

Testimony to the Practicing Physicians Advisory Council
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I am Dr. Albert Bothe Jr., Executive Director, University of Chicago Faculty Practice Plan, Compliance Officer and Professor of Clinical Surgery, University of Chicago Medical School, and Medical Director, University of Chicago Health Plan. I am also Chair-Elect of the Association of American Medical Colleges' (AAMC) Group on Faculty Practice (GFP) Steering Committee and Chair of the GFP Subcommittee on Legislative and Regulatory Issues. I am pleased to be here today to provide testimony on Medicare's Payment Policies Under the Physician Fee Schedule.

The AAMC represents the country's 125 accredited medical schools, approximately 400 major teaching hospitals and health systems, 90 academic/professional societies, and approximately 88,000 clinical faculty members (academic physicians) who are members of faculty practice plans.

The Role of Academic Physicians

Academic physicians play a unique, multifaceted role within the physician community, as well as within the larger healthcare system. As experts in their particular fields of medicine, academic physicians provide patients and referring physicians with cutting-edge clinical care. Academic physicians also educate and train the medical students, residents, and other health professionals who will become the next generation of caregivers. In addition, many academic physicians conduct clinical research that generates more effective and efficient healthcare for all Americans—including aging Americans.

Because of their clinical expertise, access to innovative technologies within teaching hospitals, and participation in clinical research, academic physicians frequently provide inpatient and outpatient care for patients—including Medicare beneficiaries—with complex, multiple, or acute health problems that are not readily managed elsewhere in the community.

Working together with their teaching hospital partners, academic physicians are vital to the delivery of essential medical services. Over three-quarters of AAMC's teaching hospital members provide geriatric care (e.g., treatment for Parkinson's or Alzheimer's disease) and operate certified trauma centers in conjunction with academic physician partners. In contrast, only 35% of nonteaching hospitals provide geriatric services and 22% of nonteaching hospitals operate trauma centers.

In addition, faculty practices partner with AAMC's teaching hospital members to provide nearly 45% of the nation's hospital-based charity care. By comprising a significant segment of America's healthcare safety net, academic physicians and their teaching hospital partners assure healthcare access for the poor and underserved—including Medicare beneficiaries who are dually eligible for Medicaid or who are unable to pay for their care. In 1999, an average of \$12

million in charity care was provided by each faculty practice plan. According to the Agency for Health Research and Quality (AHRQ) and AAMC analyses (using survey data collected by the Center for Studying Health System Change's Community Tracking Study Physician Survey), academic physicians spend more time providing charity care than physicians in all other settings. This is true both when time is measured in hours per month and as a percentage of total patient care time and medically related time.

The Impact of Stable and Adequate Physician Payments on Medicare Beneficiaries' Access to Care

Stable and adequate Medicare physician payments are critical to ensure that seniors have continued access to the professional services provided by academic physicians. Nearly one-sixth of all physicians providing Medicare services are academic physicians. Medicare reimbursements to academic physicians represent up to one-third of faculty practice revenues. In light of the fact that faculty practice revenues, on average, represent about 35 % of a medical school's total revenue, unstable Medicare payments could jeopardize beneficiary access to faculty professional services, as well as academic medicine's core missions of medical education, research, clinical services, and community services (including charity care).

A sample analysis of the impact of the 2002 Medicare fee schedule on faculty practice plans was provided to PPAC in March 2002. The analysis demonstrated that a vast majority of faculty practices stood to lose more than -5.4 percent of their Medicare revenue (the CY 2002 reduction in the Conversion Factor). In fact, Medicare revenue for some plans was projected to decline by as much as 7.5 percent. Analysis of the impact by specialty demonstrated that some specialties, because of the CY 2002 changes in Relative Value Units (RVUs)¹, were projected to experience Medicare revenue declines of 10% or greater.

Although AAMC is still analyzing the specific impact of the CY 2003 fee schedule on faculty practice plans, a two year analysis of the impact of the physician fee schedule has been conducted using AAMC CY 2002 impact data and data published by the Centers for Medicare and Medicaid Services (CMS) (Federal Register, Volume 67, No. 251, December 31, 2002, Table 24, p. 80036, Estimated Impact of All Changes on Total Medicare Allowed Charges by Specialty.) This analysis shows that many specialties which make up core programs of academic medical centers and which are frequently used by Medicare beneficiaries, will experience a two year loss greater than the average two year loss of 9.6% caused by reductions in the Conversion Factor (see Table 1 below).

¹ Currently, payment for services determined under the Medicare Physician Fee Schedule is the result of several factors. One of these is a nationally uniform "relative value" for each service that includes weights for physician work, practice expenses, and professional liability insurance components.

Two-Year Impact of Medicare Physician Fee Schedule Upon Select Specialties

Specialty	2002 Medicare Impact	2003 Medicare Impact	Cumulative Two Year Impact ²
	Average % Change on Academic Specialties*)	CMS Estimated Impact on Select Specialties	
Cardiac Surgery	-10.1%	-6.0%	-15.5%
Cardiology	-11.5%	-4.0%	-15.0%
Neurosurgery	-8.4%	-6.0%	-13.9%
Emergency Medicine	-7.7%	-5.0%	-12.3%
Gastroenterology	-7.3%	-5.0%	-11.9%
Interventional Radiology	-7.1%	-5.0%	-11.7%
Orthopedic Surgery	-4.9%	-7.0%	-11.6%
Ophthalmology	-6.9%	-5.0%	-11.6%
Psychiatry	-6.2%	-5.0%	-10.9%
Rheumatology	-7.0%	-4.0%	-10.7%
Infectious Disease	-5.8%	-5.0%	-10.5%
Pathology	-5.8%	-5.0%	-10.5%
Nephrology	-2.7%	-8.0%	-10.5%
Urology	-7.3%	-3.0%	-10.1%
Pulmonary Disease	-6.3%	-4.0%	-10.0%
Radiology	-6.2%	-4.0%	-10.0%

*Source: UHC/AAMC Faculty Practice Solutions Center

The double-digit declines in Medicare reimbursement are projected to occur within faculty practice plans for many specialties key to Medicare patients and key to the financial viability of academic medical centers. However, the Medicare reimbursement declines alone are not the only factors that impact patient access to care and the long-term viability of physicians' practices. First, many commercial payers index their rates to Medicare and thus many physicians, including academic physicians, will experience declines in revenue beyond the Medicare declines. Further, expenses associated with practicing medicine continue to increase each year. The growing disparity between expenses and reimbursement caused by the negative payment updates only serves to increase the financial challenges of maintaining medical practices in today's climate. The escalating costs and impact of the malpractice problem is an additional example of a source of increased expenses. This growing disparity will make it increasingly difficult for medical schools and teaching hospitals to maintain their patient care, education, research, and community service missions.

² Cumulative two year impact calculated as a weighted impact taking first year reductions into account
 Example: First year reduction for Cardiology was 11.5%; the second year reduction is calculated as 4% of 88.5%

Trends Related to Patient Access to Care

According to recently published data from the American Medical Association, (AMA) comparisons of physicians' responses to a 2002 and 2003 survey indicate trends that could result in decreasing access to physicians for Medicare patients. Specifically, in 2002, 92% of responding physicians indicated that they were participating in Medicare and in 2003 only 79% of physicians reported that they were likely to participate. Of this 79%, 52% indicated that they are obligated by a contract or organizational policy to sign a Medicare participation agreement. This would include physicians employed by large health systems, multispecialty group practices and faculty practice plans.

In 2002, 38% of AMA survey respondents indicated that they stopped providing certain services. That figure rose to 45% in 2003. In 2002, 38% of physicians indicated that they had begun referring complex cases and 40% indicated that they would be likely to do so in 2003. For each of these changes a majority of physicians indicated that their decision was influenced by Medicare physician payment cuts.

The above findings indicate the potential for increased access problems for beneficiaries. They also indicate a potential for increased demand for services in academic medical centers and other large systems that are maintaining their Medicare participation status and are otherwise likely recipients of new Medicare patients, or patients needing specific or complex services that are increasingly being referred by other physicians. This will only serve to exacerbate the already existing financial pressures. The ability of such institutions to sustain their financial viability under circumstances of increasing cost and reimbursement gaps and increased patient volumes is limited.

Impact of the Medical Liability Crisis

Preliminary data from a survey conducted by the AAMC regarding the impact of medical liability issues on faculty practices also indicate the potential for increased referrals to academic medical centers. Specifically, some faculty practices plans reported an increase in the volume of referrals of high risk, high resource cases, such as neurosurgical patients, as a result of the medical liability crisis. Others reported that some community physicians are no longer providing specific services at all and cases are therefore treated at the academic medical center.

The medical liability crisis is impacting academic medical centers financially, as well. The escalating costs of coverage are placing financial strains on institutions and in some cases causing a redirection of resources from the core missions of academic medical centers, including clinical service delivery. Even those institutions that are self-insured are not immune. Testimony provided by Loren H. Roth, M.D., to the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the Senate Committee on Appropriations (January 30, 2003), indicated that between fiscal years 1999 and 2003, the cost of malpractice premiums paid by the University of Pittsburgh academic clinical physicians escalated from more than 5 million dollars to more than 23 million dollars per year, an increase of more than 200% per faculty member. The increase for FY 2003 alone is 23%. At the University of Pittsburgh Medical Center, the cost for "excess coverage" for physicians (beyond state requirements and

desirable because of large verdicts in the eastern part of the state) has increased 500% from 2000 to 2002.

The Hospital Association of Pennsylvania (HAP) found in a recent survey of 150 Pennsylvania hospitals and health systems that “nearly two-thirds of hospitals report that some physicians are retiring early, curtailing practices or relocating as a result of increasing liability costs.” (HAP Healthcare Outlook, page 1, November 2002).

In summary, the impact of the current malpractice situation on both physicians and patients was stated in a July 2002 U.S. Department of Health and Human Services (DHHS) report as follows, “there are a number of obstacles that limit access to affordable health care in this country, including lack of affordable insurance and an outdated Medicare program. We now face another—the litigation crisis that has made insurance premiums unaffordable or even unavailable to many doctors, through no fault of their own. This is making it more difficult for many Americans to find care, and threatening access for many more.” (*Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System*, U.S. Department of Health and Human Services July 24, 2002 page 2)

Possible Modifications to the Medicare Physician Fee Schedule

AAMC and others have commented previously on modifications that could be made to the approach for handling certain aspects of the Medicare physician fee schedule. Such modifications would be a step toward providing more adequate and stable reimbursement to providers who are paid under the Medicare physician fee schedule.

Professional Liability Insurance (PLI)

The 11.3% change to the CY 2003 Professional Liability Insurance (PLI) component of the MEI is notably above the CY 2002 figure of 3%. However, given the data cited above regarding escalating costs, and that the Medicare Economic (MEI)/Sustainable Growth Rate (SGR) systems do not yield an actual 11% increase in payments, the net payments to physicians are likely to be inadequate to help cover the dramatic increase in expenses. We urge that CMS continue to explore methods for accurately identifying increases in medical liability costs on a timely basis and reflect those costs in the MEI.

Inclusion of Drugs in the Calculation of the Sustainable Growth Rate

CMS’ treatment of expenditures related to drugs needs to be reevaluated. Drugs are not included under the physician fee schedule. However, the actual expenditures for drugs are included in target spending calculations. The explanation for the inclusion of drug expenditures in the calculation of actual expenditures has been that it is necessary for ensuring that physicians, who control drug prescribing, do not unnecessarily or inappropriately prescribe drugs. We do not believe that physicians are unnecessarily or inappropriately prescribing drugs and no data have been produced to date to indicate such patterns. The physician community would welcome timely data on specific trends in this realm that indicate prescribing patterns that might be

addressed by professional education or other efforts. The current system does not provide feedback to individual physicians or groups of physicians (i.e., by specialty). Further, physicians do not have control over increases in drug expenditures that result from market factors that influence drug expenditures.

Inclusion of Other Services Impacting Physicians' Costs of Delivering Care

We would also recommend that CMS give consideration to how unfunded mandates are reflected in payments to physicians, such as HIPAA, compliance requirements and quality improvement initiatives. Further, CMS should review its approach to calculating changes in spending due to Medicare law and regulation as required by law related to the SGR. For example, the methodology used to evaluate the impact of national coverage decisions on utilization and spending should be reviewed to ensure that the full impact is measured.

Beneficiary Access to Care

Finally, and of great importance, we recommend that CMS continue to evaluate its data and sources for assessing beneficiary access to care. Further consideration of appropriate methods for assessing access is warranted and should include refined analyses that consider changes in participating and nonparticipating status, perhaps by geographic location and type of provider. Also, access related data, such as that provided to the Medicare Payment Advisory Commission (MedPAC), should be publicly available in a timely fashion.

The AAMC appreciates the opportunity to comment on these issues of importance related to the Medicare Physician Fee Schedule.