October 3, 2011

Glenn M. Hackbarth, JD, MA
Chair
Medicare Payment Advisory Commission (MedPAC)
601 New Jersey Avenue, N.W.
Suite 9000
Washington, DC 20001

Dear Chairman Hackbarth:

The undersigned organizations are writing to urge the Commission to revise the Sustainable Growth Rate (SGR) proposal tentatively agreed to at your September meeting. We share your concern that the SGR is undermining patient and physician confidence in the Medicare program and appreciate the Commission's effort to present a comprehensive plan intended to improve the prospects for SGR repeal. Unfortunately, however, we cannot support this plan in its present form because it retains many of the SGR's flaws, undermines physicians' ability to participate in payment and delivery reforms, and calls for payment rates that the Commission itself has previously said could reduce Medicare beneficiaries' access to medical care.

Before you finalize the proposal, we urge you to consider the following comments which are offered as a constructive effort to devise a plan that restores physician confidence in the program and ensures Medicare beneficiaries continued access to the physician of their choice.

MedPAC Should Examine a Broader Set of Proposals to Pay For SGR Repeal.
In an attempt to prompt Congress to permanently repeal the SGR rather than relying on yet another short-term, unfunded proposal, MedPAC has proposed some $333 billion in provider payment cuts and beneficiary cost increases. In an attempt to keep the proposals within the range of options that might normally be part of its purview, the Commission has kept a number of other relevant options off the table and increased the "shared sacrifice" it is asking of Medicare providers and beneficiaries. More than $250 billion of these beneficiary and provider "sacrifices" had not been previously endorsed by the Commission. Some $100 billion of the total is attributable to a plan to lower physician payments by enough to reduce the cost of repeal from $300 billion to $200 billion.

A number of groups, including the Congressional Budget Office, the Simpson-Bowles Commission and the so-called Senate Gang of Six have identified a more extensive list of potential offsets. Both the Senate Gang of Six and the Simpson-Bowles Commission came up with proposals that repealed the SGR formula while still exceeding the deficit reduction targets required under the Budget Control Act of 2011. MedPAC could and should tell Congress to rely on these existing proposals rather than offering up a new package that magnifies the size of provider and beneficiary sacrifices due to the limited scope of items within the Commission's purview.

Other Medicare Policies Compound MedPAC's Recommended Payment Cuts.
As we understand it, MedPAC's proposal would apply a 10-year freeze to payments for a narrowly defined set of primary care services estimated to account for 8 percent of Medicare spending. Services that comprise the remaining 92 percent of Medicare expenditures would be reduced by 17 percent over the first three years of the proposal and then frozen for the remaining seven years. These payment levels would be problematic under any circumstances but are particularly risky at a time when physicians have already faced 10 years of nearly frozen rates and now confront the painful choice of either making significant new investments in their practices or being hit with payment penalties of 5 percent or higher in a few years.

Today Medicare payments are just 4 percent higher than in 2001 but physician practice costs, as measured by the Medicare Economic Index (MEI), are 24 percent higher. **Using that same conservative inflation index, practice costs are expected to rise by another 19% over the next 9 years so that under MedPAC's tentative recommendation, by 2020, after adjusting for inflation, primary care services will have been cut by 16% and all other services will have been cut by 30%. (See attached chart.)**

This decline would then be exacerbated by previously enacted Medicare payment policies which in many cases have laudable goals but taken as a whole may put a severe economic burden on many physicians, especially those in small practices. For example, physicians will be required to adopt a massive new diagnostic coding system (ICD-10) by October 1, 2013. In addition, despite the medical community's general support for quality reporting and the use of electronic records, there are substantial barriers to adoption that create the risk of penalties exceeding 5 percent a year for physicians who cannot meet implementation deadlines. Budget neutral changes in geographic practice expense adjustments and a value-base modifier mandated in the Affordable Care Act (ACA) will improve the bottom line for some physicians but deepen cuts for others. Some physicians will have 3 percent of their Medicare payments withheld until the end of each year due to a provision in the Tax Increase Prevention and Reconciliation Act of 2004. Recommendations from the Independent Payment Advisory Board (IPAB) established under ACA could lead to another round of across-the-board payment cuts for physicians, who fall under the IPAB's purview sooner than hospitals. If Congress fails to meet the deficit reduction targets mandated in the Budget Control Act of 2011, Medicare payments could be reduced by another 2 percent across-the-board.

Revenue Projections in Changing Times Are Unreliable.
During discussion at the September meeting, Commissioners seemed reassured by staff projections that despite a 17 percent pay cut, aggregate Medicare revenues to physicians over the next 10 years would increase from $64 billion to $121 billion or 2.2 percent a year per fee-for-service beneficiary. Exact details are unclear but the projection appears to assume a continuation of current volume trends. In the face of the unprecedented cut in physician payment rates the Commission is considering, there is simply no real basis for this assumption. We have no experience to tell us what will happen in these circumstances. Even if expenditures per patient did go up at the projected rate, it cannot

be presumed that net incomes and physicians' ability to cover their cost of practice will increase accordingly. In fact, with such a large gap between projected practice costs and proposed payment rates, there is every reason to think that physician incomes will shrink, potentially reducing their ability to retain staff and continue providing high quality care to Medicare beneficiaries. **It is speculative at best to suggest based on these unreliable projections that access to medical care will not be affected when Medicare payments for 92 percent of medical care are cut by 17 percent and the remainder are subjected to a 10 year freeze, especially in light of all the other Medicare payment cuts physicians are confronting.**

The Proposal Could Intensify Existing Access Threats.

As noted by many Commissioners, the U.S. is confronting a shortage of primary care physicians. The same is true of other specialties as well and with more than 40 percent of physicians now over age 55 and more than 20 percent over 65, approaching retirements will intensify the shortages that exist today across a wide range of specialties, including several where more than half of all physicians are over 55. Coming at a time when an influx of baby boomers into Medicare and the availability of coverage for previously uninsured Americans is increasing demand for medical care, the implications are clear. There will not be enough physicians to meet demand under the best of circumstances and the imposition of drastic new Medicare cuts that spill over to other payers seems sure to contribute to serious across-the-board access problems.

In the past, MedPAC and virtually every serious policy body that has looked at the SGR dilemma has concluded that cuts well below the 17 percent now on the table would have serious consequences for patients and are ill-advised because they penalize all physicians equally, regardless of the quality or efficiency of the care they provide. After 10 years of flat-lined payments, physicians' ability to absorb a cut of this level is even less today than when the Commission made those earlier statements. We appreciate the Commission's promise to monitor access and recommend payment changes in the future if access problems develop. We are concerned, however, that a Congress that has refused for 10 years to fix the SGR problem will not act upon those recommendations until the problem has become severe and many Medicare beneficiaries' care has been compromised.

Unintended Consequences Could Raise Cost of Care and Derail Payment Reforms.

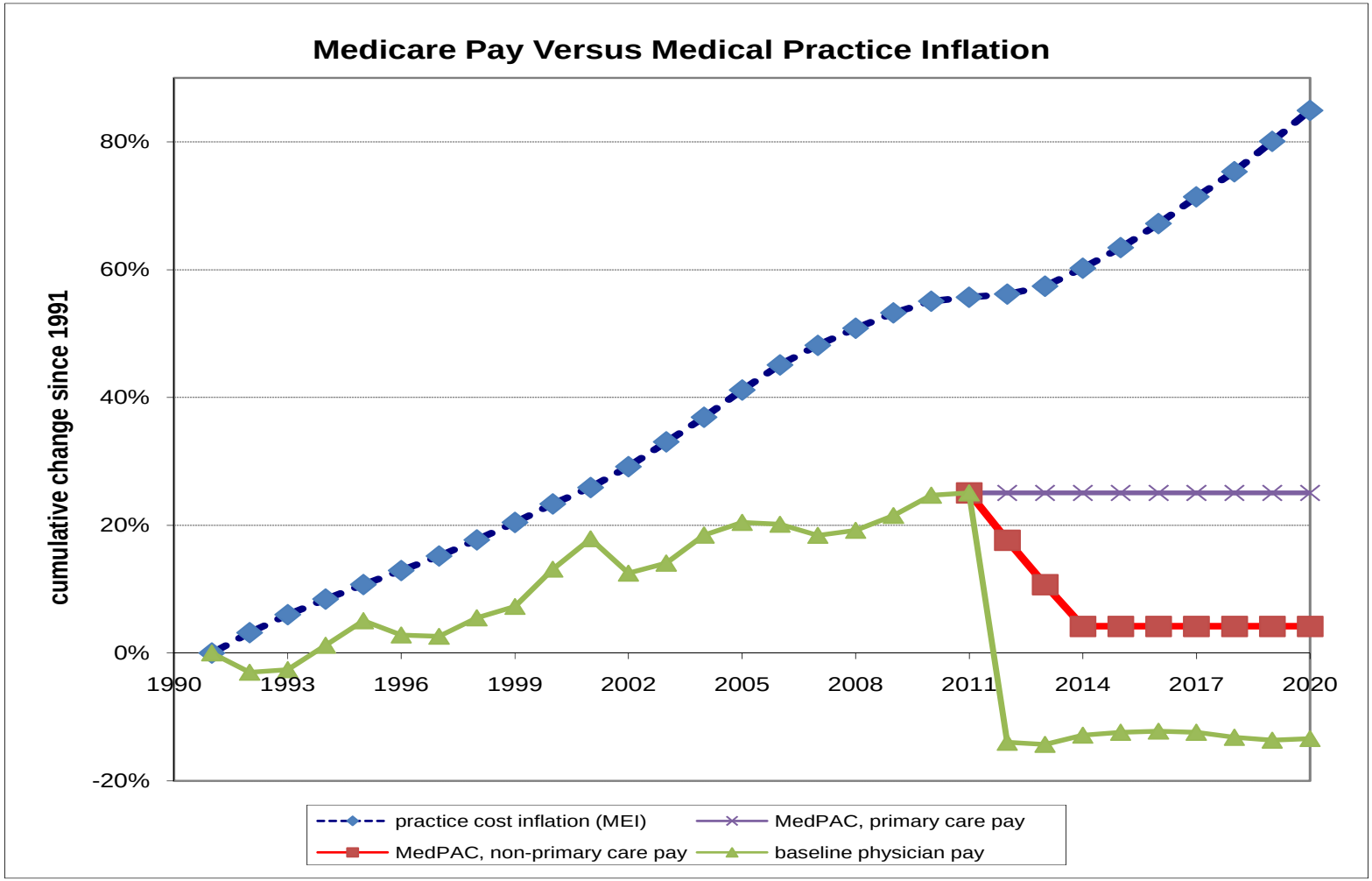
As MedPAC has frequently pointed out, more and more physicians are affiliating with hospital systems. There are many reasons for this shift and in the right circumstances, it can benefit both patients and providers. On the other hand, Medicare pays both a physician and a hospital fee in these arrangements and as shown by cardiologists' recent migration into hospital practices, Medicare payment cuts are likely to accelerate this shift. Medicare expenditures and beneficiaries' out-of-pocket liability will rise as a result. The Commission proposes to deal with this cost increase by reducing payments for hospital clinic visits but Medicare still would pay more for many other services.

Many of the payment and delivery system reforms encouraged under the ACA originated with MedPAC. The medical profession is anxious to see a wide variety of new models tested and analyzed and has already engaged with private payers to do so. The SGR

repeal policy supported by our groups calls for a period of payment stability to see which of these new models work followed by the adoption of those that do. We recognize that MedPAC has a goal of ensuring access to primary care. Unfortunately, however, under the recommendations the Commission is poised to make, neither primary care physicians nor other physician specialists will have the positive operating margin needed to support other delivery innovations—such as care coordination, chronic disease management, and quality improvement—that could improve patient care and lower Medicare costs.

To address this concern, the Commission wants to "increase the shared savings opportunity" for physicians participating in accountable care organizations that agree to two-sided risk arrangements where physicians would have to absorb some or all of the cost of care that exceeded a benchmark rate tied to average Medicare expenditures outside the ACO. This improved opportunity for savings would be accomplished by setting the benchmark rates at levels that assume all physician services would continue to be paid at the 2011 rates. There still would be no adjustment for inflation in these costs over the next 10 years and no adjustments for any additional cuts that are imposed on physicians and other providers to reduce the deficit or help pay for SGR repeal. Even at currently projected benchmarks based on today's payment rates, interest in forming ACOs has been limited. It is hard to see how a benchmark that assumes a 10-year freeze in physician updates would improve the prospects for shared savings that might mitigate the impact of payment reductions.

To summarize, we agree with MedPAC that the SGR must be repealed, that another temporary proposal will only increase the cost of a permanent solution, and that physicians should be part of the effort to constrain health care costs. We appreciate the Commission's desire to facilitate enactment of a total SGR repeal. In view of the very significant payment constraints that physicians have already absorbed over the past decade, however, we respectfully disagree with the suggestion that SGR repeal should be funded in large part by cuts in payments to physicians. We would like to work with the Commission to develop an alternative that would achieve its goals of producing stable and predictable physician payment updates, protecting beneficiaries' access to care and creating an environment that encourages payment and delivery reforms.



Source: MEI data and baseline physician pay from 2011 Medicare Trustees Report
MedPAC proposal impacts based on transcript of MedPAC's September 2011 Meeting
Prepared by The AMA Economic and Health Policy Research, Sept. 2011

Sincerely,

American Medical Association
AMDA – Dedicated to Long Term Care Medicine
American Academy of Dermatology Association
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
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American College of Osteopathic Surgeons
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American College of Radiation Oncology
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American College of Rheumatology
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American Congress of Obstetricians and Gynecologists
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American Orthopaedic Foot and Ankle Society
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Radiation Oncology
American Society of Cataract and Refractive Surgery
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Renal Physicians Association
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