STATEMENT

of the

American Medical Association

to the

Practicing Physicians Advisory Council

Re: Volume Performance

Presented by: John Nelson, MD, MPH

May 19, 2003

Medicare Payment Update

- **In accordance with the MedPAC recommendations, support replacement of the current Medicare physician payment update formula with a system that, beginning in 2004, keeps pace with annual increases in the cost of practicing medicine, starting with a 2.5 percent increase in 2004;**

- **Analyze thoroughly the full impact of all laws and regulations on physician spending, and calculate these costs as part of the SGR;**

- **Provide the Council with results of any Medicare beneficiary access study, as well as all underlying data and related analysis;**

Physician Enrollment Regulation

- **Include the physician enrollment regulation on the agenda in the near future and delay finalizing the rule until PPAC has had an opportunity to provide input to CMS; and**

Physician Education and Funding

- **Ensure that adequate funding be available for physician education and training.**

The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning volume performance with respect to the Medicare fee schedule for services furnished by physicians and other health care professionals.

MEDICARE PAYMENT UPDATE SYSTEM

At the February PPAC meeting, the AMA discussed that a 4.4 percent cut in Medicare payments to physicians and other health professionals was scheduled to become effective on March 1, 2003. The AMA is very appreciative that the Centers for Medicare and Medicaid Services (CMS) and the Administration worked closely with Congress to restore funding stemming from inadequate spending targets in 1998 and 1999, which resulted in a 1.6 percent payment update for 2003, instead of the 4.4 percent payment cut that was scheduled to take effect. At that time, CMS estimated that there would be "positive updates for 2004 and later years."

Several weeks later, however, in a March 20 letter to the Medicare Payment Advisory Commission (MedPAC), CMS stated that although it had "previously estimated positive updates for 2004 and later years," it now estimates that payments will be cut again in 2004, 2005, 2006 and 2007 because spending for physician services was higher and the GDP lower than previously estimated. Specifically, CMS actuaries are now projecting a 4.2 percent cut in 2004. This cut would mean that payment rates will be 8 percent lower next year than in

2001 and would expand the already substantial gap between payment rates and practice cost inflation. From 1991-2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation, as measured by Medicare's own conservative estimates. Additional cuts are only compounded by skyrocketing medical liability insurance costs and increasing administrative burdens.

Congress, CMS and the Administration acted just a few short months ago to avert a 4.4 percent pay cut in 2003 because there were clear indications that doctors could not keep seeing Medicare patients in the face of another cut. CMS Administrator Scully warned of a "meltdown" if Medicare payments to physicians are not increased. This outcome is as true today as it was then.

Further, CMS has announced an expansion of efforts to monitor beneficiary access to physicians services, both nationally and in local healthcare markets. While we are not aware of any results of CMS' efforts, we urge CMS to conduct a thorough analysis of the data, particularly with regard to physician participation in the Medicare program. The AMA is very concerned that CMS has inappropriately focused on the level of physician participation rates as a measure of access. Specifically, CMS has released data indicating that the percentage of par physicians has increased, but has declined to provide the actual numbers of par and non-par physicians with Medicare billing numbers. Data we have seen indicates that the number of physicians (Medicare definition includes MDs, DOs, chiropractors optometrists, oral surgeons and podiatrists) with billing numbers in both categories declined from 2000 to 2001, and again in 2002. However, since the decline was greater among non-pars than pars, the participation percentage rate actually increased.

Further, simply identifying high or increasing rates of physician participation in the Medicare program cannot indicate levels of access to the Medicare program for beneficiaries. Whether a physician continues to participate in the Medicare program does not indicate whether the physician is continuing to see new Medicare patients or whether the physician is implementing any of a number of initiatives that could seriously impact access. In addition, national statistics do not necessarily show the specific situation in local communities, especially in rural areas, and thus it is important to focus on access at the local level as well. **Accordingly, we urge PPAC to request that CMS provide the Council with results of any access study, as well as all underlying data and related analysis.**

MedPAC Recommendations on Physician Update

In March, MedPAC recommended an update for 2004 of 2.5 percent. Further, MedPAC has proposed replacing the SGR with a different update system for physicians' services using the same framework that is currently in place for evaluating payment updates for all other Medicare provider groups. Under that framework, MedPAC would make a recommendation to Congress regarding each year's update based on payment adequacy, patient access and other factors. Any inappropriate volume growth could be addressed through targeted actions that deal with the source of the increase. This would give Congress more control over the process than exists under the current system.

In accordance with these MedPAC recommendations, the AMA urges PPAC to recommend that CMS support replacement of the current Medicare physician payment update formula with a system that, beginning in 2004, keeps pace with annual increases in the cost of practicing medicine, starting with a 2.5 percent increase in 2004.

Flaws in the Physician Payment Formula

The current Medicare update formula for physicians and other health care professionals is based on a spending target called the sustainable growth rate (SGR) and is a flawed public policy that results in arbitrary and steep pay cuts never intended by Congress. As discussed above, MedPAC has recommended that the SGR be replaced. We agree.

The use of a spending target does not achieve its goal of reduced volume. As House Ways and Means Chairman Thomas and Health Subcommittee Chairman Johnson observed in a letter, dated March 21, 2002, to CMS Administrator Scully: "An individual physician who reduces volume in response to …the SGR system would not gain a proportionate increase in payments, because payment increases would be shared among *all* physicians who serve Medicare beneficiaries. Contrary to the system-wide goal of restraining volume growth, an individual physician has incentives to increase volume under the SGR system."

The SGR, in particular, is centralized government planning at its worst, and is fatally flawed for two reasons. First, payment updates under the SGR system are tied to the gross domestic product (GDP); the medical needs of patients, however, do not decline during economic downturns. Moreover, the United States' population is aging and new technologies are making it possible to perform more complicated procedures on older and frailer patients than in the past. While the SGR system artificially caps spending on medical services, this type of system inherently cannot cap the amount of medical services that are needed to adequately treat sick patients.

The second flaw under the SGR is that physicians are penalized with lower payments when volume increases exceed the SGR spending target. Yet, the factors driving these increases are often beyond physicians' control. The Congressional Budget Office says that recent Medicare volume increases are due to "increased enrollment, development and diffusion of new medical technology" and "legislative and administrative**"** program expansions.

Indeed, volume increases when the government promotes greater use of physician services through new coverage decisions, quality improvement activities and a host of other administrative decisions that are good for patients, but are not reflected in the SGR spending target. Specifically, Congress has expanded Medicare coverage to include several new screening tests that frequently trigger additional physicians' services that may or may not be related to the condition being screened. CMS also has added coverage for a variety of new technologies, such as PET scans and cryosurgery; and Medicare's Quality Improvement Organizations achieved a 5 percent increase in the use of mammograms and a 16 percent increase in lipid testing for targeted groups of beneficiaries.

In addition, although the preliminary data available from CMS show that Medicare spending growth in 2002 was about 6.5 percent, this was driven in part, however, by a 3.2 percent increase in the number of beneficiaries enrolled in fee-for-service and above average growth in clinical lab services (10 percent) and drugs (25 percent). In fact, CMS' National Health Statistics Group suggested in a *Health Affairs* article from January/February 2003 that "a wave of new blockbuster drugs...spawned steady growth in prescription drug use and physician visits."

For physician services alone, the AMA estimates that *spending* grew by less than 2 percent a year per beneficiary and that after payment cuts and benefit expansions are factored in, *utilization* per beneficiary rose by about 6 percent to 6.5 percent. Interestingly, this is only slightly higher than in 2001 when the physician update was positive and utilization (after adjustments for enrollment, pay changes, and legislation) increased by 5 percent to 5.5 percent compared to an average of 2.6 percent in 1996 through 2000. In other words, rates of growth were rising independent of what was happening to payments, and, instead appear to be fueled in large part by growth in technology and government expansion and promotion of covered Medicare services, as discussed above.

Further, this pattern of spending increases was repeated across Medicare. According to CMS data cited in the March 26, 2003, *New York Times,* 2002 increases in Medicare spending for durable medical equipment, hospital, home health, skilled nursing facility and hospice services all exceeded the increase in physician spending. Also, as the CMS actuaries wrote in the *Health Affairs* article referenced above, similar trends have been observed across all payers as "national health care spending in 2001 grew at the fastest pace since 1991."

It is neither fair nor feasible to cover the cost of all this additional care by repeated cuts in physician payments. A new payment system that adequately keeps pace with inflation is needed to ensure access to high quality care for our nations' seniors and disabled patients.

Administrative Changes Needed in the SGR Formula

As we have previously discussed with PPAC, there are a number of other problems with implementation of the SGR that inequitably affect payment updates due to factors that are beyond physicians' control, and these problems could be fixed administratively by CMS:

Inclusion Of Drugs In The SGR:

We appreciate that PPAC recommended pursuant to the February meeting that CMS remove prescription drugs from the calculation of the SGR, and the AMA continues to believe that such drugs do not belong in the SGR.

Throughout the duration of the SGR, growth in spending on Medicare-covered drugs has been more than six times that for physician services. From 1996 (the SGR base year) through 2002, drug spending per beneficiary grew by 237 percent (from $55 to $184) compared to 35 percent ($1310 to $1800) for physician services. Drug spending as a share of total SGR

spending more than doubled from 3.7 percent in 1996 to 8.7 percent in 2002. Further, early data for 2002 indicates that spending increased by 26.7 percent for drugs compared to 3.9 percent for physicians' services.

Including drugs in the SGR makes it far more likely that actual spending will exceed the SGR target and trigger pay cuts for physicians. Since drugs are not paid for under the physician fee schedule, however, drug payments are not affected by the SGR.

Changes in Medicare Spending on Physicians' Services Due to Laws and Regulations:

Again, we appreciate that PPAC recommended at its February meeting that CMS include increases in physician spending resulting from national coverage decisions for purposes of calculating the SGR, and the AMA continues to believe that these decisions should be included in the SGR. There have been 62 national coverage decisions since CMS formalized its process for making national coverage decisions [in 1999], and this number is growing rapidly, as indicated by the 23 decisions that have already been made in the first three months of this year.

We also believe that the full impact of <u>all</u> laws and regulations on physician spending should be analyzed more thoroughly by CMS and calculated as part of the SGR, and we urge PPAC to make this recommendation to CMS. For example, a number of initiatives undertaken by Congress, CMS and the Department of Health and Human Services (HHS) have increased the use of physicians' services, including new screening benefits and coverage of new technologies. In addition, as discussed above, Medicare Quality Improvement Organizations have increased the use of physician services, and these organizations have been cited as an important factor in improving quality care delivered to Medicare patients in studies conducted during 1998-1999 and 2000-2001. We applaud the QIOs' efforts, but believe any impact on physician spending should be calculated in the SGR.

SECRETARY'S ADVISORY COMMITTEE ON REGULATORY REFORM

The AMA would like to express our appreciation for the efforts of the Secretary's Advisory Committee on Regulatory Reform, which concluded its work about six months ago. The Committee's Chair, Douglas Wood, MD, is a member of this Council. We are concerned that the hard work of the members of the Secretary's Committee has yet to be acted upon by the Department of Health and Human Services and the Centers for Medicare and Medicaid (CMS). There are a number of recommendations from the Committee which would directly address a number of physician concerns: EMTALA reform, CLIA reform, provision of limited English proficiency (LEP) services, multiple carrier reviews and audits, improving the enrollment process, among others. PPAC and the medical profession deserves to know what the Administration is doing to act on these worthwhile and needed recommendations that would reduce much of the "red tape" and burden associated with these regulatory and program requirements. **Thus, we encourage CMS to update PPAC concerning the status of the important issues addressed by the Committee.**

COUNCIL AGENDA:
PROVIDER ENROLLMENT AND EDUCATION AND TRAINING

Although we are pleased that the Council's agenda includes discussion of critical issues relating to the Medicare physician payment update formula, we are disappointed that PPAC will not be updated by the Centers for Medicare and Medicaid Services (CMS) and will not have the opportunity to provide comment concerning the recently published proposed rule on physician enrollment in the Medicare program. This is an extremely lengthy regulation that will have an enormous impact on physicians, both administratively and economically. There are a number of contentious issues in the rule, including, among others: (i) Medicare carriers would be required to revalidate all physician, supplier, and provider enrollment information every three years; although no justification has been provided for the necessity of this massive administrative undertaking, CMS has estimated it will cost $15 million per year; (ii) All physicians who have not previously submitted the 855 enrollment form would be required to do so. Physicians who have received their Medicare identification numbers prior to 1996 have not previously submitted 855 Forms. CMS has not detailed how carriers will carry out this function, the deadlines associated with the process, nor how carriers will use existing resources to process these forms, without jeopardizing the 60-day deadline by which they are supposed to approve Medicare identification numbers. This is of particular concern since carriers often do not currently meet this 60-day deadline; and (iii) CMS would no longer permit physicians and others to provide services to Medicare beneficiaries (for which they would later submit claims) before their Medicare identification number has been issued.

Although CMS is currently seeking public comment on the provisions of the enrollment regulation, it has not included the regulation as an item on today's PPAC agenda. Thus, CMS will not have the opportunity to hear from members of PPAC, who are practicing physicians, with regard to the impact of this regulation. **We urge CMS in the future to ensure that these types of issues are timely included on the agenda.**

Further, we urge PPAC to request that CMS include the physician enrollment issue on the agenda in the near future and delay finalizing the rule until PPAC has had an opportunity to provide input. CMS has initiated efforts to improve the enrollment process, including improvements to the enrollment form and the procedure for obtaining an enrollment application. Nevertheless, a survey conducted by CMS and presented to PPAC last December indicated that there are still lengthy delays in the enrollment process as well as significant dissatisfaction with the process. These issues should be further analyzed by CMS and we believe PPAC could provide valuable input on this matter.

Finally, we wish to express our strong dismay concerning the Administration's proposed funding request for Medicare operations and provider education and training. The Administration has recommended a funding level of $2.497 billion for FY 2004, an increase of only $29 million over the FY 2003 level for Medicare operations and program integrity functions. We are especially alarmed about the reductions in funding for physician/provider education and training. The President's budget would significantly reduce physician education and training from $41.5 million in 2003 to just $6.5 million requested for 2004 – an 85 percent cut. During the last several years the Administration has opted to cut funding for

education and outreach activities whenever carrier budgets have constricted. Physicians are required to understand and comply with over one hundred thousand pages of rules, regulations, requirements and other Medicare directives, as well as a myriad of new laws and related regulations, such as HIPAA, that were enacted over the last several years. Physicians cannot simply digest this magnitude of information without assistance from the carriers**. Thus, we urge PPAC to request that CMS ensure that adequate funding be available for physician education and training.**

The AMA appreciates this opportunity to appear before the Council today and we are happy to work with Council and CMS to achieve timely resolution to the matters discussed above.