lower Medicare spending growth rates than their local market areas, but not sufficiently lower to share in savings under the demonstration's performance payment methodology.

Another related demonstration program that we will be implementing this summer is the Medical Home Demonstration. Like the PGP initiative, this demonstration will be focused on physicians succeeding in improving patient outcomes and lowering overall health care costs.

Finally, value-based purchasing and transparency initiatives give consumers access to data that can improve their healthcare choices. In this regard, we are exploring the possibility of posting the names of physicians who successfully report PQRI measures on the CMS Web site. This, and other public reporting of physician performance, could greatly aid Medicare beneficiaries in better understanding physician performance and their treatment options.

As noted earlier, a growing number of stakeholders, including MedPAC, now agree that well designed and comprehensive quality and efficiency measurement should play a key role in Medicare physician payments. We look forward to continuing to explore and analyze appropriate alternatives to the current system to ensure appropriate payment that will also promote high quality, efficient care.

Sincerely,

Jeffrey B. Rich, M.D.
Director
Center for Medicare Management

Attachments

Attachment 1

Under section 1848(d)(4) of the Social Security Act, the update for 2009 is equal to the Secretary's estimate of the Medicare Economic Index adjusted by an update adjustment factor. Section 101(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 provided for a temporary six month increase in the fee schedule conversion factor that would otherwise have applied for 2008. Such section also specified that the conversion factor for the remaining portion of 2008, 2009 and subsequent years must be computed as if this six month increase for 2008 had never applied. The formula for the calculation of the update adjustment factor is shown below. The calculation of the update is detailed on the next page.

Estimate of the Update Adjustment Factor

$$UAF_{09} = \frac{Target_{08} - Actual_{08}}{Actual_{08}} \times .75 + \frac{Target_{4/96-12/08} - Actual_{4/96-12/08}}{Actual_{08} \times SGR_{09}} \times .33$$

UAF_{09} = Update Adjustment Factor for 2009 = -26.5 percent
$Target_{08}$ = Allowed Expenditures for CY 2008 = $85.4 billion
$Actual_{08}$ = Estimated Actual Expenditures for CY 2008 = $93.0 billion
$Target_{4/96-12/08}$ = Allowed Expenditures from 4/1/1996 - 12/31/2008 = $862.1 billion
$Actual_{4/96-12/08}$ = Estimated Actual Expenditures from 4/1/1996 - 12/31/2008= $919.9 billion
SGR_{09} = 0.7 percent

$$\frac{\$85.4 - \$93.0}{\$93.0} \times (.75) + \frac{\$862.1 - \$919.9}{\$93.0 \times 1.007} \times (.33) = -26.5\%$$

Our current estimate of the update adjustment factor is -26.5 percent. Section 1848(d)(4)(D) of the Social Security Act indicates that the update adjustment factor may not be less than –7 percentage points. Consistent with the statute, we will limit the update adjustment factor to –7 percentage points if the above formula produces an update adjustment factor that would be less than -7 percentage points.

Attachment 2

Estimate of the 2009 Physician Fee Schedule Conversion Factor Update

(1)	Medicare Economic Index	1.7%	(1.017)
(2)	Update Adjustment Factor	-7.0%	(0.930)
(3)	2009 Conversion Factor Update	-5.4%	(0.946)

Notes: The figures on lines 1 and 2 are multiplied to produce the update of -5.4 percent on line 3. The 2009 Conversion Factor Update represents the change from the conversion factor that would apply on December 31, 2008 under current law to the conversion factor that is projected to apply beginning January 1, 2009.

Attachment 3

Estimate of the 2009 Sustainable Growth Rate (SGR)*

(1) Estimated Change in Fees	2.1%	(1.021)
(2) Estimated Change in Fee-for-Service Enrollment	-0.2%	(0.998)
(3) Estimated Change in Real GDP Per Capita	1.8%	(1.018)
(4) Estimated Change in Law or Regulation	-2.9%	(0.971)
(5) Estimated 2009 SGR	0.7%	(1.007)

Note: The figures on lines 1-4 are multiplied to produce the estimated SGR value of 0.7 percent on line 5.

* These figures represent current estimates only and may change based on new information in a Federal Register notice that we expect to publish no later than November 1, 2008.