

American Medical Association

Physicians dedicated to the health of America



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Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

**RE: PHYSICIAN FEE SCHEDULE FINAL RULE
PAY-FOR-PERFORMANCE QUALITY MEASURES**

December 5, 2005

Division of Legislative Counsel
202 789-7426

AMA RECOMMENDATIONS FOR PPAC

The AMA urges the Practicing Physicians Advisory Council to recommend that CMS —

PHYSICIAN FEE SCHEDULE FINAL RULE

- **Fully support enactment this year of legislation to implement positive Medicare physician payment updates, beginning in 2006, that reflect increases in physicians' practice costs;**
- **Help Congress avert physician pay cuts and ensure that a stable, reliable Medicare physician payment formula is in place for Medicare patients by using its authority to remove the costs of prescription drugs from calculations of the SGR;**
- **Revise Medicare policy to allow teaching anesthesiologists to be paid 100% of their fee when supervising two concurrent resident cases, similar to payment for teaching physicians involved in two overlapping surgeries; and**
- **Allow all physicians who treat the particular cancer involved to participate in the demonstration project for office-based oncology services – not just oncologists and hematologists, as is currently the case.**

PAY-FOR-PERFORMANCE QUALITY MEASURES

- **Defer implementation of value-based purchasing proposals until the SGR formula is repealed and a stable Medicare payment system is in place that reflects increases in physicians' practice costs; and**
- **As part of the continuing dialogue concerning quality improvement initiatives that may ultimately be linked to a stabilized Medicare physician payment system, adhere to the following objectives in any quality reporting initiatives:**
 1. **Performance measures must be implemented in a uniform manner across the private and public sectors;**
 2. **The reporting burden on physicians and other providers must be minimized; and**
 3. **Billing and payment processing systems must be ready to facilitate program participation so as to avoid costly payment processing problems and delays.**

The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning the physician fee schedule final rule and pay-for-performance quality initiatives.

PHYSICIAN FEE SCHEDULE FINAL RULE

Action Needed Before January 1, 2006, to Stop Looming Patient Access Crisis

The AMA is thankful to Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan for his positive statements before Congress that the Medicare physician payment system must be stabilized, including positive updates for physicians beginning in 2006. Administrator McClelland has also said that the Medicare Trustee's projection of 26% in cuts from 2006 through 2011 is not sustainable and raises real concerns about access to quality care for Medicare patients. We agree.

As of today, there are 26 calendar days until a 4.4% cut goes into effect on January 1, 2006. The verdict that the SGR is fundamentally flawed is unanimous. The Bush Administration, a bipartisan majority of Congress, the Medicare Payment Advisory Commission (MedPAC), the Medicare Trustees and the physician community have all concluded that the pending cuts triggered by the Medicare physician payment formula – the SGR – should be averted. It is time for the Administration and Congress to take action to stop the pending Medicare physician pay cuts and implement positive payment updates beginning in 2006 that reflect increases in medical practice costs. This would help preserve access to health care services for seniors and persons with disabilities.

CMS confirmed in the final physician payment rule that the 4.4% cut will become effective on January 1, 2006. This will be the first in a series of cuts over the next six years. These cuts will also have a ripple effect across other programs. Indeed, these cuts jeopardize access to medical care for millions of our active duty military family members and military retirees because their TRICARE insurance ties its payment rates to Medicare. The Military Officers Association of America (MOAA) recently sent a letter to Congress urging Congressional action to avert the 4.4% cut because it will “significantly damage” military beneficiaries’ access to health care services. MOAA stated that “[w]ith our nation at war, Congress should make a particular effort not to reduce health care access for those who bear and have borne such disproportionate sacrifices in protecting our country.”

Physicians simply cannot absorb the pending draconian payment cuts. A recent AMA survey shows that if the cuts begin January 1, 2006, Medicare patient access will be impaired:

- More than a third of physicians (38%) would decrease the number of new Medicare patients they accept;
- More than half of physicians (54%) plan to defer information technology purchases;
- A majority of physicians (53%) would be less likely to participate in a Medicare Advantage plan; and
- One-third (34%) of physicians whose practice serves rural patients would discontinue their rural outreach services.

A physician access crisis is looming for Medicare patients. More than 20 states each face cuts in Medicare funding of more than one billion dollars from 2006-2011. The MMA promised important new benefits for patients. An adequate payment structure for physicians' services must be in place in order for the government to deliver on its promise of these important benefits.

Last month, Medicare patients began enrolling for the new Medicare drug benefit that will become effective January 1, 2006. As this enrollment process continues, beneficiaries will need significant guidance in determining such factors as how the process works, which plan is best for them and coverage and benefit levels. A 2005 Kaiser survey found that 49% of seniors would turn to their physicians for help. Only 23% indicated they would turn to the Medicare program itself. **Physicians form the foundation of our nation's health care system, and Medicare patients' access to physicians' services is imperative for the success of the new prescription drug benefit. Continual cuts put such access at risk**

We urge PPAC to recommend that CMS fully support enactment this year of legislation to implement positive Medicare physician payment updates, beginning in 2006, that reflect increases in physicians' practice costs.

Overview of Steep Payment Cuts under Fundamentally Flawed SGR

The fatally flawed SGR led to a negative 5.4% update in 2002, and additional reductions in 2003 through 2005 were averted only after Congress intervened and replaced projected steep negative updates with positive updates of 1.6% in 2003 and 1.5% in each of 2004 and 2005. We greatly appreciate these short-term reprieves by the Administration and Congress. Even with these increases, however, Medicare physician payment updates during these years were only about half of the rate of inflation of medical practice costs. To make matters worse, if the 2006 cut is imposed, average physician payment rates will actually be less in 2006 than they were in 2001 (in real terms, not adjusted for inflation). Further, a 4.4% cut in January 2006, would mean that from 2002-06, payment rates will have fallen 16% behind the government's index of inflation in physicians' practice cost.

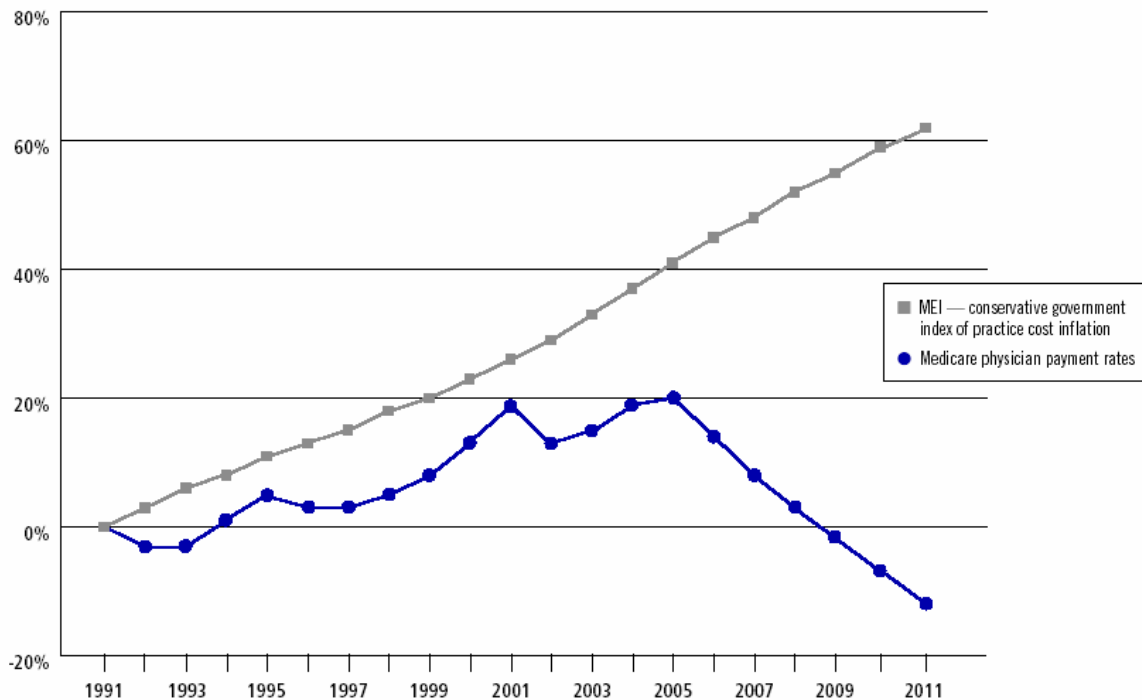
As shown by the graph below, these reductions come at a time when, even by Medicare's own conservative estimate, physician practice costs are expected to rise by an additional 15% from 2006-11 (with Medicare physician payments decreasing by 26%). The vast majority of physician practices are small businesses, and the steep losses that are yielded

by what is ironically called the “sustainable growth rate,” would be unsustainable for any business, especially small businesses such as physician office practices.

The **UN**-Sustainable Growth Rate

2006 through 2011:

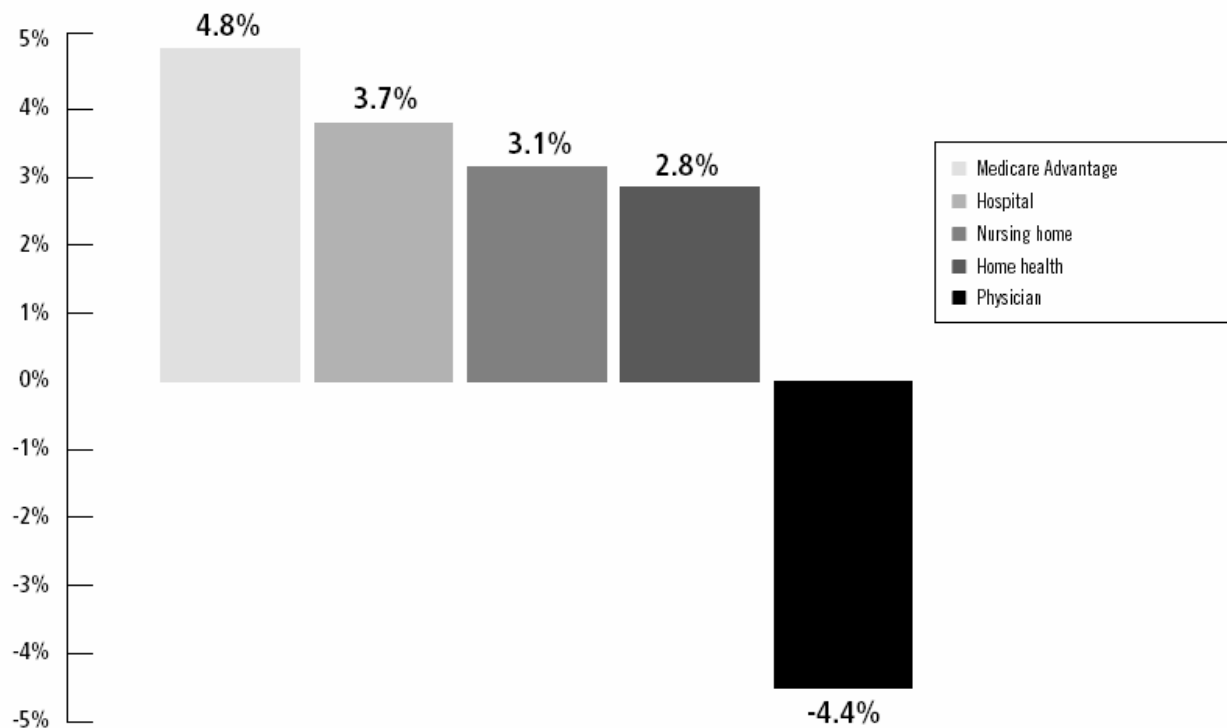
Physicians' costs up 15 percent; Medicare payments down 26 percent



Sources: Medicare Economic Index (MEI) and payment projections from the Centers for Medicare & Medicaid Services (CMS) and 2005 Medicare Trustees report. Chart by AMA Division of Economic and Statistical Research.

Only physicians and health professionals face updates of 7% below the annual increase in their practice costs. Hospitals and long-term care providers are slated for updates that fully keep pace with their market basket increases, and Medicare Advantage plans will see average updates of 4.8% in 2006, as illustrated in the bar graph below. Parity for physicians in the Medicare program must be re-established.

Projected 2006 Medicare payment updates



Sources: Projected updates based upon best available information from the Centers for Medicare & Medicaid Services as of November 2005.

Permanent SGR Solution Needed To Protect Patient Access And Quality Of Care

The Medicare physician payment problem continues to exist because, as discussed above, the SGR formula is inherently flawed and has led to deep cuts that were not projected when the formula was implemented in 1997. This means that legislators and the Administration must implement the SGR formula on the basis of an ongoing unrealistic budget baseline. Because of this unrealistic baseline, the temporary fixes achieved by Congress and the Administration in recent years have led to even deeper and longer sustained cuts because Congress recouped the cost of temporarily blocking the severe cuts in physician payments in the out-years. Without a long-term solution, repeated Congressional intervention and the “gaming” of federal budget accounting rules will be required to block payment cuts that jeopardize continued access to high quality care for the elderly and disabled. A one-year fix would provide a temporary respite and lead to another struggle to deal with this problem early next year.

Some government officials have cited the SGR formula as a method for restraining the growth of Medicare physicians’ services. Yet, there are many reasons for such growth, and there are no studies documenting systematic inappropriate care. Without valid studies, it is impossible to determine what volume growth is appropriate or inappropriate. Earlier this year, for example, Medicare officials announced that spending on Part A

services is decreasing. This suggests that, as technological innovations advance, services are shifting from Part A to Part B, leading to appropriate volume growth on the Part B side. If there is a problem with volume growth regarding a particular type of medical service, the AMA looks forward to working with the Administration and Congress to address it, rather than retaining a formula that penalizes both patients and physicians for growth that: (i) is appropriate; (ii) benefits patients; (iii) is less costly than when provided in other settings, and (iii) may actually result in total system savings.

Administrative Action Would Reduce the Cost of and Pave the Way for an SGR Solution

CMS Administrator McClellan recently stated that “the current system of paying physicians is simply not sustainable.” We agree and urge CMS to use its authority to take administrative action to help Congress avert physician pay cuts and ensure that a stable, reliable Medicare physician payment formula is in place for Medicare patients.

Despite their view to the contrary, the AMA firmly believes that CMS has the authority to remove the costs of drugs, back to the base period, from the calculation of the SGR. Because this would significantly reduce the cost of legislation and allow Congress to address the looming Medicare pay cuts more easily, CMS should take this step as soon as possible. Indeed, CMS told Congress earlier this year that removing drugs prospectively is worth about \$36 billion in lowered costs, while removing them from the base-year forward reduces \$111 billion from the cost of an ultimate fix.

It is not equitable or realistic to finance the cost of innovative drug therapies through cuts in payments to physicians and other health care professionals. CMS must act now to remove these costs from calculations of the SGR. The longer CMS waits to make this policy change, the more costly it will be for the government to do so.

Teaching Anesthesiologists

In the proposed physician payment rule issued in August 2005, CMS requested comments on a revised teaching physician policy for anesthesiologists that would be more flexible for teaching anesthesia programs. In the recently-issued final rule, CMS announced that it will continue to review the information and relevant data presented in public comments and consult with the stakeholders before the agency moves forward with any proposal.

The AMA recommends that PPAC urge CMS to revise Medicare policy to allow teaching anesthesiologists to be paid 100% of their fee when supervising two concurrent resident cases, similar to payment for teaching physicians involved in two overlapping surgeries. Medicare policies are among the factors that discourage residents from going into anesthesiology. Yet, an increasingly elderly Medicare population requires a stable and growing pool of physicians trained in anesthesiology. Allowing teaching anesthesiologists to have parity with teaching surgeons and be paid

their full fee when overseeing two concurrent resident anesthesia cases will ensure continued quality medical care and patient safety for our Medicare patients. However, this would constitute a change in law and regulation, and thus should be reflected in the SGR.

Chemotherapy Demonstration Project

CMS announced in the final rule that it is retaining for an additional year the current demonstration project for office-based oncology services under which physicians report assessments of patient symptoms at the time of chemotherapy encounters. For 2006, CMS will revise the demonstration to capture better data on quality and outcomes. Specifically, CMS will revise the G-codes for reporting data to gather more specific information relevant to the quality of care for cancer patients, their treatments and the spectrum of care they receive, and whether the care follows clinical guidelines.

The AMA supports continuation of this demonstration, and we urge PPAC to recommend that CMS allow all physicians who treat the particular cancer involved to participate in the demonstration project – not just oncologists and hematologists, as is currently the case.

PAY-FOR-PERFORMANCE – QUALITY MEASURES

The AMA deeply appreciates the commitment by Administrator McClellan to continuing an ongoing dialogue with the AMA and the physician community concerning pay-for-performance initiatives. We wish to continue working with CMS and Congress to provide the highest quality of care for our patients. In fact, the AMA and the leadership of the national medical specialty societies have invested extensive resources in quality improvement initiatives, well before the concept of “value-based purchasing” evolved. We have worked diligently to develop quality measures that are the basis for pay-for-performance (or value-based purchasing) legislation being considered by Congress, as well as ongoing CMS pay-for-performance demonstration projects and programs, including the recently announced “Physician Voluntary Reporting Program (PVRP).

As we continue in these efforts, it is important to keep in mind any barriers to optimizing quality of care and to act to eliminate these barriers. For example, continuation of the SGR eliminates opportunities for investment and innovation that will benefit patient care and generate system-wide savings. An adequate Medicare physician payment structure is fundamental for implementation of Medicare quality of care initiatives. Value-based purchasing and the SGR are not compatible. Value-based purchasing may save dollars for the program as a whole. Many performance measures, however, ask physicians to deliver more care. For example, the Leapfrog Group recently announced the results of a long-term national study, including seven experimental projects designed to test a variety of pay-for-performance models. The findings show that pay-for-performance programs, while complicated to implement, can raise the quality of patient care. In doing so, however, the study showed significantly increased physician visits for many services (including well-check ups and preventive screenings), as well as physician investment in

information technology and electronic medical records. If the SGR is linked to value-based purchasing, more physician services will result in more physician payment cuts.

Further, value-based purchasing depends on greater physician adoption of information technology, as indicated by the Leapfrog study referenced above. Unless physicians receive positive payment updates, however, these investments will not be possible. As discussed above, an AMA survey indicates that steep pay cuts beginning in 2006 would cause more than half of physicians to defer IT purchases.

In accordance with the foregoing, implementation of value-based purchasing proposals should be deferred until the SGR formula is repealed and a stable Medicare payment system is in place that reflects increases in physicians' practice costs, and we urge PPAC to make this recommendation to CMS.

This does not mean that the AMA will not continue our dialogue with CMS and the Congress concerning quality initiatives that may ultimately be linked to a stabilized Medicare physician payment system. In doing so, we emphasize that any such quality reporting initiatives must be structured in accord with the following objectives:

- Performance measures must be implemented in a uniform manner across the private and public sectors;
- The reporting burden on physicians and other providers must be minimized; and
- Billing and payment processing systems must be ready to facilitate program participation so as to avoid costly payment processing problems and delays.

The AMA looks forward to continuing this meaningful dialogue between Administrator McClellan and physician leaders. Working together, the Administration, Congress and the physician community can strengthen the Medicare program and correct problems that undermine Medicare patient access to their physician of choice, along with high quality medical services.

We appreciate the opportunity to provide our views on the foregoing and look forward to continuing to work with PPAC and CMS in resolving these important matters.