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I am Dr. Albert Bothe Jr., Executive Director, University of Chicago Faculty Practice Plan, Compliance Officer and Professor of Clinical Surgery, University of Chicago Medical School, and medical Director, University of Chicago Health Plan. I am also Chair-Elect of the Association of American Medical Colleges' (AAMC) Group on Faculty Practice (GFP) Steering Committee and Chair of GFP Subcommittee on Legislative and Regulatory Issues. I am pleased to be here today to provide testimony on the Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003, Proposed Rule.

AAMC represents the country's 125 accredited medical schools, approximately 400 major teaching hospitals and health systems, 90 academic/professional societies, and approximately 86,000 faculty members (academic physicians) who are members of faculty practice plans.

Academic physicians play a unique, multifaceted role within the physician community, as well as within the larger health care system. In addition to their consultative, educational and research roles, faculty members provide a significant volume of services to Medicare beneficiaries. Nearly one-sixth of all physicians providing Medicare services are academic physicians. Medicare reimbursements to academic physicians represent up to one-third of faculty practice plan revenues. In light of the fact that faculty practice revenues, on average, represent about 35 percent of a medical school's total revenue, Medicare payments play a significant role in the fiscal health of academic medicine.

Changes to the Physician Fee Schedule Update Calculation and the Sustainable Growth Rate (SGR)

Medicare Economic Index (MEI)

AAMC appreciates CMS' proposal to modify the methodology used to calculate the Medicare Economic Index (MEI) to more appropriately adjust for productivity in the inflation index. The proposed change should produce more stable and predictable adjustments. This approach will help to meet some of the objectives of changes to the current system that have been outlined by MedPAC and supported by AAMC and other physician organizations. CMS' proposed change, which will raise the estimated 2003 MEI update from 2.3% to 3.0%, will provide some minor relief to the projection of a second year of notable reduction in the Conversion Factor. Specifically, this increase in the MEI will result in a proposed Conversion Factor change of -4.4% instead of -5.1%.

Professional Liability Insurance (PLI)

The 11.3% change to the CY 2003 Professional Liability Insurance (PLI) component of the MEI is notably above the CY 2002 figure of 3%. This increase reflects changes in the marketplace and begins to account for the dramatic increases in malpractice expenses borne by physicians in some parts of the country. However, given that some academic institutions are reporting two to three-fold increases in PLI expenses, and that the MEI/SGR systems do not yield an actual 11% increase in payments, the net payments to physicians may not be adequate to cover these expenses.

The PLI crisis has resulted in a recent HHS report on the issue. CMS' data source for the PLI calculation, noted in the Proposed Rule as "a CMS survey of several major insurers", may need to be expanded to include other data, as available either from CMS or from other sources.

Proposed Addition to the Definition of Medicare Telehealth

AAMC supports the addition of the psychiatric diagnostic interview to the definition of Medicare telehealth services. The components of the psychiatric diagnostic interview are comparable to an initial office visit or consultation, which are currently included as Medicare telehealth services. We believe this expansion is consistent with Section 1834(m) of the Act.

New HCPCS G Codes

CMS proposes the addition of several new G codes, including those related to the treatment of peripheral neuropathy, Positron Emission Tomography codes for breast imaging, Home Prothrombin time, and for bone marrow aspiration and biopsy performed on the same date of service.

Currently, there are complex and numerous requirements for appropriately coding and documenting services provided to Medicare patients. Given that the CPT code list already includes over 7,500 codes, it is critical that the creation of new G codes be limited. We strongly recommend that to the greatest extent possible existing CPT codes be used.

The creation of some of these G codes is tied to CMS decisions to include certain services as covered services under Medicare. These specific decisions are of greater impact than the related expansion of G codes. Specifically, any services deemed by CMS to become covered services should be included in projected growth in expenditures expected from "changes in law and regulation", not just those changes resulting from specific legislative acts. On one level it is helpful to physicians to be able to treat

Medicare patients who have coverage for a broad array of medically necessary services. This obviates the need for physicians to explain to patients that services are indicated but coverage is not available. However, it is not helpful to have physicians indirectly pay for that coverage by excluding those services from projected volume growth levels. Under the SGR system, this means that anticipated expenditures for such services do not yield increases in the projected target-spending amount, but actual payments are included in the determination of actual expenditures. Thus, when actual to target expenditures are compared, the likely result is a downward adjustment of future years' payments to physicians in order to get actual and target figures back in alignment.

CMS' treatment of expenditures related to drugs results in a similar situation and needs to be reevaluated. Drugs are not included under the physician fee schedule. However, the actual expenditures for drugs are included in target spending calculations. The explanation for the inclusion of drug expenditures in the calculation of actual expenditures has been that it is necessary for ensuring that physicians, who control drug prescribing, do not unnecessarily or inappropriately prescribe drugs. We do not believe that physicians are unnecessarily or inappropriately prescribing drugs and no data have been produced to date to indicate such patterns. The physician community would welcome data on specific trends in this realm that indicate patterns of prescribing that might be addressed by professional education or other efforts.

Finally, we would also encourage CMS to reexamine its position on its inability to correct enrollment and GDP projection errors from 1998 and 1999. It is estimated that the cumulative nature of the SGR system has yielded a loss of $20.4 billion in payments to physicians up through CY 2002. Correction of these errors would not only be fair, but would also help to address some of the concerns raised by physicians relative to the CY 2002 payment reduction (-5.4%) and the currently projected CY 2003 reduction (-4.4%).

The AAMC appreciates the opportunity to comment on the Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003, Proposed Rule.