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April 1, 2004

The Honorable Mark McClellan
Administrator
Centers for Medicare & Medicaid Services
Hubert Humphrey Building, Room 314-G
200 Independence Ave., SW
Washington, D.C. 20201

Dear Dr. McClellan:

We are writing to urge your consideration of additional changes to the physician payment formula for Medicare providers reimbursed under the physician fee schedule. Certain items and services are inappropriately included in the formula and cause spending to count against the spending target. This has adversely affected physician reimbursement.

We worked closely with the Administration to avert payment cuts in 2003, 2004 and 2005. In 2003, we reversed a 4.4 percent cut, by correcting the physician formula's use of incorrect projections for the number of Medicare+Choice enrollees. Also at our urging, along with others, the Centers for Medicare & Medicaid Services (CMS) reformed its measure of productivity. These actions produced a modest 1.7 percent increase in payment rates beginning in March 2003. Additionally, these actions added $54 billion back into the SGR formula over the next 10 years, reducing the gap between targeted expenditures and actual expenditures for physician services. This ensured Medicare beneficiaries retained access to high quality heath care.

Provisions in the Medicare Modernization Act set a floor of 1.5 percent on the payment update in 2004 and 2005, and replaced the use of a single year's GDP with a ten-year rolling average gross domestic product (GDP). This change to the formula will smooth out projected expenditure calculations in the Sustainable Growth Rate (SGR) formula.

CMS actuaries now project payment updates of about minus 5 percent annually each year from 2006 through 2012, with a smaller negative update in 2013, followed by an increase of 3.9 percent in 2014. If these rate reductions were to take effect, physicians and other providers would face 8 consecutive years of reduced payment rates. By 2014, physicians would be paid at rates about 40 percent lower than in 2005. This is simply unacceptable.

We must work together to enact a reform of physician payments that preserves Medicare beneficiaries' access to high quality care, while also protecting scarce taxpayer dollars. We are writing you to request that you undertake new action on four issues that CMS could address administratively.

1. Remove prescription drug expenditures from the SGR baseline;
2. Account for costs of new benefits;
3. Examine assumptions about behavioral responses to rate decreases; and,
4. Account for other factors affecting physician income such as tax changes.

Remove Prescription Drug Expenditures

The definition of physician services in the Social Security Act is broad. Physician services include "other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice enrollee." As there is no reference to prescription drugs within this definition, and since CMS has excluded drugs from "physicians' services" in its administration of other Section 1848 provisions, we believe that removing drugs from the calculation of "physicians' services" in determining the SGR would be a consistent reading of the statute.

Prescription drugs' share of expenditures subject to the SGR has almost tripled over the last seven years. When the SGR began in 1996, prescription drugs were 3.5 percent of total expenditures subject to the SGR, increasing to 10.0 percent in 2003. This cost growth cannot be controlled by physicians, yet they are being penalized for prescription drug price increases. Taking prescription drugs out of the formula would improve the outlook for future updates considerably.

Account for Costs of New Benefits

We also request that CMS review its determination of the costs of new benefits, which are included in the SGR calculation. Specifically, the Secretary estimates change in expenditures "which will result from changes in law and regulations" (Sec.1848(f)(2)(D)). Currently CMS only includes new coverage decisions in SGR's law and regulation section if the coverage is attributable to statutory changes. However, national coverage decisions made by CMS are not added to the expenditure target. For example, CMS's coverage of Positron Emission Tomography (PET) added more than 40 codes, but these codes are not included in the target. As a result, physician's payments are reduced for spending increases that are associated with new technologies or services that have been approved and publicized by federal officials and have become Medicare covered services.

The Medicare Modernization Act provides for a new benefit -- an initial physical upon eligibility for Medicare. When the actuaries estimate the costs of this new provision, they must consider not only the actual costs of providing the physical exam, but also the additional expenditures that may occur as beneficiaries are referred for

supplementary diagnostic testing or treatment of conditions that are identified during the physical. We expect that the actuaries may have to revise their estimates as they examine actual data about the impact of the new physical on expenditures when the benefit becomes effective in 2005. At the same time, we request that CMS review its procedures for determining the costs of new benefits that are attributable to statutory changes, and share the agency's assumptions with us.

Behavioral Responses

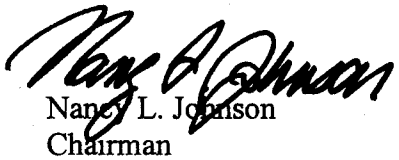
We recommend that CMS reexamine its assumptions about behavioral responses to rate changes and consider how tax changes may affect those responses. CMS assumes that physicians increase volume and intensity of services to offset about 30 percent of any rate decrease. Consequently, relatively large rate decreases are needed to reach targeted total expenditures under the SGR system. Current assumptions are based on analysis by the Office of the Actuary (OACT) of 6 to 8-year old data from 1994 to 1996 – before implementation of the SGR system. Although the OACT study states that the SGR system changed the long-term financial incentives for physicians to increase their volume and intensity, CMS has not analyzed data after implementation of the SGR system to determine if a 30 percent offset is justifiable. Newer studies may provide additional insight. If the true behavioral offset is less than 30 percent, CMS's assumption contributes to volatility in updates over time.

Moreover, if one accepts the argument that physicians have target incomes – which the behavioral offset theory appear to hold – cuts to marginal tax rates (such as those included in the Economic Growth and Tax Relief Reconciliation Act of 2001) will increase after-tax income and could lead to volume decreases. If CMS assumes a behavioral offset to price decreases, they should also include behavioral offsets to other factors that affect income. Tax cuts lead to increased physician income and could lead many physicians to reduce the volume and intensity of services provided.

We look forward to working with you to ensure continued access to Medicare providers. Your prompt response to this request is appreciated.

Best regards,

Bill Thomas
Chairman



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Chairman
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