AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY
AMERICAN SOCIETY OF OPHTHALMIC ADMINISTRATORS

American Society of Cataract and Refractive Surgery

Statement to the Practicing Physicians Advisory Council

February 10, 2003

The American Society of Cataract and Refractive Surgery (ASCRS) appreciates the opportunity to submit comments to the Practicing Physicians Advisory Council (PPAC) regarding the 2004 Medicare physicians fee schedule.

ASCRS represents more than 9,000 ophthalmologists in the United States and abroad who share a particular interest in cataract and refractive surgical care. ASCRS members perform the vast majority of the cataract procedures done annually in the United States.

We commend the Centers for Medicare and Medicaid Services (CMS) for adapting the schedule of this meeting to ensure that both PPAC members and the public have the opportunity to provide input while CMS is developing next year's physician fee schedule. We welcome the opportunity to comment on a number of issues ASCRS believes should be addressed in the 2004 Medicare physician fee schedule. Our comments will focus on specific recommendations to address current flaws in the calculation of the Medicare physician payment update.

ASCRS is deeply concerned that the CMS formula for annually updating physician payments is severely flawed and has failed to account for increasing practice costs and increasing demand for physician services. ASCRS, together with the Coalition for Fair Medicare Payment, has been actively working with Congress to address problems with the current formula. However, we also strongly believe that CMS can take specific actions to improve the current flaws in the Medicare physician payment update formula. Specifically, ASCRS urges PPAC to recommend that CMS correct erroneous data and projection errors in the Sustainable Growth Rate (SGR) target, either remove the "incident to" drug prices from the SGR pool or adjust the SGR to reflect the costs of these drugs, and to account for coverage decisions, Program Memoranda and other unfunded mandates in the SGR. Following, please find additional information further addressing each of these specific areas of concern.

Correct Erroneous SGR Estimates

In setting the SGR targets for fiscal years 1998 and 1999, erroneous errors were made in the estimates of GDP growth and fee-for-service enrollment factors. Due to the cumulative nature of the SGR, these errors are compounded annually, shortchanging the SGR each year by more than $4 billion. To date, funding for physician services has been reduced by $20 billion due to these errors. In these years, CMS omitted the costs of care for 1 million Medicare beneficiaries and as a result, the payment calculations were made as though the 1 million beneficiaries did not exist even

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though these Medicare patients were clearly visiting physicians and utilizing services. Although we understand that CMS has stated it does not have the legal authority to correct these errors, we are not aware of any provision in the Medicare statute setting forth a prohibition against such action. We recommend that PPAC urge CMS to utilize their current authority to make these changes.

Inclusion of "Incident to" Drug Costs in the SGR

The 2003 physician fee schedule final rule indicates that CMS has "refined" its methodology for tracking the costs of drugs furnished in a physician's office that are covered "incident to" a physician's service. As a result of this change, the price component of the SGR formula would be somewhat higher and the gap between actual and target expenditures would be slightly lower than it would have been under current policy. However, this measure still fails to address the overall problem with the inclusion of these drugs in the physician pool to begin with, as well as the failure to recognize their rapidly rising costs. **ASCRS believes that CMS should either remove the "incident to" drugs from the SGR pool or adjust the SGR to reflect the costs of these drugs.**

Currently, drugs covered "incident to" a physician service are included within the SGR pool, but no allowance has been made in the target for the significant increasing costs of these drugs. On its face, the inclusion of these drugs in the physician pool is particularly unfair, because the growth in Medicare expenditures in this area has been largely the result of the introduction of costly new cancer drugs, rather than a failure on the part of physicians to control utilization. In addition, CMS' repeated failure to account for these rapidly rising costs will result in physicians continuing to absorb the cost of new drugs through across-the-board pay cuts.

Therefore, ASCRS strongly urges PPAC to recommend that CMS exercise its authority to remove drugs from the SGR pool or adjust the SGR to reflect these costs.

Changes in Medicare Spending Due to Laws and Regulations

CMS is required by law to revise its estimates for the SGR to take into account the impact of changes in laws and regulations on spending for physician services. In addition, CMS is required when revising the SGR for the previous two years to reflect recent data to include the effects of regulations that were not taken into account in prior estimates of the SGR for these years.

Changes in national Medicare coverage due to a Program Memorandum or national Medicare coverage decisions must also be included in the SGR calculations. In the past, CMS has underestimated the increased utilization as a result of these related regulatory changes. Examples of the decisions that must be incorporated in the SGR include: Coverage of ocular photodynamic therapy with verteporfin for macular degeneration; expanded coverage of Positron Emission Topography scans; extended urinary continence coverage; as well as new coverage for lymphedema pumps. These changes by CMS are adopted pursuant to formal or informal rulemaking and thus constitute a regulatory change and should be included in the SGR.

In addition, CMS must also consider the costs to physician practices in complying with unfunded mandates that are not reflected in the current physician payment formula. Physicians are faced with ongoing costs to ensure their compliance with many mandated federal program that are not

recognized in the SGR. Of particular concern are the initial setup and ongoing costs currently faced by physicians in order to comply with both the administrative simplification and privacy aspects of the Health Insurance Portability and Accountability Act.

Failure by CMS to account for the impact of regulatory changes in the SGR forces physicians to finance the costs of improved new Medicare benefits as well as compliance costs associated with federal regulatory requirements. ASCRS strongly urges PPAC to recommend that when CMS calculates the 2004 SGR, as well as revising the SGR for 2002 and 2003, that they evaluate the impact on utilization and spending resulting from all national coverage decisions and Program Memoranda issued that affect utilization during these years, as well as the costs of complying with unfunded mandates that are not currently reflected in the physician payment formula.

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ASCRS appreciates the opportunity to submit these comments to PPAC as the council makes its recommendations to CMS regarding the calendar year 2004 Medicare physician fee schedule. Specifically, we urge PPAC to recommend that CMS:

- Correct errors in GDP growth and enrollment estimates in 1998 and 1999 SGR factors
- Either remove the "incident to" drug prices from the SGR pool or adjust the SGR to reflect the costs of these drugs
- Account for coverage decisions, Program Memoranda, and costs to comply with regulations not currently reflected in the physician payment formula in the SGR

Should you have any questions regarding these comments, please contact Pam Johnson, ASCRS Manager of Regulatory Affairs, at (703) 591-2220, or by e-mail at pjohnson@ascrs.org.