

ATTACHMENT A

ADMINISTRATIVE ACTIONS TO HELP REFORM THE MEDICARE PHYSICIAN PAYMENT FORMULA

CMS could assist Congress in solving the SGR problem by taking administrative actions that would significantly reduce the cost of repealing the SGR. These actions include: (i) removing drugs retroactively from the SGR; (ii) accurately reflecting in calculations of the SGR government-induced increases in spending on physicians' services; (iii) reflecting in the SGR Medicare physician spending due to national coverage decisions (NCDs); and (iv) rebasing the Medicare Economic Index.

CMS Should Remove Drugs Retroactively from the SGR

The most significant step that CMS can take to reduce the cost of an SGR solution is to retroactively remove physician-administered drugs from calculations of the SGR. CMS clearly has the authority to make this change, as shown in legal opinions by independent legal counsel, Terry S. Coleman, a former Acting General Counsel of the U.S. Department of Health and Human Services. The AMA has previously provided CMS with these opinions. House and Senate leaders have also expressed this same view to CMS, and have requested that increases in Medicare spending due to physician-administered drugs be removed retroactively from calculations of the SGR.

CMS' authority to remove physician-administered drugs from the SGR, retroactive to 1996, is derived from statute. When CMS calculates actual Medicare spending on "physicians' services," it includes the costs of Medicare-covered prescription drugs administered in physicians' offices. CMS has excluded drugs from "physicians' services" for purposes of administering other Medicare physician payment provisions. Thus, removing drugs from the definition of "physicians' services" for purposes of calculating the SGR is a consistent reading of the Medicare statute. Drugs are not paid under the Medicare physician fee schedule, and it is illogical to include them in calculating the SGR.

Further, if CMS adopts a revised definition of "physicians' services" that excludes drugs, it can revise its SGR calculations going back to 1996 using its revised definition. These revisions would not affect payment updates from previous years, but would only affect payment updates in future years. This recalculation would be similar, for example, to the recalculation of graduate medical education costs in a base year for purposes of setting future payment amounts. That recalculation was approved by the Supreme Court. It is inequitable to include drug expenditures in calculations of the SGR because drugs continue to grow at a very rapid pace. While the bulk of all physician-administered drugs are used to treat cancer patients, other factors — such as a rise in the number of patients with compromised immune systems and the number of drug-resistant infections in the U.S. — also have contributed to the rapid growth of drug expenditures. This growth has far outpaced that of the physician services that the SGR was intended to include, and Medicare actuaries predict that drug spending growth will continue to significantly

outpace spending on physicians' services for years to come. This lopsided growth lowers the SGR target for real physicians' services and significantly increases the odds that Medicare spending on "physicians' services" will exceed the SGR target and thus trigger a payment cut to align payments with the target .

The development of these life-altering drugs has been encouraged by various federal policies including streamlining of the drug approval process and increased funding for the National Institutes of Health. In fact, the National Institutes of Health has made substantial progress toward its goal of wiping out cancer deaths by 2015 and much of that progress is tied to the development and more rapid diffusion of new drugs. **The AMA shares and applauds these goals. It is not equitable or realistic, however, to finance the cost of these drugs through cuts in payments to physicians, and thus these costs should be removed from calculations of the SGR.**

Government-Induced Increases in Spending on
Physicians' Services Should be Accurately Reflected in the SGR Target

The government encourages greater use of physician services through legislative actions and 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 have either been ignored or not accurately reflected when calculating the SGR target. Since the SGR law requires that calculations of Medicare spending on physicians' services cumulates from year to year, erroneous estimates roll over into future years and compound the deficits in spending on physicians' services.

CMS has never provided details of how its estimates of new or expanded physicians' services are calculated, and certain questions remain. Further, CMS reportedly does consider multiple year impacts and the cost of related services, but, as noted by MedPAC, the agency has not provided any itemized descriptions of how the agency determines estimated costs. **CMS should provide the physician community with these itemized descriptions and accurately reflect in the SGR increased spending due to all government initiatives for purposes of the 2007 physician fee schedule rule.**

Medicare Physician Spending Due to
National Coverage Decisions (NCDs) Should be Reflected in the SGR

When establishing the SGR spending target for physicians' services, CMS, by statute, is required to take into account the impact on spending due to changes in laws and regulations. Changes in national Medicare coverage policy that are adopted by CMS pursuant to a formal or informal rulemaking, such as Program Memorandums or national coverage decisions, constitute a regulatory change. The SGR provision of the law requires that increases in Medicare spending on physicians' services due to changes in "law and regulations" must be taken into account for purposes of the spending target.

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 through cuts in their payments. Not only is this precluded by the SGR law, it is extremely inequitable and ultimately adversely impacts beneficiary access to important services. We have previously provided cost estimates for a number of coverage decisions, including drug treatment for macular degeneration, PET scans, lung volume reduction surgery, and insertion of carotid artery stents, that significantly increase Medicare spending. CMS has justified its decision not to include the cost of its own coverage decisions in the SGR based partly on its view that estimating costs or savings associated with specific coverage decisions would be very difficult and any adjustments would likely be small in magnitude.

Yet, CMS already adjusts Medicare Advantage payments to account for NCDs, so the agency clearly is able to estimate their costs and believes that costs are significant enough such that plans should not be held responsible for these coverage expansions. **Accordingly, CMS should adjust the SGR to account for increased spending due to NCDs.**

Rebasing the Medicare Economic Index

In establishing the MEI each year, CMS adjusts it downward to account for physicians' productivity in providing patient care. The AMA commented to CMS that the productivity adjustment to the MEI (1.3% for 2007) is too high, particularly in light of issues related to the Part D benefit and other Medicare programs that impose time-consuming administrative burdens on physician practices. Further, there is no reason to believe that physicians have the ability to achieve higher productivity levels than other providers, none of which have automatic productivity adjustments to their inflation update.

In response to these concerns, CMS has indicated that the HHS Assistant Secretary for Planning and Evaluation is conducting a study of physician productivity that may lead to adjustments in future MEI updates. **The AMA looks forward to working with HHS to achieve a productivity adjustment that is a more realistic measure of actual increases in physician productivity.**

Further, CMS should address the broader problem that the MEI only measures changes in the specific types of practice costs that existed in 1973. Factors (or inputs) to the MEI are 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 that did not exist in 1973, including those relating to: compliance with rules governing referrals and interactions with other providers; detailed new and modified coverage policies; advanced beneficiary notices; certificates of medical necessity; rules governing Medicare dual eligible patients; limited English proficiency; Medicare audits; the Health Insurance

Portability and Accountability Act (HIPAA) and Clinical Laboratory Improvement Act (CLIA); billing errors; quality monitoring and improvement; and patient safety. CMS is also promoting the use of electronic medical records and other new health information technology systems that facilitate physician participation in quality improvement initiatives. To ensure compliance with these requirements, physicians often must take actions that increase their practice costs, including such actions as hiring: additional types of office staff; attorneys for legal and regulatory compliance; and accountants and billing companies to ensure proper billing of claims. These types of inputs are not currently taken into account for purposes of measuring the MEI, and therefore the MEI undervalues actual medical cost increases. **Accordingly, CMS should include in the MEI any additional inputs that are needed to ensure that the MEI adequately measures the costs of practicing medicine.**