



# Statement

**Association of  
American Medical Colleges**  
2450 N Street, N.W., Washington, D.C. 20037-1127  
**T** 202 828 0400 **F** 202 828 1125  
[www.aamc.org](http://www.aamc.org)

**Jordan J. Cohen, M.D.**  
President

## 2006 Proposed Physician Fee Schedule

Presented by

Albert Bothe Jr., M.D.  
Associate Dean and Executive Director  
University of Chicago Practice Plan

Past Chair, AAMC Group on Faculty Practice (GFP)  
Chair, GFP Legislative and Regulatory Subcommittee

Before the

Practicing Physicians Advisory Council  
Centers for Medicare and Medicaid Services

August 22, 2005

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit testimony concerning the proposed 2006 physician fee schedule and physician pay-for-performance measures to the Practicing Physicians Advisory Council (PPAC). The AAMC represents nearly 90,000 full time clinical faculty associated with the nation's medical schools and group practices. Clinical faculty provide a variety of services to Medicare patients ranging from primary care to subspecialty care. On a national basis, the median amount of service provided to Medicare patients is 24% of total services, across all specialties, provided by faculty practice plans. Some departments of medicine and surgery report that as much as 49% of their clinical services are provided to Medicare patients. Thus, on behalf of its members, AAMC is keenly interested in the impact of the Medicare program on practicing physicians.

Today's testimony will address the Centers for Medicare and Medicaid Services' (CMS) proposed rule, "Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006."

### Sustainable Growth Rate

AAMC and the physician community have long commented on the negative impacts of the Sustainable Growth Rate (SGR) and interpretation of its requirements by CMS. The current payment methodology leads to volatile, inconsistent and unpredictable changes to the conversion factor (CF). Further, CMS' inclusion of drugs covered under Part B in its spending calculations contributes to negative conversion factors. These issues have not been resolved and are projected once again to negatively impact payment rates to physicians and other providers in 2006.

The proposed fee schedule for 2006 projects a -4.3% update to the CF. The impact of the proposed decrease in the CF, and thus payments, is even more disconcerting given CMS' prediction that costs to deliver medical care will grow by 2.9%. Decreasing payments to physicians at a time when costs are increasing places a financial burden on physicians who care for Medicare beneficiaries. This trend could potentially have an adverse impact on beneficiary access to care.

In March 2005, AMA released results of a survey in which physicians were asked whether they plan to make changes to accepting new Medicare patients, or to treating established Medicare patients, if Medicare payments are reduced by 5% in 2006. The AMA report includes the following findings:

*Almost 40% of physicians plan to decrease the number of new Medicare patients they accept if Medicare payments are cut by 5% in 2006. Furthermore, almost 20% of physicians say they fear such cuts may force them to reduce the number of established Medicare patients they treat if Medicare payment rates are cut by 5% in 2006.*

*Physicians were asked whether they plan to make any changes to their practice if Medicare payments are reduced by 5% in 2006 and by 31% in 2006-2013. If Medicare payments are reduced by 5% in 2006, more than half of physicians will make patient care changes within their practice, including reducing time spent with Medicare patients, increasing the referral of complex cases and ceasing to provide certain services.*

*In addition, more than half of physicians will not make investments in their practice, including deferring the purchase of new medical equipment and the purchase of information technology. Furthermore, if Medicare payments are reduced by 31% in 2006-2013, more than two-thirds of physicians will make these types of significant patient care changes and cease important investments in their practice. (Source: Member Connect<sup>®</sup>: Physicians' Reactions to the Projected Medicare Physician Payment Cuts, American Medical Association, Division of Market Research and Analysis. March 2005)*

Many academic medical centers (AMCs) and their faculty serve as safety net providers in their community and are committed to providing the best possible care to Medicare beneficiaries. However, the current proposed payment reduction, and the potential impacts noted above, would weaken the financial stability of academic medical centers.

Specifically, as safety net providers, AMCs treat Medicare beneficiaries as both primary and referral providers. If physicians nationally begin to limit their number of new and/or established patients, or begin to refer complex cases and/or certain services, such patients are likely to be referred to AMCs or other groups that continue to accept Medicare patients. Also, if physicians nationally do not invest in equipment and technology, it is possible that the rate of diffusion of new treatment technologies from academic centers into the community will be slowed, thus also resulting in more patients being treated at AMCs than would otherwise if physicians did not make such choices. If these potential responses by physicians occur, and negative conversion factor updates continue, the financial impact will likely place ever-increasing strain on academic medical centers' ability to fulfill their multiple missions and serve as safety net providers.

AAMC appreciates that CMS does not have the authority to change statutory law; however, we strongly encourage CMS to reconsider all options within its administrative authority to mitigate the effect of the SGR. Specifically we request CMS to reconsider the option of removing drugs from the spending target, retroactive to 1996.

### Quality

On page 308 of the proposed rule, CMS requested comments "that build on recent progress on payment reforms to promote higher quality and avoid unnecessary costs, and that are consistent with the President's budgetary goal of paying for better value in Medicare without increasing overall Medicare costs." Previous AAMC testimony to PPAC noted that AAMC supports the CMS quality agenda for both physicians and hospitals. All AAMC Council of Teaching Hospital and Health System members that were eligible to submit data for quality reporting did so. Several AMCs are actively involved in current CMS quality demonstration projects including the Physician Group Practice and Care Management for High Cost Beneficiaries demonstration projects.

AAMC has also advocated, as have several other physician organizations, that physician pay-for-performance programs need to be based upon clear design principles and goals for which there is broad agreement. AAMC believes that key among these are:

- Improved quality of care and safety should be the primary objective of initiatives. It is well recognized that improved quality and implementation of some preventive measures can decrease health care utilization and thus also decrease costs in the long-run. However, improved quality and safety should be the primary objective of activities.

- Performance measures must be evidence-based, broadly accepted, clinically relevant, continually updated and developed with the physician community.
- Data must be fully adjusted for case-mix, sample size, age/sex distribution, severity of illness, number of co-morbidities, and patient population characteristics that may influence results.
- Fair and accurate models for attributing care when multiple physicians treat patients must be implemented.
- Initiatives need to be flexible enough to assess performance at both the individual level or the group level, as appropriate.
- Physicians must have the ability to review and correct performance data.

### Quantity of Measures

In addition, the implementation of quality programs should be fair and equitable to all physician specialties and groups, without placing additional undue administrative burdens on a particular specialty or practice type. As CMS, specialty societies, and quality consensus building organizations examine multiple measures for different specialties, CMS should consider the feasibility of implementing large numbers of multiple measures simultaneously or at a rapid pace.

Specifically, current and foreseeable Medicare reimbursement systems will pay physicians on a service code level basis. CMS needs to be mindful of the potential unintended negative consequences of implementing pay-for-performance systems on a service code basis, whether for actual discrete payments or for metrics factored into overall payments. CMS appears to recognize that such an approach could lead to inequitable payment among specialists, and thus has initiated work to gather measures from all specialties.

However, if multiple performance measures are implemented for multiple specialties simultaneously, physicians/physician groups might have to report on all relevant performance measures to be eligible for payment and recognition. This could result in an abruptly increased administrative burden on multispecialty group practices.

AAMC data show that the median number of clinical departments and physicians at AMCs are 16 and 500 respectively and thus AMCs have physicians in essentially all specialties. Depending upon the structure of a performance improvement system, AMCs could be required to implement *all* measures. Compared to single specialty practices, large multispecialty practices would need incrementally more resources to implement, track and validate a large number of measures.

Although such practices may have information technology resources to assist with quality improvement efforts, current information technology (IT) alone cannot produce quality improvement. Quality improvement efforts also require workflow redesign for physicians and support staff, organizational system redesign, and often, IT system modifications. Despite recent increases in electronic health record systems on the market, these systems are exactly that—electronic health record systems—and do not necessarily include the functionality of ready-

to use patient registries, a key building block to population management and quality improvement.

Thus, we believe that CMS needs to consider carefully its implementation of pay-for-performance (or reporting) programs with respect to the volume of measures required to be eligible for recognition and/or payment. Most private payers implementing pay-for-performance programs have begun with a modest number of measures and increased them steadily over time. Even the current Medicare PGP demonstration project is phasing in measures for one disease state per year. Again, AAMC strongly encourages the adoption of quality standards, but requests that CMS use its administrative authority to ensure that quality programs are designed in a flexible manner to accommodate the many structures of physician practices and groups.

### Attribution of Care

Careful consideration needs to be given to the methodology used to attribute care to individual physicians or groups when more than one physician/group treats a patient. This is an issue that CMS and participants in the Physician Group Practice demonstration have strived to address in order to utilize an attribution model that is fair, can be implemented, and is consistent with patient care practices and preferences.

A patient may be followed by more than one provider, both of whom have accountability around one disease state or who have distinct accountability around separate disease states. If a primary care physician and a consulting endocrinologist do not share or have access to treatment history and results for a patient with diabetes, duplicative services could be provided. An unwanted result could be that a patient receives more than the medically-necessary number of foot or eye exams each year or undergoes duplicate lab tests. An equally unwanted result could be that a patient does not receive an indicated test because one provider assumed or was erroneously told that it was arranged. In either circumstance, these examples highlight the need for correct attribution of responsibility and delivery of care.

AAMC appreciates the opportunity to present to PPAC. AAMC also looks forward to working collaboratively in the physician community and with CMS to develop fair and effective quality improvement programs that will enhance the health of beneficiaries.

**Practicing Physicians Advisory Council**  
**August 22, 2005**  
**Summary of AAMC Testimony**

1. The SGR formula is problematic and continues to produce volatile and negative updates to physician payments. Although CMS does not have the capability to address the SGR per se, AAMC urges CMS to reconsider all options for exercising administrative authority to mitigate the effects of the SGR, and specifically consider removing the expenses for drugs covered under Part B from SGR expense targets.
  
2. AAMC testimony has previously recommended design principles for quality improvement/performance systems that promote the development of a system that will help to ensure best possible outcomes for patients and equitable and reasonable requirements for physicians. We again encourage CMS to incorporate such principles into future systems.
  
3. AAMC requests that CMS develop a quality improvement/performance system that addresses the potential burden that physician groups will encounter if large numbers of measures across multiple specialties must be implemented rapidly. AAMC strongly encourages the adoption of quality standards, but requests that CMS use its administrative authority to ensure that quality programs are designed in a flexible manner to accommodate the many structures of physician practices and groups.
  
4. AAMC requests that CMS give careful consideration to the methodology used to attribute care to individual physicians or groups when more than one physician/group treats a patient. Furthermore, CMS should develop a quality improvement/performance system that correctly attributes responsibility for and delivery of care and thereby minimizes potential unintended consequences.