Congress of the United States

U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS

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July 12, 2005

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 write to urge your consideration of administrative changes to the physician payment formula for Medicare providers reimbursed under the physician fee schedule. A permanent legislative fix to the Sustainable Growth Rate (SGR) formula would be prohibitively expensive given current interpretations of the formula, but could proceed through our joint efforts combining administrative and legislative actions. As we have argued in the past, we believe that prescription drugs are inappropriately included in the formula and increase spending that counts against the spending target. This leads to future unsustainable payment rate cuts. Furthermore, we believe that the time is ripe to tie physician payments to quality performance – a position that we know you share.

We worked closely with the Administration to avert payment cuts in 2003, 2004 and 2005. In 2003, we corrected the physician formula's use of incorrect projections for the number of Medicare+Choice enrollees and 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, and reduced the gap between allowed expenditures and actual expenditures for physician services over time. Provisions in the Medicare Modernization Act (MMA) set a floor of 1.5 percent on the payment update in 2004 and 2005, and replaced the use of a single year's gross domestic product (GDP) with a ten-year rolling average GDP. This change to the formula will smooth out projected expenditure calculations in the SGR formula. These actions ensured that Medicare beneficiaries retained access to high quality health care through 2005.

Despite these significant changes, CMS actuaries project negative payment updates of about minus 5 percent annually for 7 years, beginning in 2006. Physician payment rates would decline more than 31 percent from 2005 to 2012 while costs of providing services would increase by 19 percent over the same period. This is simply unacceptable.

The Medicare Trustees came to the same conclusion in their 2004 annual report. They wrote: "The projected physician fee schedule expenditures should be considered unrealistically low due to the current law structure" (page 127). Moreover, the 2004 Technical Expert Panel recommended that the Office of the Actuary and the Trustees simulate departures from current law and report the results in the Trustees Report when "In special and extraordinary circumstances, the continuation of current law may be extremely unlikely" (page 44). In other words, the current law baseline for physician expenditures is unrealistic. Because the baseline is unrealistic, cost estimates to fix the SGR are also unrealistic.

We must work together to reform the physician payment formula to preserve Medicare beneficiaries' access to high quality care. We request that you undertake new action on two issues that CMS could address administratively.

1. Remove prescription drug expenditures from the SGR baseline; and
2. Account for costs of new benefits.

Remove Prescription Drug and Biologic Expenditures

We believe that CMS should remove prescription drug and biologic expenditures from calculation of the sustainable growth rate. 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 is a consistent reading of the statute.

Drugs are not reimbursed under the Medicare physician fee schedule. It is illogical to include drugs in the expenditure total when calculating an update for services paid under the physician fee schedule. However, the physician's administration of the drug is clearly a physician service, and justifiably included in expenditures subject to the SGR.

The MMA reformed payments for Part B drugs to pay appropriately for drugs and for drug administration. Physicians no longer are forced to use overpayments for drugs to subsidize underpayments for drug administration. These reforms removed the need to

control the volume of drugs through the SGR system. Therefore, drugs should be removed from the SGR formula.

We believe that CMS has the authority to revise the definition of physician services to exclude drugs. Furthermore, we believe that CMS has the authority to revise its previous calculations of actual expenditures by removing the costs of prescription drugs and to do so back to the base period using this revised definition. CMS has demonstrated its authority to revise calculations of actual expenditures by actually revising expenditures to account for omitted codes and more complete claims data.

Once CMS has revised calculations of actual expenditures back to the base period, it will have a revised calculation of allowed expenditures by definition because the statute sets the base period allowed expenditures equal to the base period actual expenditures.

CMS should apply the same definition of *expenditures* to both allowed and actual expenditures. If CMS were to remove drugs from the definition of actual expenditures, it would also want to remove drugs from the definition of allowed expenditures. Since each year's allowed expenditures are based on the prior year's allowed expenditures increased by the SGR, removing drugs from allowed expenditures for next year requires recalculation of last year's allowed expenditures with drugs removed. Following this process back over time leads us to the conclusion that the allowed expenditures should be revised back to the base period. This process would remove drugs entirely from both actual and allowed expenditures back to the base period.

Account for Costs of New and Expanded Benefits

We also request that CMS review its determination of the costs of new benefits and expansion of existing benefits, which are included in the SGR calculation. 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 the 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 expanded coverage for diagnostic tests and chemotherapy treatment for cancer patients, carotid artery stenting, cochlear implants, Positron Emission Tomography (PET) scans for Alzheimer's disease and use of photodynamic therapy to treat macular degeneration will add to spending on physician services. Without proper accounting for the increased expenditures due to expansion of existing benefits, physician's payments are reduced because actual expenditures, which include spending stemming from benefit expansions, increase more than allowed expenditures, which do not include an allowance for these expanded benefits.

We request that CMS review its procedures for determining the costs of national coverage decisions, and share the agency's assumptions with us.

Paying for Better Results

We applaud the work that CMS has undertaken to pay for better results in Medicare. Our beneficiaries deserve the highest quality of care that can be provided within our means. The demonstrations on implementing performance-based payments in Medicare will provide us with the experience we need to design appropriate rewards for delivering quality care. CMS work with physician groups to identify quality indicators and achieve consensus on these measures through the National Quality Forum will bring us closer to paying for quality care. We pledge our support for your efforts in this area and look forward to working with you to develop incentives for physicians to provide high quality care to Medicare beneficiaries.

We look forward to working with you to ensure continued access to Medicare physicians and other providers paid under the physician fee schedule. Your prompt response to this request is appreciated.

Best regards,

Bill Thomas
Chairman

Nancy L. Johnson
Chairman
Subcommittee on Health

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