

# **S T A T E M E N T**

Of The



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On

**Medicare's Flawed Sustainable Growth Rate (SGR)  
Methodology and the Physician Fee Schedule:  
Its Impact on Teaching Physicians, Faculty Practice Plans  
and Medical Schools**

Submitted to the

**House Energy and Commerce Committee  
Subcommittee on Health**

**United States House of Representatives**

**May 5, 2004**

The Association of American Medical Colleges (AAMC) is pleased to submit for the record testimony to the House Energy and Commerce Subcommittee on Health on the need to replace the Sustainable Growth Rate (SGR) methodology used to calculate the update for Medicare payments under the Physician Fee Schedule ("physician payment update"). The AAMC appreciates the Subcommittee's interest in this issue of great importance to both Medicare beneficiaries and the physicians who provide their medical care. The AAMC supports replacement of the SGR with a methodology that assures adequate payments and stable updates for physicians who participate in Medicare. Appropriate and stable physician payments will help ensure that Medicare beneficiaries have access to the complex and specialized care provided by academic physicians.

The AAMC represents the country's 126 accredited medical schools and nearly 400 major teaching hospitals and health systems, 94 academic/professional societies representing approximately 105,000 faculty members, and the nation's medical students and residents.

### **The Role of Academic Physician in Serving Patients and Medicare Beneficiaries**

Academic physicians serve 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 expertise. 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, efficient, and compassionate healthcare for all Americans, including aging Americans. For example, a number of breakthroughs in research conducted by academic physicians, such as retinal transplants, inner ear implants, the development of a surgical procedure to prevent urinary incontinence in men with cancerous prostates, and others, now benefit many seniors, providing improved diagnostic and therapeutic services.

With their clinical expertise, participation in clinical research, and knowledge of innovative technologies, academic physicians frequently partner with teaching hospitals to provide inpatient and outpatient care for patients with complex, multiple, or acute health problems that can not be managed elsewhere in the community. Among the AAMC teaching hospital members that partnered with academic physicians in 2002 (most recent data available), about five of every six hospitals (85 percent) provided geriatric-specific services (e.g., treatment for Parkinson's or Alzheimer's disease). While AAMC teaching hospital members represented just 6 percent of all hospitals in 2002, nearly one-half (42 percent) maintained arthritis treatment centers, 84 percent performed open heart surgeries, 79 percent operated certified trauma centers, and 86 percent provided radiation therapy services for patients with cancer and related conditions.

Nearly one-sixth of all physicians providing Medicare services are academic clinical physicians, rendering them vital to preserving healthcare access for Medicare beneficiaries.

Academic physicians also partner with AAMC teaching hospital members to provide nearly one half (43.3 percent in 2001) 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, faculty practices provided an average of \$12 million in charity care. (In contrast, in 2001, one-quarter (29 percent) of all physicians did not provide any charity care and 27 percent of the country's specialists did not provide charity care services, according to the Center for Studying Health System Change Community Tracking Survey which includes a survey of physicians.)

### **Calculating Annual Physician Updates: The Sustainable Growth Rate (SGR) Methodology**

Each year, the Centers for Medicare and Medicaid Services (CMS) calculates the "Medicare Physician Update" by determining the difference between actual spending on physician services and an annual spending target. In general, when spending exceeds the annual target, CMS issues a "negative physician update." When spending falls below the annual target, CMS issues a "positive physician update."

CMS calculates the annual spending target using the SGR methodology. Passed as part of the Balanced Budget Act of 1997 (BBA), the SGR methodology was intended to set annual spending targets to control government expenditures for Medicare physician services as well as account for increases in the cost of providing those services.

The AAMC is concerned that the SGR has failed to establish an equitable balance between fiscal management of the Medicare program and the actual cost of caring for Medicare patients. For example, from 1996 to 2004 the cost of providing physician services, as measured by the Medicare Economic Index (MEI), climbed an average of 2.3 percent. However, the physician update grew an average of 1.1 percent over that same period. This shortfall occurred despite intervention by Congress to increase the physician payment update in CYs 2003-2005.

### **Recent Congressional Action Averts Projected Medicare Cuts for Physicians**

The AAMC appreciates Congress' efforts to avert the harmful impact of the flawed SGR methodology. Congress acted twice in 2003 to address reductions in the Medicare physician updates for CYs 2003, 2004, and 2005.

As part of the "Consolidated Appropriations Resolution for FY 2003" passed in February 2003, Congress gave CMS the legal authority to revise the CY 2003 physician update from negative 4.4 percent to positive 1.6 percent, avoiding a sharp and significant drop in payments to physicians. In December, Congress similarly averted projected cuts in the CY 2004 and CY 2005 physician updates as part of the "Medicare Prescription Drug, Improvement and Modernization Act of 2003" (P.L. 108-173). Because of Congress'

quick action to prevent potentially devastating cuts, the Medicare physician payment update for CY 2004 and CY 2005 are set at “not less than 1.5%.”

When these favorable, yet short-term “fixes” expire in CY 2006, the physician update calculation reverts to the SGR methodology. Both the Congressional Budget Office (CBO) and Medicare Trustees anticipate the SGR formula will once again trigger dramatic cuts to physician payment updates. In fact, the Medicare Trustees project the problematic SGR will produce cuts of 5% per year from 2006 through 2012.

### **The Impact of Fee Schedule Reductions on Faculty Practice Plans and The Need for Stable, Adequate Medicare Payments**

Stable and adequate Medicare physician payments are critical to ensuring that seniors have continued access to the professional services provided by academic physicians. In light of the fact that faculty practice revenues, on average, represented about 36 percent of medical school revenue in 2002, unstable Medicare payments could jeopardize beneficiary access to faculty professional services, as well as academic medicine's core missions of medical education, research and clinical services.

Changes to the fee schedule have both direct and indirect impacts on faculty practices. In terms of a direct impact, a change in the physician update is not necessarily translated into a proportionate change in actual payments. Since payments under Part B are calculated on a service-specific basis, and a variety of factors are used to calculate each specific payment, the change in payment for individual services typically varies from the annual change in physician update.

The variation occurs among specialties and institutions. An impact analysis by the University Health Consortium (UHC)/AAMC Faculty Practice Solutions Center found that despite the 1.6 percent increase in the CY 2003 update, several academic physician specialties, on average, saw their Medicare payments actually decrease:

<b>Specialty</b>	<b>Average Payment Change</b>
Nephrology (Kidneys)	- 2.6 %
Orthopedic Surgery	- 1.4 %
Ophthalmology (Glaucoma)	- 0.2 %
Colon/Rectal Surgery	- 0.1 %

Another UHC/AAMC analysis provides an example of how the change in actual payments to academic physicians often varies from the change in the update. Focusing on relevant data submitted by a cohort of academic physician practice groups, the mean impact of the negative 5.4 percent update in CY 2002 across those institutions was negative 5.8 percent (Attachment A), with some practices reporting a decline of nearly 8 percent. A similar analysis of the 1.6 percent physician update in 2003 shows a mean change across the cohort practice groups of just 0.5 percent (Attachment B).

Academic physicians also face the indirect impact of a negative physician update when community-based physicians begin limiting the number of Medicare beneficiaries they serve. According to a 2001 Center for Studying Health System Change Community Tracking Survey which includes a survey of physicians, over one-third (35 percent) of primary care physicians limited the number of new Medicare patients in their practice, while 16 percent did not accept any new Medicare patients. Among specialists, 27 percent of physicians limited their number of new Medicare patients.

The increased volumes of Medicare services, coupled with unstable and often declining reimbursement rates, place financial pressures on academic physician practices, endangering their fiscal viability and ability to maintain their societal missions, including providing care to Medicare beneficiaries.

Increased financial pressures on academic physicians also creates a “ripple effect” that extends to their medical schools. Declining revenue ultimately causes academic physicians to devote more time to generating additional clinical revenue, which may force them to either reduce the time they spend mentoring medical students and residents or spend less time on research, thereby slowing the pace of life-saving and cost-saving innovations.

Increased clinical productivity demands and/or subsequent reductions in education and research time can frustrate physicians that enter academic medicine because they are committed to a career that combines two or three of these activities. Growing frustration can ultimately result in an academic physician’s resignation, relocation, and/or a decision to leave academic medicine. It can also hinder efforts to replace retiring physicians and place an organization’s education, research, and patient care missions at risk.

In addition, the volatility, instability, and inadequacy of Medicare payments also affects payments from payers beyond Medicare. Many private payers and some Medicaid programs tie their reimbursement systems to Medicare.

### **Revising the Physician Update Methodology**

The need for an alternative physician payment system is obvious, given the drastic cuts that will resume in 2006 under the SGR methodology. The AAMC enthusiastically welcomes the opportunity to work together with Congress, the Administration, and the physician community to develop a more workable reimbursement system. The AAMC also urges any SGR reform efforts to carefully consider the data sets, proxies, and indicators necessary to generate adequate, equitable, and fiscally responsible physician payments.

For example, the past few years have demonstrated that the country's volatile gross domestic product (GDP) does not contribute to adequate and stable physician payments. Physicians have faced rising costs of caring for Medicare beneficiaries despite downturns in the national economy. Because the current payment formula failed to account for this phenomenon in 2002, CMS cut the physician update by 5.4 percent, while the cost of care

(MEI) rose by 2.6 percent. Additionally, sudden and unexpected changes in the GDP trigger similarly dramatic and unanticipated fluctuations in the physician update. The 2002 update of negative 5.4 percent represented a substantial and sudden drop from a positive 4.5 percent update in 2001. This volatility jeopardizes the ability of academic physician practices to make sound, long-term financial decisions and further endangers already fiscally strained medical schools, research programs, and teaching hospitals.

Another flaw in the current SGR methodology is its failure to reflect changes in Medicare laws and regulations. Despite the fact that Medicare statute requires CMS to account fully for legislative and regulatory changes in the SGR, the agency appears to have underestimated the physician cost implications of newly mandated screening benefits. Similarly, coverage decisions are completely excluded from the SGR calculation, despite the potential that increased patient demand would increase expenditures for physician services.

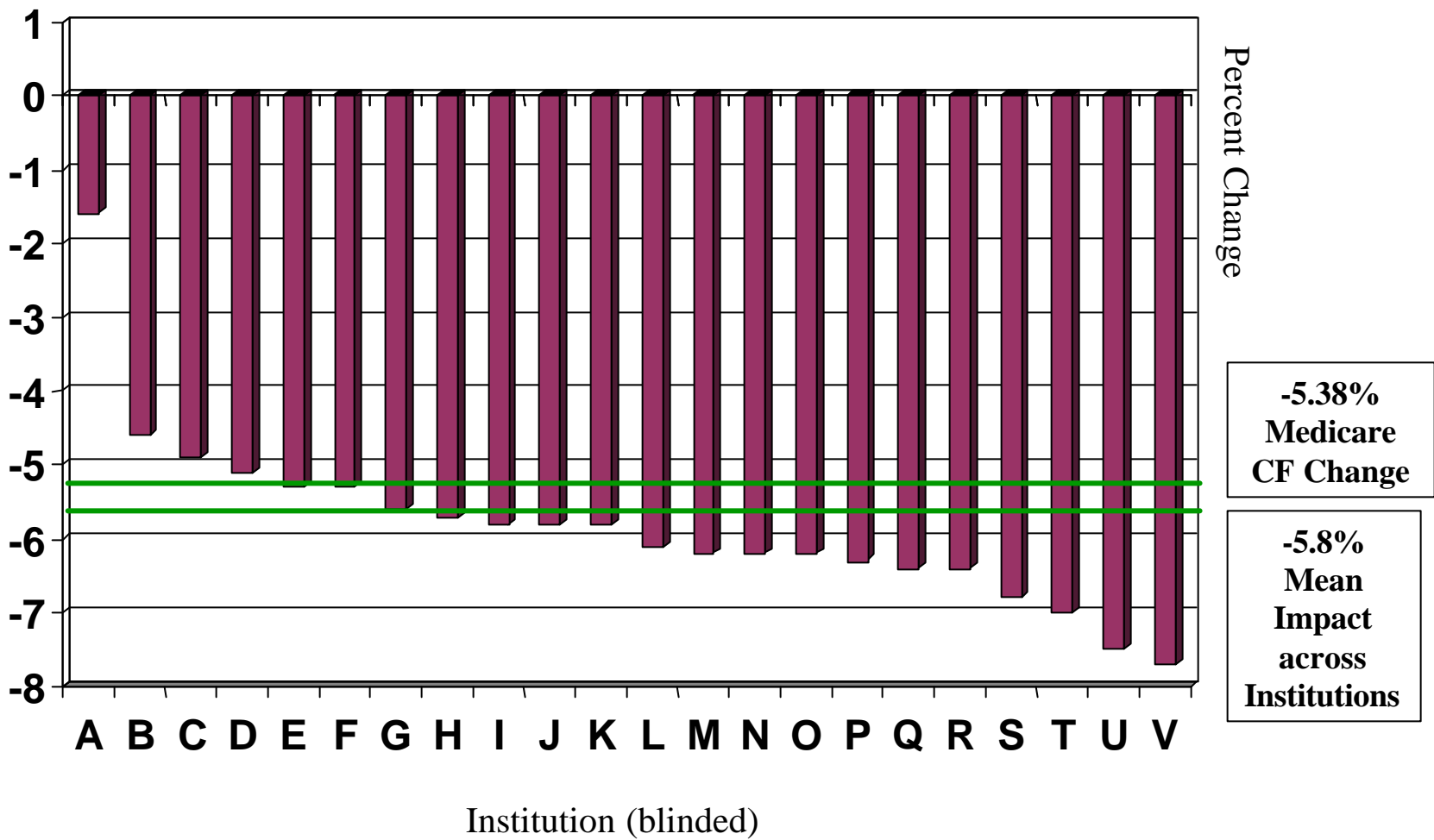
The AAMC is also concerned that, while Medicare law does not define physician-administered drugs as “physician services,” CMS includes those costs in the annual calculation of actual physician spending. Given the growth in life-saving outpatient drug therapies, drug costs help push actual spending on physician services beyond the SGR target, and physicians subsequently face a negative physician update. Eliminating physician-administered drugs from the cost of doctors’ services would more accurately reflect actual Medicare spending on physicians. Some may argue that including drugs in the actual spending calculation is a way to discourage inappropriate drug prescribing by physicians. The AAMC has not seen data that indicates such patterns. If indeed data exists that indicates inappropriate prescribing patterns, the AAMC welcomes the opportunity to work with Congress and the Administration to address the issue in an educational manner that improves the quality of care for beneficiaries.

Finally, CMS should consider that the most recently enacted Medicare provisions will likely increase spending on physician services. For example, increased beneficiary access to drugs may lead to more physician visits for monitoring drug efficacy or side effects. Expanded screening benefits provided under the law will also drive an increase in actual spending. These increased costs to the Medicare program cannot be linked inherently to physician behavior.

## **Conclusion**

In conclusion, Medicare beneficiaries rely on academic physicians and academic medical centers to provide high quality, innovative, and accessible healthcare. They also rely on academic physicians to develop the clinical advances and train the new generation of physicians that will assure a high quality of life for all American seniors. The AAMC looks forward to working with Subcommittee members in devising a long-term solution to replace the current SGR methodology and assure adequate and stable Medicare physician payment updates.

# Impact of 2002 Medicare Fee Schedule on Faculty Practice Plans, by Institution

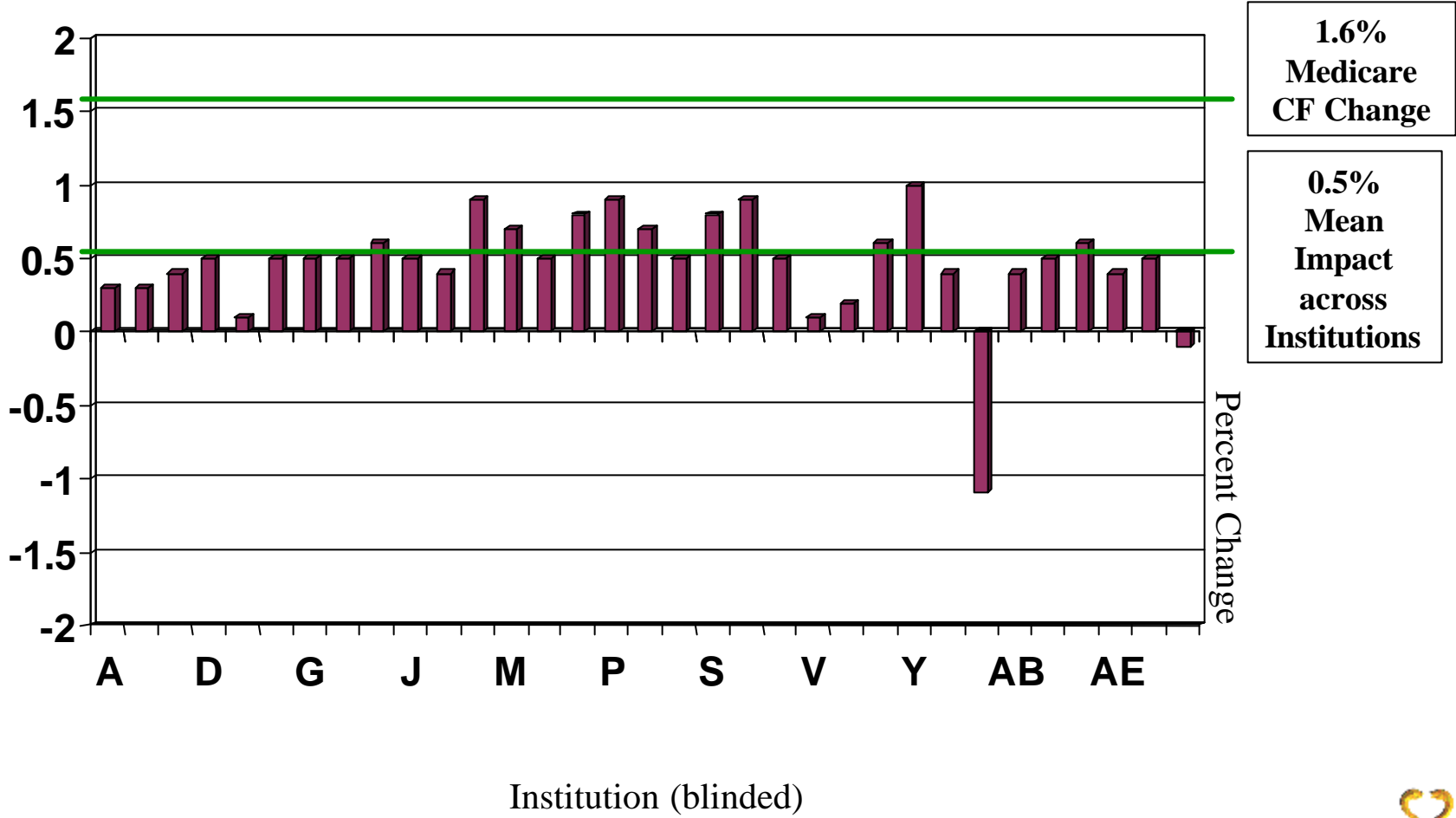


Note: Institution A reported data for only 1 specialty

Source: UHC-AAMC Faculty Practice Solutions Center, 2001 data



# Impact of 2003 Medicare Fee Schedule on Faculty Practice Plans, by Institution



Source: UHC-AAMC Faculty Practice Solutions Center, 2002 data

