



October 10, 2006

**Association of
American Medical Colleges**
2450 N Street, N.W., Washington, D.C. 20037-1127
T 202 828 0460 F 202 862 6161
www.aamc.org

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1321-P
P.O. Box 8014
Baltimore, MD 21244-8014

Darrell G. Kirch, M.D.
President

Dear Administrator McClellan:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to provide comments regarding the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the *Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Other Changes to Payment Under Part B*, 71 Fed. Reg. 48,982 (August 22, 2006). The AAMC represents 125 U. S. allopathic medical schools employing approximately 90,000 clinical faculty, approximately 400 major teaching hospitals and health systems, 96 academic societies and residents and students.

CY 2007 PHYSICIAN PAYMENT RATES

CMS estimates in the proposed rule that CY 2007 Medicare payment rates for physicians and other health care practitioners will be cut by 5.1%. The AAMC is grateful for the interventions implemented by Congress and the Administration for each of the last four years that have averted steep cuts to the Medicare physician payment rates. Along with other physician organizations, AAMC is hopeful that CMS and Congress can intervene once again and address the CY 2007 cut resulting from the flawed Sustainable Growth Rate (SGR) formula and ensure that physician payment updates for 2007 and subsequent years accurately reflect increases in medical practice costs.

As a result of the SGR, physicians can expect drastic Medicare payment cuts totaling almost 40% over the next nine years, a time during which physician practice costs are expected to increase by approximately 20%. CMS noted the inadequacy of Medicare physician payments in a proposed rule released earlier this year, the "Five-Year Review of Relative Value Units under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology." Data in that proposed rule indicate that current Medicare payments cover only about two-thirds of the labor, supply and equipment costs of each service.

According to surveys by the American Medical Association (AMA) and Medical Group Management Association (MGMA), 45% of physicians and 40% of group practices will limit the

number of new Medicare patients they accept when the first cut of at least 5% goes into effect January 1, 2007.

Some group practices, and certainly academic faculty practice plans, are comprised of a variety of specialists and subspecialists. Many of these clinical disciplines provide services that are critical to geriatric patients. This reality, combined with the missions of academic medical centers, has resulted in an ongoing willingness of academic medical centers to accept and treat patients that need specialized care not otherwise available in the community and/or patients that are not accepted by community providers, such as the indigent, underinsured/uninsured and dually eligible Medicare-Medicaid beneficiaries. If community providers decrease the number of new Medicare patients accepted, the patients are likely to turn to, or be referred to, group practices and academic medical centers that continue to accept Medicare patients. This potential decline in the number of providers available to Medicare patients is likely to result in access problems for patients, as providers continuing to treat Medicare patients reach capacity.

OTHER POLICIES IMPACTING PHYSICIAN PAYMENTS

In addition to the 2007 physician payment cuts resulting from the annual calculation of the SGR system, Medicare physician payment policy changes recently announced by CMS also will take effect on January 1, 2007. These changes relate to:

- changes in both the physician work and practice expense relative values under CMS' recently-proposed five-year review rule
- payment cuts in imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005 (DRA).
- expiration of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA) provision that set a floor on geographic practice cost adjusters for the work component of Medicare's physician fee schedule

These policy changes will have a significant impact on a large number of physicians who could experience combined pay cuts of 10% or more for many physicians' services. Analyses conducted recently by the AMA indicate that if the SGR cut is allowed to take effect in 2007, 13% of physicians will face cuts exceeding 10%, and 32% will see cuts of 6% to 10%. Thus, almost half of physicians will face cuts in addition to the 5.1% across-the-board cut that is scheduled for January 1, 2007.

Recent AAMC analyses of CMS-1512-PN, Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology indicate that academic clinical faculty will face a greater impact from the proposed changes than will the general physician population. AAMC has also found this trend in prior analyses of the impact of the annual fee schedule changes.

CMS estimates the impact of CMS-1512-PN Five Year Review to vary across specialties, ranging from an 8% decrease (nurse anesthetist) to an 8% increase (infectious disease). Other specialties that are expected to receive at least a 5% increase due to the WRVU proposal are emergency medicine (7%), endocrinology (6%), family practice (5%), and pulmonary disease (5%). Similarly, specialties whose payments are estimated to decrease by at least 5% include anesthesiology, nuclear medicine, pathology, and physical/occupational therapy.

The AAMC analysis of Medicare services provided by 66 faculty practice plans associated with U.S. medical schools indicates an even wider impact for specialties at academic health centers. Results of the analysis indicate the range to be from negative 15.7% (nuclear medicine) to positive 12.7% (family medicine without obstetrics).

ADMINISTRATIVE ACTIONS TO IMPROVE PAYMENTS

AAMC urges CMS to administratively address issues related to payments to physicians and other providers that will assist with diminishing the negative impact on physicians. Specific areas include:

- CMS Should Remove Drugs Retroactively from the SGR

Drug expenditures continue to grow rapidly. The majority of all physician-administered drugs are used to treat cancer patients, however, 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 outpaced the growth of 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 unbalanced growth lowers the SGR target for actual physicians' services and significantly increases the likelihood that Medicare spending on "physicians' services" will exceed the SGR target.

- Program Related Increases in Spending on Physicians' Services should be Accurately Reflected in the SGR Target

Greater use of physician services results from legislative actions and various regulatory decisions. These initiatives benefit patients and, in theory, their impact on physician spending is recognized in the SGR target. In practice, however, many initiatives have either been ignored or undercounted in the calculation of SGR targets. Since the SGR is a cumulative system, omitted or erroneous estimates compound each year and create further deficits in Medicare spending on physicians' services.

CMS has not provided details of how its estimates of new or expanded physicians' services are calculated, and certain questions remain. CMS reportedly does consider multiple year impacts and the cost of related services; however, the agency has not provided itemized descriptions of how the agency determines estimated costs. AAMC requests that CMS provide 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.

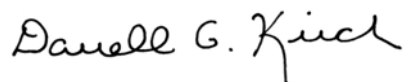
- Rebasing the Medicare Economic Index (MEI)

In establishing the MEI each year, CMS adjusts the MEI downward to account for physician productivity. The productivity adjustment to the MEI for 2007 is 1.3%. The AMA believes that a 1.3% productivity adjustment for physicians' services is too high. It is nearly impossible for physicians to increase their productivity in treating patients in light of various new Medicare initiatives, such as the new welcome to Medicare benefits and comprehensive Medicare Part D drug benefit, each of which impose numerous time and paperwork burdens on physicians. This would tend to slow productivity, not increase it. Also, CMS assumes and calculates increased productivity levels for physicians while other providers do not have assumed or automatic productivity adjustments.

Additionally, AAMC encourages CMS to examine and address the broader problem that the MEI only measures changes in specific types of practice costs that existed in 1973. 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 the Medicare Part D drug benefit, fraud and abuse, billing errors, quality monitoring and improvement, and patient safety. Further, some physicians, including many academic medical centers, are implementing electronic systems to improve patient safety and care and population management strategies. These systems are costly unto themselves and require additional resources for technological implementation and human resource training, as well as ongoing maintenance.

AAMC appreciates the opportunity to provide input on these matters and looks forward to opportunities to work with CMS on these issues.

Sincerely,



Darrell G. Kirch, M.D.

cc: Robert Dickler, Senior Vice President
Denise Doderer, Associate Vice President