



August 31, 2007

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Herb Kuhn  
Acting Deputy Administrator  
Centers for Medicare and Medicaid Services  
200 Independence Avenue  
Washington, DC 20201

Dear Mr. Kuhn:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to comment on the proposed rule “Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for Calendar Year 2008”. The Association of American Medical Colleges represents all 125 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems and 94 academic and scientific societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

Of the 109,000 faculty members, nearly 97,000 are full-time clinical faculty associated with the nation's medical schools and their group practices. These faculty members provide a variety of services, including primary, subspecialty, and tertiary level care, to Medicare and other patients. On a national basis Medicare is nearly one quarter (24.9%) of the total practice plan payer mix and Medicaid represents 16.6% of the total payer mix. Thus, many practice plans have a combined payer mix of greater than 40% for these two public payers and also serve many of the dually eligible Medicare-Medicaid beneficiaries. On behalf of its members, AAMC is keenly interested in the impact of the Medicare program on practicing physicians.

### **Updates to the Physician Fee Schedule**

Several items discussed in the proposed rule will have negative financial consequences for physicians and practice plans. These include the mandated 9.9% decrease to the conversion factor (CF), an increase to the budget neutrality factor (BNF) for work relative value units (RVUs); and changes to the Geographic Practice Cost Indices (GPCIs).

#### Impact (p. 38211)

AAMC and the physician community have long commented on the negative impacts of the Sustainable Growth Rate (SGR) and are concerned that, if not resolved, patient access to care

will deteriorate. The nearly 10% decrease to the conversion factor comes at a time when inflation costs, as measured by the Medicare Economic Index (MEI), are expected to grow by 1.9%. Many academic medical centers (AMCs) and their faculty serve as safety net providers in their communities and are committed to providing the best possible care to Medicare beneficiaries. However, the current proposed payment reduction has the potential to weaken their financial stability.

In 2007, CMS completed the statutorily required comprehensive five-year work RVU review. AAMC applauds CMS for appropriately recognizing and valuing the work effort for services such as anesthesia. However, the AAMC is concerned that under the current Sustainable Growth Rate (SGR) Part B payment methodology, increases in payments for specified services automatically decreases payments for other services. Because CMS is required to maintain budget neutrality, the total increase in work RVUs due to the five-year review led to an overall adjustment in payment. In the 2007 rule, CMS instituted a 10.1% budget neutrality factor to deflate the work RVUs for payment purposes. For 2008, CMS proposes to increase the BNF to 11.8%, an increase of 1.7% from the 2007 rate. The change in the BNF makes it increasingly more difficult for specialties, or practice plans as a whole, to accurately project and budget for future payments.

#### Geographic Practice Cost Indices (GPCIs) (p. 38137)

Changes to the geographic practice cost index will add to the financial stress of some practice plans. The Medicare Improvements and Extension Act of 2006, as part of the Tax Relief and Health Care Act of 2006, extended a floor for work GPCIs to the end of 2007. The floor, set at 1.0, is due to expire in 2008. An analysis of 77 practice plans identified that removal of the work GPCI floor will negatively impact over half of these practice plans (41 practice plans or 53%). One midwestern practice plan estimates that removing the 1.0 floor for work GPCIs will further decrease their Medicare revenues by an additional 0.8%. When the GPCI change is considered with the other proposed changes, this practice plan projects a revenue decrease of \$2.8 million compared to payments received for providing the same services in 2007.

The AAMC conducted a preliminary analysis of the impact of the proposed fee schedule on fifty faculty practice plans. Medicare billing data for the most recent twelve months for all departments, excluding anesthesiology were analyzed (complete Anesthesiology data were not available). Forty-seven of the fifty practice plans (94%) are projected to experience decreases greater than the nearly 10% national decrease projected by CMS, and twenty practice plans (40%) are expected to experience decreases greater than 12%.

AAMC appreciates that CMS does not have the authority to change statute; however, we strongly encourage CMS to reconsider all options within its administrative authority to mitigate the effects of the SGR changes on the physicians' practices. We also request that CMS work collaboratively with Congress so that issues such as the SGR and GPCI floor may be addressed legislatively.

## **Physician Self-Referral Provisions**

### Obstetrical malpractice insurance subsidies (p. 38182)

In the discussion in the preamble, it is stated that “we are concerned that our exception for obstetrical malpractice insurance subsidies is unnecessarily restrictive.” The AAMC agrees, and requests that CMS considers proposing a further change in this exception to allow subsidies for malpractice insurance for other specialties and in broader geographic areas. Given growing concern that the number of physicians will not be adequate in the coming years, it may be particularly important for hospitals to provide assistance with malpractice insurance in a way that will not be subject to abuse. To attain this goal, CMS could expand the exception and impose a new requirement—similar to that involving the donation of electronic health records to physicians—that physicians must pay a certain percentage of the premium to qualify for this exception.

### Set in advance (p. 38184)

The AAMC asks CMS to clarify that the proposed revision to the “set in advance” requirement would not affect compensation arrangements that include patient satisfaction survey results, pay for performance (P4P) measures, or that take into account faculty contributions made through teaching and research. AAMC considers that these compensation criteria are based on personally performed services. In addition, the latter two criteria support missions that are recognized in the academic medical center exception. We understand that there can be no link between the compensation paid under these arrangements and the volume or value of referrals. In recent years AAMC has been encouraged by CMS’s apparent recognition that in the realm of hospital-physician relationships it is important that there be sufficient flexibility to allow parties to appropriately align incentives without fear of violating fraud and abuse laws. We believe that this further clarification will be helpful in maintaining flexibility without incurring the risk of program abuse.

Thank you in advance for consideration of our comments. Please contact Ms. Denise Dodero at 202-828-0568 or [ddodero@aamc.org](mailto:ddodero@aamc.org).

Sincerely,

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