

# American Medical Association

Physicians dedicated to the health of America



**Statement**  
**of the**  
**American Medical Association**  
**to the**  
**Subcommittee on Health**  
**Committee on Energy and Commerce**  
**U.S. House of Representatives**  
**RE: "The Medicare Payment System"**

**May 5, 2004**

Chairman Bilirakis, Representative Brown and Members of the Subcommittee, the American Medical Association (AMA) appreciates the opportunity to provide our views today regarding the Medicare payment update formula for physicians' services.

The AMA would like to take this opportunity to commend you, Mr. Chairman, and each Member of the Subcommittee, for all of your hard work and leadership in recognizing the fundamental problems inherent in the Medicare physician payment update formula and enacting recent short-term "fixes" of the update formula. We deeply appreciate enactment of provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which greatly assist in averting access problems for Medicare beneficiaries, including replacement of the 4.5% Medicare physician pay cut for 2004 and another severe cut in 2005 with a positive 1.5% update in each of these years, as well as placing a floor on geographic adjustments and providing bonus payments for certain physician "scarcity" areas.

We also applaud your commitment to developing a long-term solution to the current flawed physician payment formula. The flaws in this formula led to a 5.4% payment cut in 2002, and additional cuts in 2003 through 2005 were averted only after Congress intervened. Further, the formula has produced payment updates that have failed to keep pace with the cost of practicing medicine. From 1991 through 2005, medical practice costs will have increased by 41%, yet, during the same time period, Medicare payments to physicians will have increased only by about 18% (see chart in Attachment A). Without intervention, the situation will worsen. The Medicare Trustees have projected that physicians and other health professionals face pay cuts of 5% a year from 2006 through 2012. The result, according to 2004 Annual Report of the Medicare Board of Trustees, is a cumulative reduction of more than 31% in physician payment rates 2005 through 2012, while medical practice costs (MEI) during that time frame are expected to increase by 19%.

A physician access crisis is looming for Medicare patients unless action is taken to enact a long-term solution to the current physician payment formula. The MMA has made significant strides in improving the overall system for Medicare beneficiaries, including broad-scale improvements for care furnished to patients in rural areas as well as important new benefits. These critical improvements must be supported by an adequate payment structure for physicians' services. Physicians are the foundation of our nation's health care system, and continual cuts (or even the threat of repeated cuts) put Medicare patient access to physicians' services at risk and threaten to destabilize the program.

The AMA looks forward to working with Congress to achieve a successful solution to the problems with the current payment system. We are happy to have the opportunity today to address the historical problems with the formula.

### **THE SUSTAINABLE GROWTH RATE SYSTEM**

**Medicare pays for services provided by physicians and numerous other health care professionals on the basis of a payment formula that is updated annually in accordance with a sustainable growth rate (SGR). Under the SGR, enacted by the Balanced Budget Act of 1997 (BBA), the Centers for Medicare and Medicaid Services (CMS) establishes allowed expenditures for physicians' services based on certain factors set forth in the law: (i) inflation, (ii) fee-for-service enrollment, (iii) real per capita gross domestic product (GDP), and (iv) laws and regulations. CMS then compares allowed expenditures to actual expenditures. If actual expenditures exceed allowed expenditures in a particular year, then physician payments are reduced in the subsequent year. Conversely, if allowed expenditures are less than actual expenditures, physician payments increase.**

### **PROBLEMS UNDER THE SUSTAINABLE GROWTH RATE SYSTEM**

The flawed SGR system has led to payment volatility and substantial patient access concerns requiring Congressional intervention to avoid erosion of beneficiary access to care.

The vast majority of physician practices are small businesses, and, as such, do not have the economic and other necessary resources to absorb sustained losses or the steep payment fluctuations that have occurred under the SGR system. Further, the unpredictability of the SGR system makes it difficult for physician office practices, as small businesses, to project revenue into the future and make the necessary business and financial decisions needed to operate a sound business over time. For example, when these small medical practices experienced the 5.4 percent Medicare cut in 2002, physicians and non-physician practitioners were left with very few alternatives for maintaining a financially sound practice without limiting their Medicare patients' access in some way. It is also nearly impossible for physician practices to plan ahead since SGR estimates for future years (which are based on numerous factors that are impossible to predict), in addition to being quite grim, are also completely unreliable.

It took strong efforts by Congress, in particular by this Committee, in addition to similar efforts by the Senate, the Administration and CMS to avoid another SGR-triggered pay cut in 2004 and 2005. While we greatly appreciate this effort, we do not believe Congress and the Administration (nor patients, physicians and other health care professionals) should have to struggle with the ill effects of such a system, year after year.

**The Medicare Payment Advisory Commission (MedPAC) has recommended that the SGR be replaced with a system where updates are based on an assessment of increases in practice costs, adequacy of payment rates, and beneficiaries' access to care, and we agree. There are several fundamental problems with the SGR formula:**

- 1. Payment updates under the SGR formula are tied to the gross domestic product, which bears little relationship to patients' health care needs or physicians' practice costs;**
- 2. The SGR formula is highly dependent on projections that in effect require CMS to predict the unpredictable; and**
- 3. Physicians are penalized with lower payments when utilization of services exceeds the SGR spending target, yet, the factors driving these increases are often beyond physicians' control (as further discussed below under "Administrative Action Needed.")**

#### Problems with the Payment Formula Due to GDP

##### *GDP Does Not Accurately Measure Health Care Needs*

The SGR permits utilization of physicians' services per beneficiary to increase by only as much as GDP. The problem with this "relationship" is that GDP growth does not track the health care needs of Medicare beneficiaries. For example, when a slowed economy results in a decreased GDP, the medical needs of Medicare patients remain constant, or even increase, despite the economic downturn. Yet, physicians and numerous other health professionals, whose Medicare payments are tied to the physician fee schedule, are penalized with lower payments because of the decreased GDP.

Further, GDP does not take into account the aging of the Medicare population, technological innovations or changes in the practice of medicine. This is a key reason that MedPAC has recommended replacing the SGR system.

Use of GDP has also led to a system that relies on economic forecasts that nearly always need to be modified as additional data becomes available, and thus it is impossible to make accurate projections about payment update levels. For example, in March of 2001, CMS projected that physician payments would fall slightly by about -0.1 percent in 2002. CMS noted that this projection was based on very early information and could change before a final update was announced in January 2002. In fact, those estimates did change, and Medicare payments to physicians and other health care professionals were cut by 5.4 percent in 2002.

##### *Technological Innovations Are Not Reflected in the Formula*

The United States' population is aging and new technologies are making it possible to perform more complicated procedures on patients who are older and more frail than in the past. The Congressional Budget Office has said that recent Medicare volume increases are due to "increased enrollment, development and diffusion of new medical technology" and "legislative and administrative" program expansions. The SGR system's artificial cap on spending growth ignores such medical advances when it limits target utilization growth to GDP growth.

Both Congress and the Administration have demonstrated their interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process

**The only way for technological innovations in medical care to really take root and improve standards of care is for physicians to invest in those technologies and incorporate them into their regular clinical practice. The invention of a new medical device cannot, in and of itself, improve health care—physicians must take the time to learn about the equipment, practice using it, train their staff, integrate it into their diagnosis and treatment plans and invest significant capital in it. Although the Medicare hospital payment system allows an adjustment for technological innovations, the physician payment system does not do so. The physician payment system is the only fee structure of Medicare that is held to GDP, and no other Medicare payment system faces as stringent a growth standard.**

**Government efforts to foster technological innovations could be seriously undermined as physicians now face disincentives to invest in new medical technologies or to provide them to Medicare beneficiaries.**

#### *Site-of-Service Shifts Are Not Considered in the Formula*

Another concern that is not taken into account in the SGR formula is the effect of the shift in care from hospital inpatient settings to outpatient sites. As MedPAC has pointed out in the past, hospitals have reduced the cost of inpatient care by reducing lengths-of-stay and decreasing staff, as well as by moving more services to outpatient sites, including physician offices. This trend, which has been encouraged by private payers because it saves money for both the government and patients, has increased the number and intensity of services as patients with increasingly complex conditions are treated in physicians' offices. This increased use and intensity, however, is not recognized in the SGR formula.

#### *Beneficiary Characteristics Are Not Reflected in the Formula*

A related factor that also is unrecognized in the SGR formula is changes over time in the characteristics of patients enrolling in the fee-for-service program. For example, increases in patients diagnosed with, or having complications due to such diseases as obesity, diabetes and end stage renal disease, require greater utilization of physicians' services. Yet, these types of changes in beneficiary characteristics are not reflected in the SGR.

#### ***Inability to Predict Payment Updates under the SGR***

Instead of making payments more predictable for physicians and budgets more predictable for policymakers, use of the SGR has had the opposite effect. Future updates are dependent on forecasts of (i) GDP, (ii) how many beneficiaries will choose Medicare Advantage versus fee-for-service Medicare, (iii) the rate of medical practice cost inflation each year, (iv) the rate of utilization growth each year, and (v) spending changes that will occur as a result of legislative and regulatory changes, such as expanded coverage for preventive services.

None of these factors can be accurately predicted before they occur. As a result, policymakers cannot predict the impact of Medicare physician services on overall Medicare spending and medical practices cannot predict their revenue streams for the short- or long-term. Estimates of payment updates initially are based on incomplete data and such estimates can fluctuate significantly as more data becomes available. Indeed, the chart in Attachment B illustrates the numerous changes in CMS estimates of the SGR target beginning in the Fall of 1997 through Spring 2004.

### **ADMINISTRATIVE ACTION NEEDED TO CORRECT SGR IMPLEMENTATION PROBLEMS**

Apart from the inherent problems in the physician payment formula, there are other problems with implementation of the SGR that seriously threaten patient access and inequitably affect payment updates due to factors that are beyond physicians' control. **CMS could and should use its administrative authority to address these issues in the 2005 Medicare physician payment rule:**

1. Remove Medicare-covered drugs and biologics from the physician payment formula

As discussed above, Medicare payments to physicians are reduced when actual Medicare spending for physicians' services exceeds a pre-determined spending target (the SGR). When CMS calculates actual spending on physicians' services, it includes the costs of Medicare-covered prescription drugs administered in physicians' offices. Although the physician's administration of the drug is clearly a physician service that by statute must be included in the pool, the drugs themselves are not "physicians' services" and drugs are not paid under the Medicare physicians fee schedule. Thus, it is inconsistent to include drugs in the SGR. In fact, in an interim final rule issued last year, (on the application of inherent reasonableness to Medicare Part B services), CMS chose to exclude drugs from the definition of "physicians' services." To include drugs as a "physicians' service" for certain purposes, but not for others, is inconsistent and inequitable. Indeed, this policy has been questioned by many legislators, including Subcommittee Chairman Bilirakis and former Committee Chairman Tauzin, who noted in a June 2003 letter to former Administrator Scully that "good public policy demands" elimination of these drugs from the SGR formula.

In the past, some CMS officials have argued that including drugs in the SGR was necessary to counter-balance incentives for over-utilization in the drug reimbursement system. While the AMA does not accept this premise, even if such incentives existed, they were surely eliminated by the reductions in payment for these drugs under the MMA. **Thus, we urge the Subcommittee to reiterate the request that CMS reconsider its current policy in light of the changes made in the MMA.**

Drug expenditures are continuing to grow at a very rapid pace. Between 1996 and 2002, per enrollee spending on drugs grew 244% compared to 38% for physicians services. This is partly due to a net increase in the number of drugs included in the SGR, from 365 in 1998 to 435 in 2002. Further, there is no end in sight, with over 650 drugs and biologics in development, as reported in a study conducted for MedPAC. As a result, including drugs in the SGR greatly increases the odds that Medicare spending on physicians' services will exceed the SGR target, triggering pay cuts that penalize physicians for providing important new drugs to their patients. Essentially, physicians are being asked to finance drug costs through cuts in their Medicare

payments even though they do not have the ability to control the factors that are causing increases in drug utilization.

These life-saving and quality-enhancing drugs have been developed with support from government policies such as expanded funding for the National Institutes of Health and streamlining of the drug approval process. In fact, it is this Administration's goal to accelerate the pace of drug development as evidenced in a Department of Health and Human Services (HHS) action plan developed last year and a recent Interagency Agreement between the National Cancer Institute and the Food and Drug Administration. In announcing the agreement last May, NCI and FDA officials described it as "an important step toward NCI's goal to eliminate suffering and death due to cancer by 2015" and said the collaboration "holds great promise for getting better cancer drugs to patients sooner."

The AMA shares and applauds these goals, but we must also note that Medicare's current policy of counting drugs in the SGR threatens to undermine these goals. More than half of all cancers diagnosed in the United States today are found in those over 65. Yet CMS's policy of including drugs in the SGR creates the distinct possibility that physicians will exceed the SGR target and be penalized with pay cuts if Medicare beneficiaries use of covered drugs continues to grow.

The medical profession does not condone inappropriate use of these drugs. Indeed, the AMA, in concert with specialties responsible for 96% of physician-administered drugs, has previously committed to work with CMS to develop and disseminate educational programs and guidance in any instances where the agency has evidence of misuse or abuse. We continue to believe that this option is better for everyone concerned than the current policy.

2. Ensure that government-induced increases in spending on physicians' services are accurately reflected in the SGR target

As discussed above, the government encourages greater use of physician services through legislative actions, as well as a host of other regulatory decisions. These initiatives clearly are good for patients and, in theory, their impact on physician spending is recognized in the SGR target. In practice, however, many are either ignored or undercounted in the target.

For example, the new prescription drug benefit enacted under the MMA will significantly expand expenditures for physician services because beneficiaries who previously could not afford to purchase drugs will visit physicians to get prescriptions. Moreover, these patients will have to be monitored by the physician for the impact of the drugs and may need to be seen for other conditions discovered at the time of the visit.

Further, the MMA contains a number of other provisions that will increase physician spending. The Medicare prescription drug discount card will become available for beneficiaries in the next several weeks (June 2004) and is now expected to achieve significant out-of-pocket cost savings on drug purchases. The RAND Health Insurance Experiment demonstrated that when patients' out-of-pocket costs are reduced, their utilization of services will increase. Thus, lower out-of-pocket drug costs are likely to lead seniors to fill more prescriptions and utilize more drugs. This would also mean

that more seniors will visit physicians' offices more often. Of course, these physicians' office visits would increase total physician spending, and additional spending likely would occur due to the fact that increased visits may trigger an array of other medically necessary services, including laboratory tests, to monitor the impact of the drug usage and treat conditions that might have otherwise gone undetected and untreated. **All of these costs should be included in the calculation of the SGR target.**

Further, the MMA establishes new Medicare benefits for (i) an initial preventive physical exam by a physician, which also includes adult immunizations, an electrocardiogram, pelvic exam, pap smear and mammogram, prostate and colorectal cancer screening, glaucoma, diabetes outpatient self-management training, and cardiovascular disease screening and other preventive services, (ii) cardiovascular screening blood tests, and (iii) diabetes screening tests. While these benefits will increase physician spending, additional spending will occur since these new services are certain to trigger ongoing care for a chronic condition or surgery for an acute condition.

CMS has not provided details of how estimates are calculated regarding the impact on physician spending due to changes in laws and regulations, and certain questions remain: How does CMS estimate the effects of new preventive benefits? Do these estimates include the costs of the new screening services only, or do they also include the costs of diagnostic tests and treatment plans ordered as a result of the screening? Are impacts estimated for multiple years as more beneficiaries take advantage of the new benefits, or do they only include the first year when the benefits may be significantly underutilized?

**CMS should provide answers to these important questions. In addition, CMS should ensure that all increases in spending resulting from the new MMA benefits, including both the spending due to use of the new benefit, as well as additional services triggered by implementation of the new benefit, are included in the SGR target. In other words, all direct and indirect increases in spending resulting from use of these or any other new or expanded benefit should be included in the SGR.**

**In summary, CMS should adequately reflect, in the SGR target, physician spending increases due to such initiatives as the following: (i) legislative mandates, e.g., new preventive screening benefits, Medicare drug discount cards and the new prescription drug benefit; (ii) CMS coverage expansions for new procedures and technology; (iii) government “good health” policies, such as efforts to reduce health care disparities, streamlining drug approvals, fighting diabetes, improving women’s health; and (iv) federal “quality initiatives,” which tend to increase the use of physician services to save money elsewhere in the system.**

3. Ensure that the SGR fully reflects the impact on physician spending due to national coverage decisions

When establishing the SGR spending target for physicians’ services, the law requires that impact on spending, due to changes in laws and regulations, be taken into account. The AMA believes that any changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal or informal rulemaking, such as a Program Memorandum or a national Medicare coverage policy decision, constitute a regulatory change as contemplated by the SGR law, and must also be taken into account for purposes of the spending target.

CMS’ authority to make any regulatory change is derived from law — whether it is a law specifically authorizing Medicare coverage of a new service or a law that provides the Secretary of HHS with general rulemaking authority. Thus, any new coverage initiative is a direct implementation, by regulation, of a law. **This is exactly what the SGR requires be taken into account —increases in spending due to “changes in law and regulations.”**

When the impact of regulatory changes for purposes of the SGR is not properly taken into account, physicians are forced to finance the cost of new benefits and other program changes. Not only is this precluded by the law, it is extremely inequitable and ultimately adversely impacts beneficiary access to important services.

HHS and CMS actively promote utilization of newly-covered Medicare services through press releases and other public announcements. For example, the Secretary of HHS released a 2002 report highlighting the importance of medical innovations and new technology, especially new drugs, in helping seniors live longer and healthier lives. Further, another HHS release regarding Medicare coverage of sacral nerve treatment for urinary incontinence stated, “[u]rinary incontinence affects approximately 13 million adults in the United States, with nearly half of nursing home residents having some degree of incontinence. It is twice as prevalent in women as it is in men, and costs more than \$15 billion per year, including both direct treatment of the disease and nursing home costs.” The Secretary made a similar announcement when Medicare expanded its coverage of lymphadema pumps, stating, “[i]t's important to make effective technologies available to Medicare beneficiaries when it helps them the most. This coverage decision simplifies Medicare policy to allow older Americans who need these pumps to get them more quickly and easily.”

While the AMA strongly supports Medicare beneficiary access to these important services, physicians and other practitioners should not have to finance the costs resulting from the attendant increased utilization.

**Accordingly, CMS should ensure that the impact on utilization and spending resulting from all national coverage decisions is taken into account for purposes of the SGR spending target.**

#### 4. Rebasing of the Medicare Economic Index

The Medicare Economic Index (MEI) is a measure of medical inflation, and is a factor used by CMS to update Medicare payments to physicians each year. The AMA appreciates and agrees with CMS' recent initiative to revise weights in the Medicare Economic Index (MEI) to reflect more current data and changes in the cost of practicing medicine. This initiative, however, does not address the broader problem that the MEI only measures changes in the prices for specific physician practice inputs, but there has been no effort to look at the inputs themselves and ensure that the market basket for which price changes are being measured is still the appropriate market basket.

Inputs to the MEI may be vastly different now than when the MEI was first developed in the early 1970s, and thus additional inputs may be needed to ensure that the current MEI adequately measures the costs of practicing medicine. For example, physicians must comply with an array of government-imposed regulatory requirements, including those relating to fraud and abuse, billing errors, quality monitoring and improvement, patient safety, and interpreter services for patients with limited English proficiency. To ensure compliance with these initiatives, physicians have had to hire additional office staff to handle these additional responsibilities. Indeed, The Project Hope survey for the Medicare Payment Advisory Commission (MedPAC) in early 2002 found that "half of all physicians reported that their practice had hired additional billing and administrative staff in the past year, and more than 80% indicated that the practice had increased the training given to staff regarding billing and insurance matters."

**CMS should include in the MEI any additional inputs that are needed to ensure that the MEI adequately measures the costs of practicing medicine.**

---

We appreciate the opportunity to provide our views, and look forward to working with the Subcommittee, Congress and the Administration to ensure an adequate and reliable Medicare physician payment system that keeps pace with the cost of practicing medicine.