The Alliance of Specialty Medicine appreciates this opportunity to share its recommendations concerning the 2004 Medicare physician fee schedule with the Practicing Physicians Advisory Council (PPAC).

The Alliance is comprised of 13 national medical specialty organizations representing more than 160,000 specialty physicians. The current membership of the Alliance includes: American Academy of Dermatology Association, American Association of Neurological Surgeons/Congress of Neurological Surgeons, American Association of Orthopaedic Surgeons, American College of Cardiology, American College of Emergency Physicians, American College of Osteopathic Surgeons, American College of Radiology, American Gastroenterological Association, American Society for Clinical Pathology, American Society of Cataract and Refractive Surgery, American Urological Association, National Association of Spine Specialists, and the Society of Thoracic Surgeons.

The Alliance's mission is to improve access to quality medical care for all Americans through the unified voice of specialty physicians promoting sound federal policy. A fee schedule that adequately and fairly accounts for the costs of furnishing medical services to Medicare beneficiaries indisputably affects access to and the quality of care for our nation's elderly citizens, and thus is of paramount concern to us. We therefore applaud the Centers for Medicare and Medicaid Services (CMS) for changing the date and format of this meeting so that both PPAC members and the public can offer input to CMS while next year's fee schedule is under development.

The serious flaws in the current formula for annually updating physician payments are of primary concern to the Alliance. Last year, physicians absorbed a 5.4 percent across-the-board reduction in their Medicare reimbursement, largely because of this flawed formula. On March 1, physicians are scheduled to receive an additional 4.4 percent reduction unless action is taken by Congress to prevent this development.

With this unwelcome scenario in mind, the Alliance is grateful for the language approved by the Senate as part of the Fiscal Year 2003 omnibus appropriations bill (H.J.Res. 2) that would delay the 4.4 percent cut from taking effect until September 30. The House version of this bill does not include language addressing the reimbursement

situation. It is our hope that the House and Senate will quickly reach agreement on an approach for halting this reimbursement cut so the president can sign a final bill into law before March 1. Even if Congress halts the cut from taking effect this year, however, it should be noted that physicians still face deep cuts in 2004 and 2005.

As much as a short-term legislative lifeline is appreciated, it is no substitute for fixing the underlying problems in the fee schedule formula itself. **The Alliance therefore urges PPAC to recommend that CMS:**

- **Support Congressional efforts to replace the current Sustainable Growth Rate (SGR) payment formula and provide authority to CMS to correct data and projection errors in the 1998 and 1999 SGR targets.**

In the interim, CMS should:

- **Remove "incident to" drug prices from the SGR pool or conversely adjust the SGR to reflect the costs of these drugs,**
- **Revise SGR estimates to reflect changes in Medicare spending due to laws and regulations, and**
- **Recalculate the Medical Economic Index (MEI) to reflect the rapid escalation of professional liability insurance (PLI) and recalculate medical liability relative value units (RVUs).**

<u>Correct Data and Projection Errors in the SGR</u>

Errors were made by CMS in calculating the 1998 and 1999 expenditure targets for Medicare physician spending, including an underestimate of the Gross Domestic Product (GDP) and failure to account for the enrollment of one million beneficiaries in Medicare fee-for-service. Given the cumulative nature of SGR calculations, these considerable errors are compounding annually and to date have shortchanged funding for physicians' services by at least $20 billion.

Linking the update to the business cycle rather than to patient needs is inappropriate. This approach punishes physicians when the national economy takes a downturn, fails to accurately measure the costs of furnishing medical services to Medicare beneficiaries, and ignores the expenses associated with new technology, resulting in volatile swings in payment updates from year to year. The instability in annual updates is even more disruptive when the GDP is substantially underestimated, as was the case in 1998 and 1999.

The failure to count 1 million Medicare beneficiaries during this time period did not stop them from visiting their physicians or utilizing covered services. Omitting the costs of their care from physician payment calculations had the perverse consequence of forcing down reimbursement in subsequent years due to a mistaken perception that the volume of services in 1998 and 1999 was too high.

The Alliance is disappointed by CMS's claims that it lacks the statutory authority to revise the projection errors used to determine physician payment updates in 1998 and 1999. We are unaware of any provision in the Medicare statute that specifically bars CMS from taking corrective action. **Accordingly, we strongly recommend that PPAC urge CMS to support efforts to revise these flawed projections and estimates, and correct this problem.**

Furthermore, the PPAC should also consider recommending that CMS support abandoning the SGR method altogether and replacing it with a more straightforward approach for updating inputs affecting physician spending. The Medicare Payment Advisory Committee (MedPAC) will recommend that for 2004, the Congress should enact legislation that updates payments for physician services by the projected change in input prices, less an adjustment for productivity growth currently estimated at 0.9 percent. An approach such as the MedPAC proposal that links updates in Medicare physician spending more closely to actual physician costs is a step in the right direction, and merits examination.

Incident-to Drug Costs in the SGR

At present, drugs covered incident to a physician service are included within the Medicare physician spending pool although no allowance is made for the increasing costs of these drugs. Spending on these drugs increased from 3.7 percent of the pool in 1996 to 6.6 percent of the pool in 2000, although SGR targets have not been adjusted to reflect the growing costs of these drugs. The inclusion of these drugs in the physician pool is especially unfair because expenditure growth in this area results from the addition of costly, new cancer-fighting drugs and not from a failure by physicians to control utilization. **We urge PPAC to recommend to CMS that the agency completely exclude incident-to drugs from the SGR system, which it has legal authority to do, or adjust SGR targets to reflect the impact of this spending.**

Changes in Medicare Spending due to Laws and Regulations

In the final fee schedule rule for 2003, CMS responded to comments about recognizing the costs of national coverage determinations (NCDs) in the SGR by stating that a shift from local to national coverage may result in an aggregate increase or decrease in spending, since the service may have been widely available and paid for by regional carriers. **Such regulatory changes are supposed to be included in the SGR, and the full impact of these changes must be included from now on in SGR calculations. CMS must also take into account the compliance costs associated with a myriad of federal mandates.**

Professional Liability Insurance

PPAC should recommend that CMS make additional adjustments to the Medicare Fee Schedule (MFS) to more accurately reflect the increases in professional liability insurance (PLI) costs that physicians are actually experiencing. Under the

current system, there are three ways in which PLI costs are reflected in the MFS – relative value units in the medical liability component of the fee schedule, the MEI and the geographic practice cost indexes (GPCIs). Responding to the recommendations of the physician community, CMS did make changes in the MEI for 2003 to reflect these increased costs by increasing the MEI's PLI factor from 3.2 to 11.3 percent. This change alone, however, is insufficient and CMS needs to make additional changes in the medical liability RVUs themselves.

First, the data on which the current medical liability RVUs is based is extremely outdated, as CMS is using PLI cost information from 1996. Since CMS used 2001 data to increase the PLI factor in the MEI, it should also use this same data to adjust the medical liability RVUs as well. Secondly, the current weights for each component of the MFS are inadequate to reflect the real costs of PLI for physicians. At present, physician work accounts for 54.5 percent of the total MFS payment amount, 42.3 percent accounts for practice expenses, and only 3.2 percent accounts for the medical liability component. For most specialists, PLI costs account for much more than 3.2 percent, and in some cases it may be as high as 10 to 15 percent. CMS should therefore consider "rebasing" the MFS weights and increase the dollars available for adjusting the medical liability RVUs to reflect their current percentage of total payment. If such changes were indicated for the MEI, then surely the same should be true for the medical liability RVU component as well. Finally, the GPCIs should be updated to reflect the various regional differences in PLI costs. While the medical liability crisis is being felt nationwide, clearly there are some states where the problem is more acute. The PLI component of the GPCIs must therefore reflect these steep regional increases.

That CMS has not adequately accounted for increasing medical liability costs is deeply disappointing. Skyrocketing medical liability insurance premiums are of concern to all medicine, but are a particular crisis for the membership of the Alliance, which includes neurosurgery, thoracic surgery, orthopedic surgery, emergency medicine and other specialties hit hardest by increasing PLI costs. Because of this crisis, Alliance members are making difficult choices about limiting the scope of their practice, relocating to other states, accepting outrageously high deductibles, or retiring early. This clearly is having an impact on Medicare and other patients' access to specialty care.

President Bush has made controlling the costs of medical liability insurance a priority and we strongly urge PPAC to do the same by recommending that CMS include accurate PLI costs in the Medicare Physician Fee Schedule.

Conclusion

The Alliance of Specialty Medicine is pleased to submit these recommendations to the PPAC as the council develops its proposals concerning the 2004 Medicare physician fee schedule. Thank you for considering our views on these important matters. Please do not hesitate to contact Laura Saul Edwards at ledwards@aad.org or 202-842-3555 if you have any questions regarding our recommendations.