



**A Coalition of 13 Medical Societies Representing
200,000 Specialty Physicians in the United States**

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**Statement
of the
Alliance of Specialty Medicine
to the
Practicing Physicians Advisory Committee**

March 7, 2005

Founded in 2001, the Alliance of Specialty Medicine (the Alliance) represents over 200,000 physicians in 13 medical specialty organizations and serves as a strong voice for specialty medicine. The Alliance is dedicated to addressing many of the complex healthcare issues debated in Washington. Today, we would like to address Medicare payments to physicians and “*Pay-for-Performance*”.

As advocates for patients and physicians, the Alliance of Specialty Medicine supports modifications to the current Medicare physician payment formula to ensure continued beneficiary access to timely, quality healthcare. The current SGR formula has significant flaws; however, causing steep reductions in physician reimbursement and prompting an increasing number of specialty physicians to reconsider their participation in the Medicare program, limit services to Medicare beneficiaries, or restrict the number of Medicare patients they will treat.

The sad reality of the current situation is that the only way that physicians can avert negative updates is to somehow limit care to the population that needs quality health care the most, our nation’s elderly and disabled. No doctor wants to turn away patients or leave a practice and the patients she or he have been serving for years. No doctor wants to end a career earlier than he or she intended. To take such actions goes against the very reasons our members became doctors.

Why the SGR Formula is Flawed

Flaws in the complex Medicare physician reimbursement update formula include, but are not limited to:

- Including the costs of Medicare-covered outpatient drugs and biologicals in setting the expenditure target for physicians' services, even though these items are not physicians' services and therefore, under the formula, lead to decreases in the annual payment update;
- Linking Medicare physician fees to the Gross Domestic Product (GDP) – which does not accurately reflect changes in the cost of caring for Medicare patients;
- Inadequately accounting for changes in the volume of services provided to Medicare patients due to new preventative screening benefits, national coverage decisions that increase the demand for services, a greater reliance upon drugs to treat illnesses, and a greater awareness of covered health benefits and practices due to educational outreach efforts; and
- Improperly accounting for costs and savings associated with new technologies.

Recent Congressional Action

While problems with the SGR were in some respects anticipated when the law was passed in 1997, the first detrimental effects were not experienced until 2002, when physicians received a 5.4 percent reduction to the conversion factor. Since then, the flaws with the SGR formula have been so pronounced that Congress has been forced to pass two temporary measures to keep the system from falling apart completely.

In 2003, after the Centers for Medicare and Medicaid services delayed a second payment reduction for three months, Congress passed the first law, which required CMS to fix accounting mistakes that were made during 1998 and 1999. Fixing these errors infused an additional \$54 billion into the Medicare physician payment system and prevented another year of reductions in reimbursement, but the legislation did nothing to fix the overall problems that plague the formula. With physicians anticipating a 4.4 percent reduction in 2004,

Congress again acted and included a provision in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) that mandated an increase of at least 1.5% in both 2004 and 2005. While we appreciate the intervention of Congress in preventing the reductions, the statutory increase did nothing to change the underlying formula. In fact, while the statutory update in the MMA prevented the additional reductions for 2004 and 2005, no additional funds were provided to pay for this temporary fix, exacerbating the problem. As a result, the money used to fund the increase in these updates must be paid back to the Medicare program, with interest, over the next ten years.

Reimbursement Rates in 2006 and Beyond

Again, if the SGR formula is not fixed this year, physicians will receive negative updates of approximately 5 percent each year from 2006 until 2012 and rates will not return to their 2002 level until well after 2013. In other words, physicians will receive less reimbursement in 2013 than they did in 2002 for the exact same procedure, regardless of inflation and increased practice costs. While reimbursement will likely be cut by over 30 percent under the current formula during that time period, it is estimated that costs for providing services will rise by close to 20 percent. Such cuts will further inhibit each physician's ability to provide services to Medicare beneficiaries, as many physicians will simply be unable to afford to treat Medicare patients.

The Solution

As previously stated – Congressional action has delayed the imminent meltdown of the Medicare program and has allowed some breathing space to evaluate approaches to fixing the payment update formula. It is now time, however, to put an end to these stop-gap measures and fix the formula and the Alliance of Specialty Medicine looks forward to working with PPAC, the Administration and Congress to develop a

solution. Physician payments must be stabilized and further cuts must be prevented, and to this end, the Alliance of Specialty Medicine believes the following issues need to be addressed:

- **Medicare-covered outpatient drugs and other incident-to services that are included in the expenditure target need to be removed retroactively.**

CMS must exercise its statutory authority and remove Medicare covered drugs, primarily consisting of expensive chemotherapeutic agents used by oncologists, from the physician payment pool retroactively. We thank those members of the PPAC who have supported the removal of these drugs. As you know, physicians do not control the costs of these products and services and each year these costs represent a greater proportion of actual costs incurred by the Medicare program. And, as the agency has acknowledged in the past, physician-administered drugs are not a “true physician service. Yet the cost of these drugs continue to have a negative impact on reimbursement for real physician services.

The Congressional Budget Office (CBO) has predicted that spending for outpatient drugs and other incident-to-services will grow faster, on a per-beneficiary basis, than allowed by the expenditure target. Each year these services will consume a greater portion of the expenditure target, rising from \$12 billion (20 percent of the \$62 billion expenditure target) in 2004 to \$28 billion (\$23 billion of the \$121 billion expensive target) in 2012. These services must be removed from the expenditure target retroactively, so that it accurately reflects what it is supposed to represent – payment for physician services. Recent estimates show that this will have an immediate substantial impact on the predicted cuts by bringing up the baseline and, therefore, filling in much of the “hole” that has been created. Only Congress can replace the flawed SGR formula, however, without assurance from CMS

that it will remove drugs from the physician payment pool, we understand that Congress will be left with few options for replacing the flawed formula.

- **Replace the SGR Formula With a System that Adequately Accounts For the True Costs of Delivering Healthcare Services. – The Medicare Economic Index (MEI)**

The Alliance believes that the current SGR formula needs to be repealed and replaced with a system that is more predictable and recognizes the true costs of providing physician services to Medicare beneficiaries. The current MEI is a fairly accurate measure of these costs. Other providers, such as hospitals and skilled nursing facilities, are reimbursed based upon changes in the costs of providing services and the physician reimbursement formula should be based on this, as well.

Pay for Performance

All of The Alliance's member specialty physician organizations are continually striving to offer the highest specialized quality care to all Medicare beneficiaries. However, with our physicians facing over 30% reductions in Medicare reimbursement from 2006 through 2013 compounded by exorbitant liability premium increases, many of these specialty physicians are reconsidering their Medicare participation status.

Therefore, the Alliance believes that if Congress is to begin to explore alternative payment systems – such as pay for performance – then the current unsustainable Medicare physician payment system needs to be fixed. The Alliance represents 12 physician specialties, which are all at varying stages of sophistication regarding pay for performance initiatives; therefore, we believe that the following points need to be considered:

- Any type of system that rewards providers by improving patient care and outcomes should not be subject to budget neutrality or be used as a physician volume control.
- The reporting of quality or efficiency indicators – and health outcomes data could be administratively prohibitive to many physicians, especially those in small practices that do not have

electronic medical records. It is impossible to link payment to performance without an interoperable health information technology infrastructure.

- Pay for performance programs must not be punitive.
- Measures will need to be specialty specific. Some measures may be appropriate for some specialties, and not others. In some areas, particularly surgery – it can be difficult to keep quality measures up-to-date enough to be perceived as relevant.
- Any measures would have to be developed with significant input by the physician community.
- Given the limitations on the current status of specialty performance measures, the Alliance believes that incentives should be placed on optimizing quality of care and physician participation, not on performance of specific quality measurements.
- If a pay for performance system is implemented, it should be phased-in and pilot tested on a voluntary basis first.

Conclusion

Congress must find a solution to implement a rational Medicare physician payment system and the Alliance of Specialty Medicine looks forward to working with PPAC, the Administration and Congress on a system that is more predictable, insures fair reimbursement for physicians, and offers continued beneficiary access to quality specialty healthcare.

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American Association of Neurological Surgeons
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