Statement of the American Academy of Otolaryngology – Head and Neck Surgery to the Practicing Physicians Advisory Council

Re: The 2004 Medicare Physician Fee Schedule

February 10, 2003

The American Academy of Otolaryngology-Head and Neck Surgery (the "Academy" or "AAO-HNS") is pleased to submit this written testimony to the Practicing Physicians Advisory Council (the "Council"). The Academy represents approximately 12,000 physicians in the United States who diagnose and treat disorders of the ears, nose, throat, and related structures of the head and neck. The medical disorders treated by this specialty are the most common that afflict all Americans, old and young, and include hearing loss, swallowing disorders, and head and neck cancer. The Academy appreciates the opportunity to provide comments to the Council on the 2004 Medicare Physician Fee Schedule.

The Academy's statement will include a discussion of the following issues as they relate to the 2004 Medicare Physician Fee Schedule:

- Calculation of the Conversion Factor
- G Codes
- Evaluation of Anomalous Codes Prior to Five-Year Review
- Review of Utilization Data for Low Volume Medicare Codes
- Increasing CMS interaction with the AMA/Specialty Society RVS Update Committee (RUC), National Medical Specialty Societies, and Carrier Medical Directors

I. Calculation of the Update Factor

AAO-HNS is concerned that the reductions under the current payment formula for calculating the Medicare physician fee schedule update factor will have a detrimental effect on beneficiary access to quality medical care. An American Medical Association survey conducted during 2002 found that

one in four physicians either has restricted or plans to restrict the number or type of Medicare patients treated, and one in three has stopped or intends to stop delivering certain services to Medicare beneficiaries. Further complicating matters, Florida and West Virginia, the two states with the highest concentration of Medicare beneficiaries, both have very high percentages of family physicians nearing retirement age. In Florida, 60% of family physicians are 50 or older and almost 40% are 60 or older, making the possibility of retirements due to reduced Medicare payments a high risk situation in that state. In West Virginia, surveys have found that about 80% of physicians over 50 were considering leaving or reducing their medical practice and the combination of malpractice premium increases and Medicare pay cuts could prove the catalyst that leads them to act on that plan.

While we support congressional efforts to legislate improvements to the sustainable growth rate (SGR) and update methodologies under the Medicare physician fee schedule, we also believe CMS should make every possible effort to improve the accuracy and fairness of the current process to avoid exacerbation of the problems Medicare beneficiaries are experiencing with access to care.

2. Background on Sustainable Growth Rate (SGR)

In the Balanced Budget Act of 1997, Congress replaced an earlier expenditure target for physicians' services with the SGR system. The use of SGR targets is intended to control the growth in aggregate Medicare expenditures for physicians' services. The SGR targets are not direct limits on expenditures. Payments for services are not withheld if the SGR target is exceeded by actual expenditures. Rather, the fee schedule update is adjusted to reflect the comparison of actual expenditures to target expenditures. If expenditures exceed the target, the update is reduced. If expenditures are less than the target, the update is increased. Under the statute, the update for a year is determined by comparing cumulative actual expenditures to cumulative target expenditures. Target expenditures for each year are equal to target expenditures from the previous year increased by the SGR.

The statute specifies a formula to calculate the SGR based on the CMS estimate of the change in each of four factors. The four factors for calculating the SGR are as follows:

a. The estimated percentage change in fees for physicians' services.
b. The estimated change in the average number of Medicare fee-for-service beneficiaries.
c. The estimated projected growth in real gross domestic product (GDP) per capita.
d. The estimated change in expenditures due to changes in law or regulations.

3. Behavioral Offset

CMS assumes that physicians increase the volume and intensity of the services they provide in order to recover about 30 percent of any payment rate decrease. When the

SGR system dictates a reduction in payment rates, this assumption requires even deeper rate cuts in order to offset any increased spending attributable to the assumed volume and intensity response by physicians.

This so-called behavioral offset is based on dated studies that have no relation to the SGR system and that do not reflect that changing realities of health care delivery and physician behavior. First, they do not take into account the fact that physicians do not have the capacity to increase their volume and intensity of services indefinitely into the future. Second, these studies also fail to recognize the fact that, in recent years, some physicians have responded to unreasonably low payment rates by limiting their Medicare practices to established patients, not by "making it up in volume."

Revised assumptions on physician behavior to better reflect these realities would significantly increase the annual inflation update under the Medicare fee schedule in future years. **AAO-HNS urges the Council to recommend that the agency to reconsider its position on this issue and to reduce the physician behavioral response it assumes for purposes of the SGR.**

5. Inclusion of Drugs in the SGR

In addition, the Academy urges the Council to recommend that CMS revise the manner in which it treats outpatient prescription drugs under the SGR system. CMS has exercised its discretion to exclude outpatient prescription drugs administered in a physician's office from the Medicare fee schedule, but has nonetheless included them in the spending pool that is subject to the spending constraints of the SGR. Spurred mostly by the addition of 40 new drugs, spending on these drugs has increased from 3.7 percent of the pool in 1996 to 6.6 percent of the pool in 2000. However, SGR targets have not been increased to account for the growing costs of these drugs. **AAO-HNS urges the Council to recommend that CMS either exclude these drugs from the SGR system completely – which the agency has ample legal authority to do – or adjust the SGR targets to reflect the impact of this spending.**

6. Medical Liability

AAO-HNS urges the Council to recommend that CMS ensure that the skyrocketing costs of medical liability insurance are adequately and promptly recognized in the calculation of the MEI. According to the CMS Office of the Actuary, the professional liability insurance component of the MEI is given a weight of 3.2 percent of the total index. The Actuary's current estimates of the increase in liability insurance costs are 7.3 percent for 2001, 4.0 percent for 2002, and 4.6 percent for 2003. CMS explained in the 2003 final physician fee schedule that it uses malpractice insurance data collected from only 5 to 8 carriers who volunteer their liability premium data. They claim that this is the best available data. However, based on recent surveys, both the weighting of the component and the estimated increases in premiums are inaccurate and inadequate. For example, *Medical Liability Monitor*, a well-established monthly newsletter on professional liability issues, estimates that the average annual increase in premiums for 2001 and 2002 was 15

percent for the three physician specialties accounting for 46 percent of all physicians. This data suggests that the data used by CMS in its calculation of the 2003 physician fee schedule may not necessarily be the best available data.

We also note that some states have experienced unusually large liability insurance rate increases: specifically, Florida, Mississippi, Pennsylvania, Tennessee, Texas, West Virginia, and Nevada. Such dramatic increases have led to patients experiencing extreme difficulty accessing medical care, with physicians planning on relocating or quitting medical practice altogether, and trauma centers that treat life-threatening emergencies closing.

Until the MEI methodology can be revised more systematically to reflect actual changes in the costs of professional liability insurance, AAO-HNS urges the Council to recommend that CMS adjust the MEI on an ad hoc basis to provide immediate recognition of the recent increases in these costs.

7. National Coverage Decisions

CMS should adjust the SGR to reflect changes in Medicare benefits that are attributable to national coverage decisions made by the agency. As noted above, the SGR includes a component to reflect changes in law and regulations. However, CMS currently only includes in this component changes in program benefits that are attributable to legislation. By excluding from calculation of the SGR important benefit expansions that are made through national coverage decisions, CMS effectively compares actual expenditure data that include these services against a spending target that does not, thereby making it more likely that the target will be exceeded.

In the 2003 Medicare fee schedule final rule, CMS asserted that: (i) it is not clear to what extent national coverage decisions result in an increase in costs because some local carrier coverage decisions already have the same decisions in place; and (ii) a national coverage decision is not a change in law or regulation. We disagree with both these points. First, we believe that it is possible to estimate the financial impact of a national coverage decision, notwithstanding the extent to which local carriers have the same policies in place. Second, CMS's creation of national coverage decisions have the force of law as controlling authority for Medicare contractors and thus should be a factor that is included in the calculation of the SGR.

We urge the Council to recommend that CMS consider national coverage decisions to be changes in "law or regulations" and factor the increased spending into the calculation of the SGR targets.

8. Conclusions Regarding the Update Factor

In conclusion, we believe that the effect of SGR projection errors, questionable assumptions and an apparent unwillingness to use the agency's administrative authority

to revise the methodology for calculating the update factor all contributed to this year's minus 4.4 percent update factor. Unless changes are made, there will be least two more years of negative updates. In addition to the obvious impact on physician payments and access to care, failure to make these changes creates an inappropriately high physician spending baseline which makes it more difficult for Congress to enact a reasonable solution to the significant and successive payment reductions.

The Academy urges the Council to recommend that CMS revisit its assumptions and use its administrative authority to make appropriate modifications.

II. G Codes

The Academy is concerned that CMS has been creating G codes without providing adequate opportunity for public comment. Currently, CMS publishes new G codes to be used in the Medicare physician fee schedule in the final rule. Often, such G codes appear without prior formal notice in the proposed physician fee schedule or discussion with national medical specialty societies, whose members may be affected by such new codes. We understand that occasionally new G codes will appear in the final physician fee schedule in response to a congressional mandate. However, short of such last minute statutory changes, we believe that CMS should publish G codes and their assigned RVUs in the proposed rule for the Medicare physician fee schedule. Without following such procedures, inserting G codes in the final rule does not provide for the notice and comment required by the Administrative Procedure Act. The Academy also recommends that CMS discuss potential new G codes with the CPT Editorial Panel prior to their issuance to obtain input from the health care industry as a whole, including the physician community.

The Academy urges the Council to recommend that CMS publish new G codes and their assigned RVUs in the proposed rule for the Medicare physician fee schedule and to discuss these new G codes, prior to their issuance in regulation, with the CPT Editorial Panel.

III. Evaluation of Anomalous Codes Prior to Five-Year Review

The Academy believes that certain existing CPT codes have been assigned work RVUs that may be anomalous and will need to be resurveyed. In the past, CMS has reviewed work RVUs for existing codes through the five-year review process. However, the Academy believes that CMS should accept and consider work RVU recommendations from the RUC for existing codes assigned anomalous values in between five-year reviews. CMS is statutorily permitted to do reviews of existing work RVUs prior to the five-year review pursuant to Social Security Act section 1848(c)(2)(B)(i), which states that the Secretary shall review work RVUs "*not less often than* every 5 years". Permitting reviews of codes with anomalous work RVUs, on an as needed basis, will promote consistency and fairness in the assignment of work RVUs for all services paid under the Medicare physician fee schedule.

The Academy urges the Council to recommend that CMS accept and consider work RVU recommendations from the RUC for existing codes assigned anomalous values outside of the five-year review process.

IV. Review of Utilization Data for Low Volume Medicare Codes

As you may know, CMS applies utilization data to its methodology of developing practice expense RVUs. This utilization data is used to determine what percentage of procedures is performed by a given medical specialty. Because each specialty is assigned a different practice expense dollar amount per hour, the utilization data provides a significant factor in the practice expense RVU calculation. The Academy supports this method of calculating practice expense RVUs.

However, the Academy is concerned that for some codes that have a low volume of Medicare claims, the utilization data may be easily skewed, causing a significant negative effect on the practice expense RVUs. For example, a pediatric otolaryngology code may have very few Medicare claims. Some of the claims data may reflect billing errors that may be obvious at a glance. The Academy believes that a review by CMS of the utilization data with an eye toward eliminating glaring errors, particularly for low volume Medicare codes, would improve CMS's accuracy in developing practice expense RVUs. **The Academy urges the Council to recommend to CMS that it perform a review of the Medicare utilization data, particularly for low volume Medicare codes, to eliminate glaring errors and ultimately improve the overall accuracy of the practice expense RVUs.**

V. Increasing CMS interaction with the RUC, National Medical Specialty Societies, and Carrier Medical Directors

The Academy appreciates CMS's current efforts to solicit comments from the public on a wide variety of issues, including the Medicare physician fee schedule. However, we believe that increased CMS interaction with the RUC, national medical specialty societies, and carrier medical directors would provide CMS an opportunity to gather feedback prior to issuing the final Medicare physician fee schedule and create a greater consensus among all groups affected by the fee schedule.

Under the current process, new CPT codes appear only in the final rule, not the proposed rule, with their newly assigned RVUs. If CMS decides to issue RVUs in the final rule that differ from the RUC's recommendations, CMS's issues with the RUC's recommendations are not raised in any forum that allows the RUC, national medical specialty societies, or carrier medical directors to provide feedback to CMS. The Academy believes that such a forum would improve the quality of the decisions CMS makes. Thus, the Academy believes that a meeting between CMS and the RUC -- after CMS has received and reviewed the RUC's recommendations, but prior to issuance of the final rule -- would serve the interests of all involved.

The Academy urges the Council to recommend to CMS that it meet with the RUC after it has received and reviewed the RUC's recommendations, but prior to issuance of the final rule, to permit an open discussion of any issues CMS has with the RUC's recommendations.

In addition, the Academy believes that a meeting of CMS policy-makers with representatives of the national medical specialty societies and carrier medical directors regarding the decisions made in the final rule would serve as a guide to changes to be made in the following year's physician fee schedule. Such a meeting could be held subsequent to issuance of the final physician fee schedule (and after any comment period). Certainly, the Council has served as one forum for discussion. However, such a meeting would provide the physician community an open opportunity to discuss issues related specifically to the physician fee schedule directly with the CMS policy-makers.

The Academy urges the Council to recommend to CMS that it meet with representatives of national medical specialty societies and carrier medical directors after the final rule is released (and any comment period has ended) to discuss changes that can be made to the following year's Medicare physician fee schedule.

In summary, the Academy urges the Council to recommend that:

- **CMS revisit its assumptions and use its administrative authority to make appropriate modifications.**
- **The agency reconsider its position on the behavioral offset and reduce the physician behavioral response it assumes for purposes of the SGR.**
- **CMS either exclude these outpatient prescription drugs from the SGR system completely or adjust the SGR targets to reflect the impact of this spending.**
- **CMS reconsider its position on the accuracy of the medical liability data it uses and adjust the MEI on an ad hoc basis to provide immediate recognition of the recent increases in these costs.**
- **CMS reconsider its position on national coverage decisions and factor the increased spending attributable to national coverage decisions into the calculation of the SGR targets as changes in "law or regulations".**
- **CMS publish new G codes and their assigned RVUs in the proposed rule for the Medicare physician fee schedule and to discuss these new G codes, prior to their issuance in regulation, with the CPT Editorial Panel.**

- **CMS accept and consider work RVU recommendations from the RUC for existing codes assigned anomalous values outside of the five-year review process.**

- **CMS perform a review of the Medicare utilization data, particularly for low volume Medicare codes, to eliminate glaring errors and ultimately improve the overall accuracy of the practice expense RVUs.**

- **CMS meet with the RUC after it has received and reviewed the RUC's recommendations, but prior to issuance of the final rule, to permit an open discussion of any issues CMS has with the RUC's recommendations.**

- **CMS meet with representatives of national medical specialty societies and carrier medical directors after the final rule is released (and any comment period has ended) to discuss changes that can be made to the following year's Medicare physician fee schedule.**

The Academy appreciates the opportunity to provide our views to the Council on these issues related to the 2004 Medicare physician fee schedule. We look forward to working with the Council on these recommendations and any other issues that may arise.