STATEMENT

of the

Medical Group Management Association

to the

Practicing Physician's Advisory Council

2004 Medicare Physician Fee Schedule

William F. Jessee, MD
President and Chief Executive Officer
Medical Group Management Association

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Mr. Chairman and members of the Council, the Medical Group Management Association (MGMA) is pleased to submit our testimony regarding the 2004 Medicare Physician Fee Schedule. My name is William F. Jessee, MD and I am the President and Chief Executive Officer of MGMA. MGMA is the nation's oldest and largest medical group practice organization representing 19,000 members who manage and lead 11,000 organizations in which approximately 220,000 physicians practice medicine. Our individual members, who include practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently so physician time and resources can be focused on patient care. As such, MGMA members are uniquely qualified to assess the direct impact of the Medicare payment system on the delivery of quality care to Medicare beneficiaries.

Today, many physician group practices are in a state of financial crisis. Decreasing Medicare reimbursement rates coupled with increasing operational costs, including skyrocketing professional liability insurance premiums, are leaving physician groups across the country in peril. Many are at the crossroads concerning their current and future ability to provide access to Medicare beneficiaries.

Mr. Chairman, Medicare is unsustainable at present physician reimbursement rates. Medicare providers cannot continue to offer care to Medicare beneficiaries without the financial resources required to support the operation of their practices. MGMA urges this Council to recommend that CMS (1) remove prescription drug expenditures from the definition of "physician services" used to calculate the physician payment update factor; (2) identify and utilize more industry specific measures for overhead costs and include accurate measures for the regulatory compliance costs of medical practices across the nation; (3) correct past errors to the payment system for years prior to 2000; and (4) work with key stakeholders to develop and establish a new payment update system that reflects the actual cost of delivering services to Medicare beneficiaries.

REALITY OF CURRENT REIMBURSEMENT SYSTEM IN THE MARKET-PLACE

MGMA has conducted extensive surveys of medical practice costs for more than 50 years. In addition to reflecting sharp cost increases in recent years, our data highlights the steep Medicare reimbursement shortfall. In CY 2000, median practice costs per physician in multi-specialty practices increased 6.2 percent. The same data for CY 2001 reflects an additional 5 percent rise in practice costs. Long term, MGMA data indicates that practice costs over the past 10 years increased, on average, by more than 3.8 percent per year. Medicare reimbursements increased only an average 1.1 percent per year during the same period. (Chart 1.)

While the impact of reduced Medicare payments is severe, this issue alone does not fully reflect the extent of the program's impact on the American health care system. Most of the nation's private health insurance companies benchmark their fee schedules to the Medicare physician fee schedule. Thus, the downward trend of the Medicare update is magnified across the nation and affects access to health care for both Medicare and non-Medicare populations.

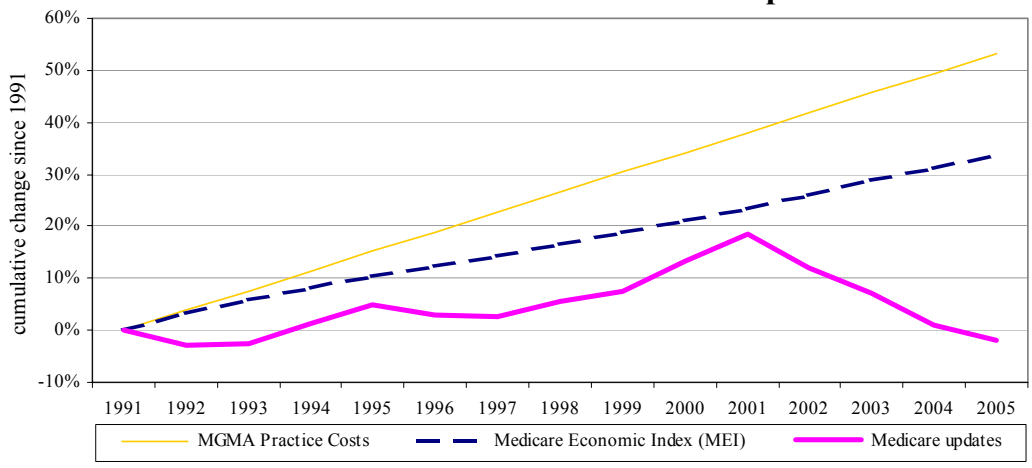
BENEFICIARY ACCESS THREATENED AS PROVIDERS LIMIT ACCESS TO NEW MEDICARE PATIENTS

Coupled with increasing costs, widespread reductions in reimbursement have left practices that are participating Medicare providers with a serious question – should they continue to be fully vested in the Medicare program? In a recent MGMA survey of our members, respondents from 240 physician group practices, in which over 6,800 Medicare participating physicians practice,

indicate that doctors are not planning to abandon their Medicare patients at this time. (Table 1.) In fact, 91 percent of physicians plan to continue their participation despite the anticipated 4.4 percent reimbursement cut this March. However, formal participation rates hide the true story. Over 50 percent of the responding groups plan to reduce the number of Medicare beneficiaries the practice treats if additional payment reductions occur. These survey results illustrate the growing trend of Medicare providers to continue to care for Medicare patients, but to limit access for new patients in order to remain economically viable.

Specifically, the results of the survey show that physician groups are struggling to subsidize the Medicare segment of their practices. To offset rising costs and declining reimbursement, 52 percent of responding group practices plan to eliminate staff, 68 percent plan to postpone investments in new technology and 62 percent will limit expansion of their practice. Each of these actions directly affects the integrity and quality of the Medicare program.

Chart 1. Comparison of MGMA Practice Costs, the Medicare Economic Index and Medicare Updates



Sources: Medical Group Management Association (MGMA), Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), and Medicare Payment Advisory Commission (MedPAC). Estimates for 2004 and 2005 operating costs and MEI are average gains between 1991 and 2003.

THE REAL WORLD

The disparities between payments and the cost to deliver medical services to Medicare beneficiaries have a very real consequence – a negative impact on the economic viability of medical practices. Let me cite a few specific examples from practices managed by MGMA members.

A 64-physician multi-specialty practice in Arkansas reports, "In the northwest Arkansas region, we are currently one of only two physician groups that are accepting new Medicare patients. We are evaluating our ability to continue offering services to new Medicare patients in our area. The second largest group in this area recently stopped taking new Medicare patients, and the Area Health Education Center associated with the family practice residency program recently stopped taking new Medicare patients. This has caused an excess number of patients that we cannot accommodate, and if reimbursement continues to fall, we may also have to stop taking new Medicare patients."

A 135-physician multi-specialty practice in Connecticut reports that they "are not able to meet all general community needs. Efforts to improve quality [of care] have been prolonged due to lack of working capital. If cuts continue, it will jeopardize our ability to continue seeing new Medicare patients and have sufficient funds to remain in business. Reduced reimbursement has limited our ability to expand services to the community such as diabetes management and cardiac disease prevention."

A cardiology, cardiac surgery and vascular surgery group with 53 physicians in Iowa faces drastic measures to cut its operating costs due to falling Medicare reimbursement, including staff reductions. Their costs are increasing by 7-12 percent a year and the practice has been unable to recruit new physicians or extend its services to the surrounding rural population. The practice points out that the demand for services of these specialists by Medicare patients will increase in the coming years, while the practice's ability to supply them will diminish.

These examples reflect but a handful of the medical groups that face the daunting task of evaluating their ability to continue caring for their Medicare patients. As the downward spiral in Medicare reimbursement continues, these practices will be joined by thousands of others unable to continue serving our nation's elderly.

ACCURACY AND FAIRNESS IN UPDATING PAYMENT RATES

CMS has made strides to enhance the current system, and MGMA would like to applaud the Agency for adopting program changes included in the 2003 fee schedule. In particular, CMS' implementation of the multi-factor productivity measure was a significant step in the right direction. However, the Agency must take additional steps to prevent the deepening of the Medicare access crisis.

Prescription Drug Expenditures

The statutory language of the Social Security Act that defines the formula used to annually update physician payment rates requires CMS to assess the allowed and actual expenditures of the Medicare program. Today, CMS uses a definition of "physician services" which is incorrect since it includes the cost of physician administered prescription drugs. A significant factor in the growth in Medicare expenditures has been the introduction of costly new prescription drugs. The inclusion of drugs in the definition of physician services is patently unfair to physicians. MGMA asserts that the current definition of "physician services" as required by the statute, does not include the cost of prescription drugs.

CMS's behavior in this area is, at best, inconsistent. To serve its own purpose, CMS clearly distinguished drugs from the definition of physician services in the December 2002 "Inherent Reasonableness" rule (67 FR 76684). The rule gives CMS broad administrative authority to further reduce reimbursement rates for certain ancillary items under the Medicare program. The Agency cannot choose in one instance to include drugs in the definition of physician services when it is convenient and advantageous to the government and exclude it when it is not. The definition of physician services must be applied consistently for fair and equitable administration of the Medicare program. **MGMA appeals to this Council to urge to CMS to remove prescription drug expenditures from the definition of "physician services" used to calculate the physician payment update factor.**

Overhead Costs

As part of the annual update to Medicare payments, the cost of delivering medical services is assessed through the Medicare Economic Index (MEI). The MEI uses a number of non-medical

price measures to estimate the cost of delivering medical services to Medicare beneficiaries. These measures clearly fail to account for the real world costs running a physician practice. For example, MGMA multi-specialty group practice data shows that over the most recent two-year period, general administrative expenses rose 15 percent. Costs for employee benefits climbed 14 percent. Clinical staff salaries, such as those for Licensed Practical Nurses, increased 9 percent.

The MEI also fails to take into account the cost of complying with the numerous regulatory burdens of the government's own creation. For example, the MEI does not consider the financial impact of increased documentation requirements, conflicting Medicare rules, costly compliance programs, needle stick prevention rules, privacy provisions, and the mandate that practices provide free interpreters for patients with limited English proficiency.

If physicians are to continue to participate in the Medicare program they must trust CMS to base its cost data on the fiscal realities their practices face every day. **MGMA encourages PPAC to recommend that CMS identify and utilize more medical specific measures for overhead costs and include accurate measures for regulatory compliance costs of group practices across the nation.**

Correct Past Errors

The Medicare payment system relies on the availability of quality data and the ability of CMS to correct erroneous estimates used in previous years when more accurate information becomes available. Congress gave CMS the authority to revise previous estimates in the Balanced Budget Refinement Act (BBRA) of 1999 beginning in 2000. MGMA asserts that the legislative language of the BBRA does not prohibit the Agency from correcting estimates prior to 2000. **Consequently, we encourage the Council to direct CMS to correct past errors to the payment system for years prior to 2000.**

CONCLUSION: CMS MUST ACT TO ALLEVIATE THE INCREASING BURDEN ON PHYSICIAN GROUP PRACTICES

The current system setting reimbursement rates for Medicare services is premised on a flawed formula and erroneous data. The system does not reflect the continued growth in overhead cost to provide medical services to our nation's elderly as evidenced by MGMA data. Continued inadequate reimbursement rates will further strain the already thinly stretched fabric which makes up the national network of Medicare providers. For these reasons, MGMA appeals to the members of this Council to recommend CMS do the following:

(1) remove prescription drug expenditures from the definition of "physician services" used to calculate the physician payment update factor;
(2) identify and utilize more industry specific measures for overhead costs and include accurate measures for regulatory compliance costs of medical practices across the nation;
(3) correct past errors to the payment system for years prior to 2000; and
(4) work with key stakeholders to develop and establish a new payment update system that reflects the actual cost of delivering services to Medicare beneficiaries.

On behalf of the Medical Group Management Association, I thank you for the opportunity to share our concerns as the 2004 Medicare Physician Fee Schedule is developed. MGMA realizes that you have been called upon to accomplish an extremely difficult and complex task. We applaud your commitment to America's seniors and look forward to working with you, CMS and HHS to address the content of the upcoming fee schedule.

Table 1. MGMA Participation Survey,* March 2002

Respondent Physician Group Practices:	239
FTE Physicians Represented By Physician Group Practices:	6838
Median Practice Size:	10 physicians
Average Medicare beneficiary population as a percentage of patient population:	39 %

1. What best describes your practice?		
	Primary care	22 %
	Specialty care	54 %
	Multi-specialty	24 %
2. Is your practice located in a rural area?		
	Yes	25 %
	No	75 %
3. What are your plans regarding participation in Medicare in 2003 (all groups responding participated in 2002)?		
	Participating	91 %
	Non-participating	5 %
	Opting out of Medicare	2 %
4. As a result of the 2002 and 2003 Medicare fee reductions, are you limiting the number of Medicare beneficiaries you treat?		
	Yes	52 %
	No	45 %
5. As a result of the 2002 and 2003 Medicare fee reductions, what steps have you taken or plan to take?		
	Cut staff positions	52 %
	Cut physician salaries	62 %
	Cut staff salaries	28 %
	Postpone technology investments	68 %
	Limit expansion plans	62 %

* Data were collected through MGMA's bimonthly electronic newsletter, *MGMA e-Connexion*, which goes to MGMA members. Respondents clicked on a link within the newsletter to respond to the questionnaire. Data were compiled by the MGMA Government Affairs Department.