PHYSICIAN PAYMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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THURSDAY, FEBRUARY 28, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:41 a.m., in room 1100 Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 20, 2002
No. HL–12

CONTACT: (202) 225–3943

Johnson Announces Hearing on Physician Payments

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the Medicare administrative pricing formula for physicians, which has resulted in a negative 5.4 percent update in 2002. **The hearing will take place on Thursday, February 28, 2002, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. The hearing will conclude by 1:30 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Dr. Glenn Hackbarth, Chairman, Medicare Payment Advisory Commission (MedPAC); Dan Crippen, Director, Congressional Budget Office; Dr. Paul Ginsburg, President, Center for Studying Health System Change; and representatives of physician organizations. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Driven by high growth in payments for physician services in the 1980s, the Medicare Volume Performance Standard (MVPS) was enacted in the Omnibus Budget Reconciliation Act of 1989 (P.L. 101–239) to give physicians an incentive to control volume and to limit the growth in Medicare expenditures for physician services. Based on the recommendations of MedPAC and with the support of physician groups, the Sustainable Growth Rate (SGR) replaced the MVPS in 1997. The SGR formula is linked, in part, to projected Gross Domestic Product, so when the economy slows the update is reduced accordingly. It is also tied to the difference between actual expenditures and target expenditures. The SGR is used in combination with the Medicare Economic Index (MEI), a measure of the increase in physician office and salary costs. Therefore, the SGR is not a direct limit on expenditures—payments are not withheld if the target is exceeded—but the update is increased or decreased.

Under the SGR formula, a "saw-tooth" pattern of funding has emerged. For example, the update increased 5.2 percent in 2000 and 4.8 percent in 2001—more than twice the rate of physician cost inflation. Then in 2002, the update decreased to a negative 5.4 percent, resulting in more than a 10 percent swing in just one year. The SGR formula is inflexible in its administration. For example, the SGR is dependent on economists accurately predicting economic trends; otherwise, the target is missed. Moreover, past errors in setting the target carryover and must be absorbed in future years, making it difficult to correct for the missed target in one year. Consequently, the Office of the Actuary is predicting negative payment updates through 2006.

MedPAC has recommended replacing the SGR with a simple model based on the MEI. Because successive and negative changes are projected, however, a change to

the formula that produces moderate payment increases results in significant budgetary costs and increased beneficiary cost-sharing.

In announcing the hearing, Chairman Johnson stated, "Medicare's formula for paying physicians is completely irrational and must be reformed this year. These cuts are unjustifiable. They result from factors in a formula that has nothing to do with the cost of providing health care. Inadequate payment of health professionals will discourage the top quality candidates that medicine has traditionally attracted and harm patient access to care."

FOCUS OF THE HEARING:

This hearing will focus on the Medicare physician fee schedule formula. It will discuss the effect of the formula on physician payments and beneficiary access to care. The hearing will also analyze reforms to the current sustainable growth rate and the impact of any change on access and Medicare outlays.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to *hearingclerks.waysandmeans@mail.house.gov*, along with a fax copy to (202) 225–2610, by the close of business, Thursday, March 14, 2002. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the Subcommittee on Health in room 1136 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse unopened and unsearchable deliveries to all House Office Buildings.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to *mailto:hearingclerks@mail.house.gov*, along with a fax copy to (202) 225–2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov/*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call (202) 225–1721 or (202) 226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

NOTICE—CHANGE IN TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 20, 2002
No. HL–12 Revised

CONTACT: (202) 225–3943

Change in Time for Subcommittee Hearing on Physician Payments

Congresswoman Nancy L. Johnson (R–CT), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on physician payments, scheduled for Thursday, February 28, 2002, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will now be held at 9:30 a.m. The hearing will conclude by 12:30 p.m.**

All other details for the hearing remain the same. (See Subcommittee Advisory No. HL–12, dated February 20, 2002.)

Chairman JOHNSON. Good morning, everyone, and welcome to our witnesses and the panels that will follow. We appreciate your input on what we consider to be a very important hearing.

Last year we held over a dozen hearings on why Medicare must be reformed and modernized. We unanimously reported and passed a bill to reduce the regulatory burden on our providers and to modernize Medicare's contracting system. Yet, the Senate has failed to even hold a hearing on that issue.

Medicare's erratic and unpredictable payments to physicians clearly epitomize just one more reason why we cannot wait any longer to fundamentally modernize Medicare. When payments oscillate from 4.8 percent in 2001 to a negative 5.4 percent in 2002 and actuaries project additional payment cuts in the future, something is wrong.

The cost of practicing medicine will not get cheaper, it will get more expensive. If we do not reform the so-called sustainable growth rate payment formula, I fear our seniors may suffer access problems and our physicians will only become more demoralized in dealing with Medicare. I am committed to fixing this irrational payment formula as part of a larger Medicare modernization and prescription drug bill this year.

Driven by high growth in payments for physician services in the eighties, the Medicare Volume Performance Standard (MVPS) was developed to give physicians an incentive to control volume and to limit the growth in Medicare expenditures for physician services. In 1997, the Sustainable Growth Rate (SGR) replaced the MVPS, based on the recommendations of Medicare Payment Advisory Commission (MedPAC) and with the support of physician groups.

The SGR formula is linked to projected Gross Domestic Product (GDP), so when the economy slows, the update is reduced accordingly. It is also tied to the difference between actual expenditures and target expenditures. The SGR is used in combination with the Medical Economic Index (MEI), a measure of the increase in physician office and salary costs. Therefore, the SGR is not a direct limit on expenditures. Payments are not withheld if the target is exceeded, but if the update is increased or decreased accordingly.

Today we will hear from MedPAC, who has recommended scrapping the SGR and linking payments to the Medicare Economic Index. Second, the Congressional Budget Office (CBO) will testify why payments to physicians and related providers are projected to be cut in the future and the fiscal implications of reforming the SGR. Finally, we will hear from an academic and several physician and provider groups about their ideas on reforming Medicare's payments to physicians and providers.

We look forward to your input during this hearing. I personally am extremely concerned about the volatility of our payment formula and its interaction with Medicaid reimbursements, particularly out there in the urban communities. So, it is important that we understand not only the problems in our payment formula, but also what is happening to reimbursements to physicians out there in different types of communities. Because only then can we assure that there will be doctors there to provide the quality care that seniors need and deserve throughout the cities and hamlets of our Nation.

So I welcome our witnesses and would yield to my Ranking Member and colleague, Mr. Stark.

[The opening statement of Chairman Johnson follows:]

Opening Statement of the Hon. Nancy L. Johnson, a Representative in Congress from the State of Connecticut, and Chairman, Subcommittee on Health

Last year, we held over one dozen hearings on why Medicare must be reformed and modernized. We unanimously reported and passed a bill to reduce the regulatory burden on our providers and to modernize Medicare's contracting system. Yet the Senate has failed to even hold a hearing on that issue.

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The cost of practicing medicine will not get cheaper; it will get more expensive. If we do not reform the so-called "sustainable growth rate" payment formula, I fear our seniors may suffer access problems and our physicians will only become more demoralized in dealing with Medicare. I am committed to fixing this irrational payment formula as part of a larger Medicare modernization and prescription drug bill this year.

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Mr. STARK. Thank you, Madam Chair, and thank you for holding this important hearing. I agree in part with MedPAC that we should revisit the formula of the system under which we reimburse physicians. I think it is important to note, however, that while it is proper to be concerned about cost containment or fair reimbursement for services that we take this in context of what this Committee has to do.

We have had 2 years of record increases in payments to physicians. In 2000, surgeons' median income in this country was well over $200,000. Even the poor GPs, general practitioners, and pediatricians were making about between $100,000 and $120,000 median, which means that half of them were making a lot more. The tax cuts that we have so generously bestowed on the richest Americans, which would include these physicians, further increases their take-home pay and we have done nothing to help the lowest income seniors in the program, so that I would like to see us perhaps, as we think about fair reimbursement for people making $2, $3, $4, $600,000—we have given them huge tax cuts. I hope we will be as quick and as concerned about the 70 percent of the 40 million Medicare beneficiaries whose incomes are below $40,000 and who have no access to pharmaceutical benefits and to the 12 million children in this country who have no health insurance at all and therefore no health care. And so let us take care of the top and hope that we set a standard for helping the less fortunate in this country.

Chairman JOHNSON. Thank you. It is my privilege and pleasure to welcome our first panel. Mr. Crippen.

STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Mr. CRIPPEN. Thank you, Madam Chairwoman and——

Mr. STARK. Use the microphone.

Mr. CRIPPEN. Does that work?

Mr. STARK. Yes. Pull it up, swallow it. There you go.

Mr. CRIPPEN. The issue before us today, as I understand it, is the adequacy of recent and future updates for physician payments under Medicare and ultimately the acceptability of the formula that produces those updates. More pointedly, we are here to discuss the price taxpayers and Medicare patients pay each year to physicians. But this discussion, this question, cannot, I would argue, be addressed in isolation. Physician fees, or prices, are only one part of the equation. We need to examine payments and payment policy in the context of both the history and the future of this program.

With the indulgence of the Committee, I would therefore like to take a little temporal jig and try to address how we got here, ad-

dress where we go from here, and then, ultimately, get to here and see if that enlightens us any.

As the Committee is painfully aware, price controls or administered prices are difficult to establish and seemingly impossible to enforce. History is replete with the failure of price controls, in this case, on physician services to manage or control spending. That failure has a unique aspect in this case because physicians are able to adjust the volume of services they provide.

This chart shows the perpetual, if you will, increase since the beginning of the program in total spending for physicians. There is a discontinuity because the physician services definition has changed, but nevertheless it is almost a straight line up. Throughout the eighties, despite fee schedules and regulation, Medicare spending for physicians per beneficiary, per beneficiary, rose at an average annual rate of 12 percent.

Virtually no matter what price controls have been employed, spending for physician services has almost always gone up. Even in those years after enactment of the Balanced Budget Act (BBA) 1997 when hospital and total spending declined, physician payments went up. Total spending was targeted, beginning in 1992, as you all know, and that approach was revised in 1997 along with fee schedules to rein in what appeared to be an ever-increasing amount that taxpayers were contributing to this aspect of Medicare.

I will return to that point in time—the near past—in a moment, but against this backdrop of apparently inexorable increases in spending for physician fees, I want to turn to the period that is our near future. The Committee has seen me present this chart in many and varied circumstances, but I think it is always important to establish a backdrop when we are considering these programs.

As we see, current spending on Medicare, Medicaid, Social Security, much of which spending for retirees, is running at about 7 percent of GDP. When my generation retires, we will literally double the number of recipients from something like 39 million today to about 80 million, come 2030. So it is not surprising that this chart suggests we will at least double and probably more than double the amount of the economy consumed by these programs.

Of course, the single biggest increases that the chart shows—just graphically, let alone numerically—are for Medicare—which, again, is not surprising. The Congressional Budget Office assumes that Medicare costs are going to rise even faster than the economy in this projection, and that is probably a conservative estimate given the program's spending history.

The point here is that we have a future before us—that is a good redundant statement—we have a future that suggests that the total Federal budget itself, which is now only about 18 percent of GDP, is going to be consumed largely by these three programs or else we are going to have to increase taxes dramatically or increase government debt dramatically. Anything we tend to add to these payments, whether it is higher fees for physicians or whether it is pharmaceutical benefits, will only exacerbate that outcome.

This is not to say—and I certainly don't want to say—that there is any crisis here that needs to be addressed today; or maybe the Congress this year and in the future will not consider this to be

a problem, in which case one would go about fixing up the program's finances to accommodate a physician payment increase. But I want to remind the Committee, as I have in the past, that the fiscal pressures of this demographic bulge are almost upon us, and anything we do to add to Medicare spending will certainly make them worse.

Returning to the present, the Committee is faced with the prospect of a reduction in the prices for physician services for last year, this year, and possibly several more years. The reasons for that are several. As we see from this rather complicated, or apparently complicated, chart, the single largest reason is an error that was made a few years ago and that resulted in price increases—large price increases—that it turned out were not warranted under the formula.

So a large piece of your current dilemma—the volatility of the increases and the fact that we have negative updates—is that physicians were overpaid according to the formula in 2000 and 2001. In fact, if the correct data had been used, the updates would have been much less volatile, with a 2.1 percent reduction in 2002, a 4.9-percent reduction next year, and positive updates thereafter. Of course, the updates of more than 5 percent that were paid in 2001 and 2002 would have been smaller, but positive nonetheless.

Some of the rest of the adjustment is due to volume increases, which put total spending somewhat above the target, and the slowing economy. There are at least two other pieces of information of which I think the Committee should be aware. Not all physicians have been hit equally over the past several years, primarily because of other changes taking place in the Medicare fee schedule. For example, in the past 4 years, family practice physicians experienced a 3 percent reduction in fees this year but an overall increase 19 percent in the prior 3 years.

Volatility, Madam Chairwoman, while undesirable, certainly has characterized the structure of this program virtually from the beginning, and a big piece of the current volatility is due to the data error, or correction, that needed to be made. The current sustainable growth mechanism rate I suggest, can probably be modified to further reduce volatility.

What are we to make of all this? First, physicians' revenues from Medicare are not declining. Spending for physicians' services will go up even with the past and projected reductions we have in physician fees. Indeed, CBO projects—as we say in our written statement, Madam Chairwoman—that total spending for physicians will go up by 5.9 percent in fiscal year 2002, despite the fact that the fee schedule will be reduced. By the way, some of you may have a copy of the testimony that has the increase occurring in 2003. The first paragraph should read "2002." I just note that correction.

Second, even if the Congress does not change current law and does not increase physician compensation or anything else, even holding total physician spending to per capita growth in GDP will still ultimately lead to what are probably unsustainable costs for taxpayers, mostly our children.

Third, the lion's share of the negative updates is attributable to unjustifiably large increases in total spending for physicians' services in 2000 and 2001.

Fourth, not all physicians' fees have been reduced by even as much as the updates.

In closing, I want to reiterate that it is the responsibility of the Medicare Payment Advisory Commission and my colleague on this panel to give you their best advice about appropriate payment of providers. However, it is the responsibility of this Committee and the rest of government to balance the various competing interests of present and future providers, beneficiaries, and taxpayers. Eliminating spending targets will only increase the burden on other providers, other government programs, and, ultimately, on our kids.

Thank you.

[The prepared statement of Mr. Crippen follows:]

Statement of Dan L. Crippen, Director, Congressional Budget Office

Chairwoman Johnson, Congressman Stark, and Members of the Committee, I am pleased to be here today to discuss Medicare payments to physicians. As you know, the fees that Medicare pays per physician service have fallen by 5.4 percent this year. What you might not know is that the Congressional Budget Office (CBO) projects that total Medicare payments to physicians will rise by 5.9 percent in fiscal year 2002. Although the average fee per service will continue to fall for the next several years, total Medicare payments to physicians will continue to increase.

The pattern of seemingly inexorable increases in Medicare spending for physicians' services spurred the creation of the sustainable growth rate (SGR) method to automatically link increases in Medicare physician spending per beneficiary to growth in the national economy. CBO estimates that the recent recommendation by the Medicare Payment Advisory Commission (MedPAC) would increase Medicare spending by $126 billion over 10 years as a result of repealing the SGR system. Before discussing the reasons for that estimate, my testimony will review the relationship between Medicare payments to physicians, program spending, and the budget, as well as summarize the history of efforts to control Medicare spending for physicians' services.

PHYSICIAN FEES AND PHYSICIAN SPENDING

Allow me to begin by reviewing the relationship between the fees Medicare pays to physicians, overall Medicare spending for physicians' services, total Medicare spending, and the economy. Fees are paid for each medical service. But the amount paid per service is only one of the components driving Medicare physician spending. One other factor is obvious: Medicare spending for physicians' services increases with the number of beneficiaries. In testimony before this Committee, I have highlighted the massive changes associated with the impending retirement of my generation. According to last year's report by the Medicare trustees, the number of Medicare beneficiaries will virtually double between 2000 and 2030. During the same period, the number of workers paying for Social Security and Medicare will increase by about 15 percent (see Figure 1).

IMPACT OF CHANGING DEMOGRAPHICS ON MEDICARE SPENDING

The aging of the baby boomers has dramatic fiscal implications for Medicare (see Figure 2). If we spent the same fraction of gross domestic product (GDP) on each Medicare beneficiary in 2030 that we spend today—a proposition reflecting only the increased number of beneficiaries—Medicare spending would grow from today's 2.3 percent of GDP to 4.5 percent in 2030. The fiscal implications of the boomers' aging are compounded by the fact that health care costs measured per beneficiary routinely grow significantly faster than does the economy measured on a per capita basis. As a result, if current law remains unchanged, Medicare spending will climb to 5.4 percent of GDP by 2030.

Also projected to climb is spending for the "big three" programs for the elderly—Social Security, Medicare, and Medicaid—taken as a whole: between now and 2030, such spending as a share of GDP will virtually double. Transfers to the elderly will grow from 7.8 percent of GDP to 14.7 percent in 2030 (see Figure 3).

Let me underscore that that increase in spending of almost 7 percentage points of GDP will occur under current law. Proposals to increase payments to Medicare providers (such as MedPAC's recommendation to increase payments to physicians) or to expand Medicare benefits (such as proposals to create a Medicare prescription

drug benefit) will exacerbate the long-term budgetary pressures projected for the next several decades. As this Committee knows, paying for those increased costs will require either dramatic reductions in spending, sizable tax increases, or large-scale borrowing.

MEDICARE SPENDING ON PHYSICIANS

In addition to fees and growth in the number of beneficiaries, the number and type (or "intensity") of the services provided by physicians determine total Medicare physician spending. Taken together, the number and type of physicians' services constitute their "volume." Medicare physician spending measured per beneficiary equals fees times volume of services. Each year, Medicare sets fees for physicians' services using formulas in the Medicare Fee Schedule (MFS) and the SGR mechanism. However, because Medicare does not control the volume of services that physicians provide, its physician spending per beneficiary can grow even if fees are reduced.

Medicare spending for physicians' services grew faster than Medicare spending for all other services throughout the 1980s; in the 1990s, that trend reversed. From 1981 through 1990, spending for physicians' services grew at an annual rate of 13.7 percent; spending for all other services grew at a rate of 11.1 percent per year. By 1990, Medicare's total payments to physicians were more than three-and-a-half times greater than they had been 10 years earlier, and the average physician was receiving more than two-and-a-half times as much in Medicare payments. Indeed, Medicare payments per physician increased almost twice as fast as did the nation's economy during the 1980s. That rapid growth led policymakers to add expenditure targets to the formulas used to set the overall level of physician fees in order to control total spending for physicians' services. In the 1990s, growth in the volume of physicians' services moderated. To the extent that there have been surges in that growth, the system has lowered the update—the annual adjustment to physicians' fees—to offset the higher spending.

A BRIEF HISTORY OF MEDICARE'S EFFORTS TO CONTROL PAYMENTS TO PHYSICIANS

The chronology of payments to physicians under Medicare can be divided into three periods. The first, shortly after the program began in 1965, was characterized by a rapid rise in spending as physicians increased both their charges and the volume of services that they provided. Even when the Congress limited the growth of fees for physicians' services by pegging the annual fee update to the Medicare economic index, or MEI, spending continued to climb rapidly.[1] That experience led to the second period of physician payments, when the Congress froze fees and limited increases in them to less than the rise in the MEI.

Despite those actions, spending for physicians' services continued to grow throughout the 1980s, and the Congress realized that limitations on the growth of fees alone—without regard to the volume of services that physicians provided—was not enough to control spending. That realization led to what is now the third period in Medicare's payments to physicians (beginning in 1992), a span distinguished by restraints on the uncontrolled growth in expenditures for physicians' services that Medicare experienced in the past.

Abandoning the Charge-Based System

When Medicare was created in 1965, the program paid physicians fees that were based on their charges, the method of payment then used by private insurers. In addition, Medicare permitted physicians to bill beneficiaries for the amount of their charges that exceeded the fee that Medicare paid, a practice known as "balance billing." The charge-based reimbursement system gave physicians the incentive to increase their charges from year to year to boost their revenues, and those increases led to the spiraling expenditures of the first period of Medicare physician payments.

As concerns grew about the program's rising costs, policymakers focused on restraining those fees. In 1972, the Congress mandated that the annual update to physicians' fees be limited to the increase in the MEI, a provision that was implemented in 1975. Tying increases in fees to growth in the MEI was not sufficient to keep total payments from rising, however, and the Congress took further steps to limit spending through legislation enacted from 1984 through 1991, during the sec-

[1] The Medicare economic index measures changes in the costs of physicians' time and operating expenses; it is a weighted sum of the prices of inputs in those two categories. The components of the index come from the Bureau of Labor Statistics. Changes in physicians' time are measured through changes in nonfarm labor costs. Labor productivity is also factored into the index.

ond period of physician payments. The Congress froze fees from 1984 through 1986; from 1987 through 1991, it updated them by amounts specified in legislation.

Limiting Beneficiary Liability

Balance billing was another issue that prompted Congressional action during the 1980s. On average, liability for balance billing per beneficiary grew from $56 in 1980 to a high of $94 in 1986.[2] Subsequently, the Congress responded by imposing limits on such billing, which prevented physicians from raising their charges; beneficiaries thus in effect made up for the constraints on Medicare physician fees. Balance billing is currently restricted to 109.25 percent of Medicare's fees for participating physicians.[3]

The program's limits on balance billing protect beneficiaries' liability for physicians' charges. However, those limits reduce the potential usefulness of balance billing either as a safety valve or signal that Medicare's fees are below the level necessary to attract a sufficient number of doctors to serve Medicare enrollees.

Redistributing Income Among Physicians' Services

Policymakers also took steps to redistribute payments among physicians. In the 1980s, many analysts believed that Medicare's reimbursement for physicians' services was distorted by factors that tended to overcompensate so-called procedural services at the expense of what were termed cognitive services. Before the MFS was adopted, fees varied widely, with physicians in different specialties and in different geographic regions receiving different payments for comparable services.

The response to those concerns was the implementation in 1992 of the Medicare Fee Schedule, which based payments for individual services on measures of the relative resources used to provide them. There are two parts of the formula for fees. One part is a set of weights that indicates the resource costs of each service relative to all others. (For example, a CAT scan has a higher relative value than an intermediate office visit with an established patient.) The other part is a fixed dollar amount, called the conversion factor, which is multiplied by each relative weight to calculate the fee to be paid for each service. The fee schedule was intended to promote equity and to be budget neutral—in 1992, the conversion factor was set so that estimated expenditures under the MFS equaled estimates of what expenditures would have been under the earlier payment system. One thing the MFS was not designed to do, however, was control costs.

Controlling Volume

In an attempt to control total spending for physicians' services driven by volume, the Congress also enacted a mechanism that tied the annual update to fees under the MFS to the trend in total spending for physicians' services relative to a target. Under that approach, the conversion factor was to be updated annually to reflect increases in physicians' costs for providing care, as measured by the MEI, and adjusted by a factor to counteract changes in the volume of services provided per beneficiary. The introduction of expenditure targets to the update formula initiated the third period in physician payments. Known as the volume performance standard (VPS), the approach provided a mechanism for adjusting fees to try to keep total physician spending on target.

The method for applying the VPS was fairly straightforward, but it led to updates that were unstable. Under the VPS approach, the expenditure target was based on the historical trend in volume. Any excess spending relative to the target triggered a reduction in the update two years later. But the VPS system depended heavily on the historical volume trend, and the decline in that trend in the mid-1990s led to large increases in Medicare's fees for physicians' services. The Congress attempted to offset the budgetary effects of those increases by making successively larger cuts in fees, which further destabilized the update mechanism. Indeed, between 1992 and 1998 (the years that the VPS was in effect), the MEI varied from 2.0 percent to 3.2 percent, but the annual update to physician fees varied much more widely, from a low of 0.6 percent to a high of 7.5 percent (see Figure 4).

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[2] Physician Payment Review Commission, Annual Report to Congress (March1988).

[3] Under Medicare's rules, the program pays 80 percent of the fee schedule, and beneficiaries or their supplemental insurer pays 20 percent. Balance billing occurs when beneficiaries pay more than 20 percent of the fee. A physician elects either to "participate" (that is, take Medicare fees as payment in full for all services) or to receive Medicare payments as a "nonparticipating" physician allowed to balance-bill patients up to the statutory limit. Fees for nonparticipating physicians are set at 95 percent of the fees for participating physicians. Nonparticipating physicians are permitted to bill up to 115 percent of their fees.

That volatility led the Congress to modify the VPS in the Balanced Budget Act of 1997 (BBA), replacing it with the sustainable growth rate mechanism, the method in place today.

The SGR Approach

Like the VPS, the SGR method uses a target to adjust future payment rates and to control growth in Medicare's total expenditures for physicians' services. In contrast to the VPS, however, the target under the SGR mechanism is tied to growth in real (inflation-adjusted) GDP per capita—a measure of growth in the resources that society has available per person. The update under this approach is equal to the MEI adjusted by a factor that reflects cumulative spending relative to the target (the VPS did not use cumulative spending).

Policymakers saw the SGR approach as having the advantages of objectivity and stability in comparison with the VPS. From a budgetary standpoint, the SGR method, like the VPS, is effective in limiting total payments to physicians over time. GDP growth provides an objective benchmark; moreover, changes in GDP from year to year have been considerably more stable (and generally smaller) than changes in the volume of physicians' services.

PROBLEMS WITH THE CURRENT APPROACH

A key argument for switching from the VPS approach to the SGR mechanism was that over time, the VPS would produce inherently volatile updates. But updates under the SGR method have proven to be volatile as well. Until 2002, that volatility has tended to be to the benefit of physicians. Overall, the update in the first three years during which the SGR method was in place was almost twice as high as the MEI over the same period. It is the reduction for 2002 that has raised concerns among physicians.

In 2002, for the first time since the MFS method was implemented in 1992, physicians' fees have been reduced, drawing objections from physicians and raising concerns about assertions that beneficiaries' access to physicians' services will be impaired. Several factors contributed to the fee reductions:

*As of November 2001, the cumulative spending target (that is, the allowed spending from April 1996 through December 2001) that was used to set the physician fee update for 2002 was $302.7 billion. That target was $1.5 billion lower than the amount expected a year earlier. The reduction was driven largely by slower growth of GDP than had been estimated previously; also contributing, however, were revisions in some of the other factors that determine the spending targets.[4, 5]

*In addition, cumulative spending for physicians' services far exceeded the spending target. The estimate of actual spending through 2001 that was made in November of that year and used to set the update for 2002 was $311.6 billion—or $8.9 billion (2.9 percent) above the corresponding target.

*A large part of that discrepancy, however, resulted from the omission previously of a portion of actual expenditures related to certain service codes, which by mistake were not counted (including, for example, chiropractic services). In March 2001, the Centers for Medicare and Medicaid Services (CMS) estimated that actual cumulative expenditures through 2001 would be $303.9 billion—or $7.7 billion less than the November 2001 estimate. Although part of that difference is attributable to the availability of more recent data on physician spending than those used for the initial estimate, the size of the discrepancy indicates that the effect of the previously omitted services was substantial.

Therefore, much of the reason for the large decline in Medicare physician fees this year may be related to a counting error. That error was a major factor in the large positive updates in fees for 2000 and 2001, which otherwise would not have occurred. The effects of that oversight should not be confused with basic problems associated with the update mechanism.

The BBA limited the maximum annual offset to the MEI to −7 percentage points, so the update for 2002 was −5.4 percent. Because actual spending exceeded the expenditure target by more than 7 percentage points for 2002, a portion of the past

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[4] Centers for Medicare and Medicaid Services, "Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002; Final Rule," Federal Register, vol. 66, no. 212 (November 1, 2001), pp. 55312–55321.

[5] Centers for Medicare and Medicaid Services, Office of the Actuary, "Estimated Sustainable Growth Rate and Final Conversion Factor for Medicare Payments to Physicians in 2002" (February 4, 2002), available at www.hcfa.gov/pubforms/actuary/sgr/sgr2002f.pdf, compared with previous versions dated March 19, 2001, and November 21, 2000.

excess will lower the update for 2003. Currently, CMS projects negative updates through 2005 (see Figure 4).

Because of changes to the relative payment amounts, or weights, for individual services for 2002, the −5.4 percent reduction in the conversion factor does not change all fees by the same amount. Indeed, payments for some services will increase in 2002, and payments for others will drop by more than 5.4 percent below last year's. Those varying effects occur because 2002 is the final transition year in the reform of the "practice expense" portion of the fee schedule, which redistributed income among physician specialties. Starting in 2003, little redistribution of physician payments is anticipated.

There are four general courses of action the Congress can take to address these issues. One possibility is to eliminate spending targets and determine the updates to fees without linking them to overall spending for physicians' services—that plan represents MedPAC's proposed approach. A second is to modify the SGR to reduce volatility. A third option is to legislate temporary relief from the reductions in fees generated by the current system. A fourth option is to make no changes to the current mechanism.

MEDPAC'S PROPOSAL

In March 2001 and again this year, MedPAC recommended that the Congress discontinue using the SGR method for computing the update and replace it with a framework similar to that used for updating the fees of other types of providers. CBO estimates that implementing the MedPAC proposal would cost $126 billion over 10 years. That estimate is virtually the same as the estimate of the CMS actuary.

Not only would the MedPAC recommendation lock in place the overstated payments and fees set in earlier years, but it would also increase annually the fees paid to physicians. For 2003 through 2005, the MedPAC recommendation would substitute positive updates for the reductions expected under current law. Total spending for physicians' services in the subsequent year would also be above the spending that would occur under current law.

The new framework that MedPAC is proposing would end the use of expenditure targets, opening the door to large spending increases driven by volume. MedPAC's proposal would base the update on the forecast for the MEI and on changes in productivity—without any limits on volume or total spending.

WHY PHYSICIANS ARE DIFFERENT FROM MEDICARE'S OTHER SERVICE PROVIDERS

Physicians are unique among Medicare providers in being subject to an overall spending adjustment. By contrast, Medicare pays for most other services now through prospective payment systems that set a price for a bundle of services. Under those systems, the provider is free to make decisions about the volume of services provided to the patient, but the payment for the bundle is fixed.

Physicians are unique as well in their ability to determine the volume of services they can provide. They are the gatekeepers and managers of the health care system; they direct and influence the type and amount of care their patients receive. (Physicians, for example, can order laboratory tests, radiological procedures, and surgery.)

Moreover, the units of service for which physicians are paid under the MFS are frequently very small. The physician may therefore receive one payment for an office visit and a separate payment for individual services such as administering and interpreting x-rays—all of which can be provided in a single visit. That contrasts with the policy for hospitals, which receive payment for each discharge and no extra payment for additional services or days (except in extremely costly cases).

Further, once a physician's practice is established, the marginal costs of providing more services are primarily those associated with the physician's time. The current method of physician payment takes that unique role into account by explicitly linking the update in fees to the level of spending, which—as I said before—is determined by both fees and volume.

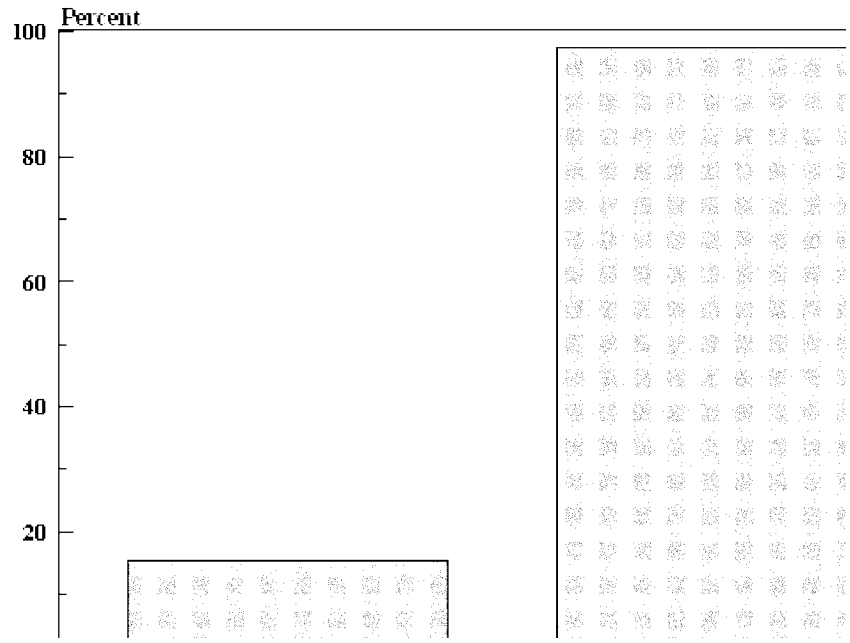
CONCLUSION

In considering whether to change the current system for setting Medicare physician payments, the Congress confronts the prospect of reductions in the fees paid per service for the next several years. MedPAC's recommendation would increase the federal government's spending for physicians' services under Medicare by $126 billion over the next 10 years. In contrast, other approaches might have the potential to lessen the volatility in the update without dismantling the mechanism for linking physician fees to total spending for physicians' services or growth in the economy.

Maintaining access to care for Medicare beneficiaries is a key consideration in assessing Medicare's fee structure. MedPAC reports that the most recent systematic data currently available about access to care are from 1999. In evaluating that information, MedPAC reports that it found no evidence of problems in beneficiaries' and physicians' views about access. However, the lack of timely data makes it hard to know whether and to what extent problems exist in access to care. More timely data on that issue would be an important improvement over the current situation and could assist the Congress in its deliberations.

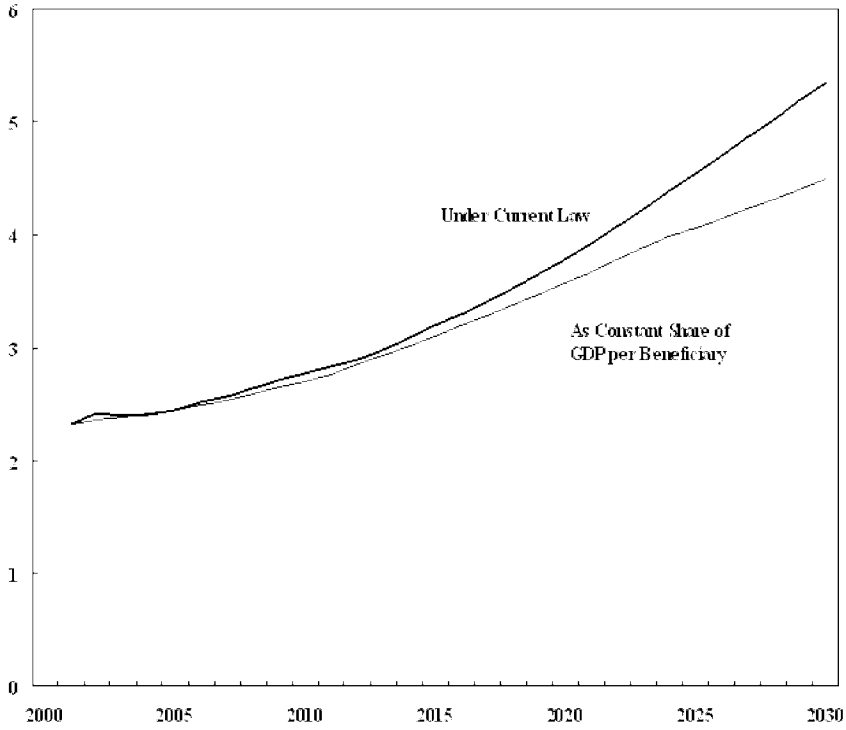
Changes that increase Medicare payments to physicians will increase federal spending. Incorporating higher fees for physicians' services into Medicare spending as currently projected would add to the already substantial long-range costs of the program and to the fiscal challenge to the nation posed by the aging of the baby boomers. Raising fees would also increase the premium that beneficiaries must pay for Part B of Medicare (the Supplementary Medical Insurance program). Inevitably, over the long run, higher spending by Medicare for physicians' services will require reduced spending elsewhere in the budget, higher taxes, or larger deficits.

FIGURE 1. PERCENTAGE INCREASE IN BENEFICIARIES AND WORKERS, 2000–2030



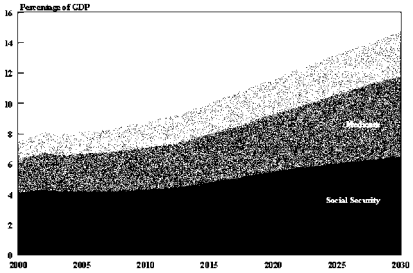
SOURCE: 2001 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund.

FIGURE 2. PROJECTED MEDICARE SPENDING UNDER ALTERNATIVE ASSUMPTIONS, 2001–2030



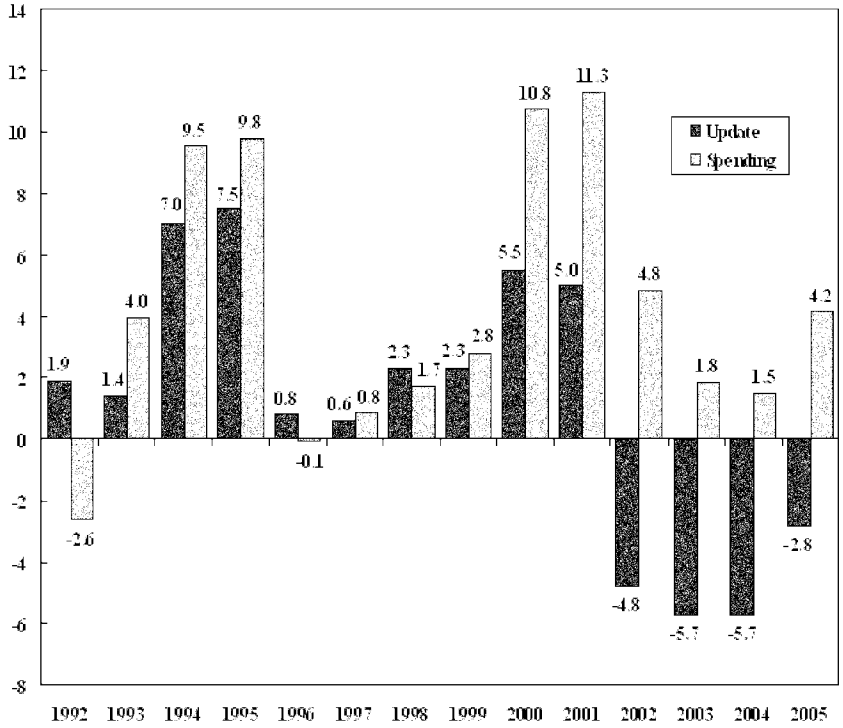
SOURCE: Congressional Budget Office.

FIGURE 3. SPENDING FOR SOCIAL SECURITY, MEDICARE, AND MEDICAID, 2000-2030



SOURCE: Congressional Budget Office based on its midrange assumptions about growth in gross domestic product and program spending. For further details, see Congressional Budget Office, The Budget and Economic Outlook: Fiscal Years 2003-2012 (January 2002), Ch. 6.

FIGURE 4. COMPARISON OF ANNUAL PHYSICIAN UPDATES AND CHANGE IN MEDICAREPHYSICIAN SPENDING, 1992–2005



SOURCES: Centers for Medicare and Medicaid Services for updates and historical spending and Congressional Budget Office for projection of spending from 2001 through 2005.

NOTE: The actual increase in the conversion factor, which is a fixed dollar amount that is multiplied by relative weights to calculate Medicare physician fees, is also affected by a budget-neutrality adjustment.

Chairman JOHNSON. Thank you very much, Mr. Crippen.

Mr. Hackbarth of the MedPAC, very glad to have you.

STATEMENT OF GLENN M. HACKBARTH, J.D., CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Thank you.

As you know, MedPAC recommends that we repeal SGR and replace it with a system under which the Secretary would update fees annually based on estimated change in the prices that physicians need to pay for their inputs minus an adjustment for improved productivity.

This is not a recommendation that we arrive at lightly. Controlling spending is obviously an important issue for the Medicare Program for all of the reasons that Mr. Crippen has outlined. Controlling spending, however, is not the only goal that we need to keep in mind. Here are some of the other goals that we at MedPAC think are important for the Medicare Program.

One of course is to assure access to quality care for seniors. This is the overriding purpose of the Medicare Program. At MedPAC we believe that the best way to do that is to try to match payments for individual provider groups, including physicians, to the cost of efficient providers of those services, and that is what our recommendation would do. So that is another goal.

A third goal is fairness to providers, and one type of fairness is rewarding good behavior and reserving punishment, if you will, for poor performers, and this is a critical area where we believe the current system, the SGR system, fails. If spending increases above the target, the punishment is distributed across all providers without regard to who contributed to the excess spending.

A fourth goal, from our perspective, is to assure that clinical considerations, not payment policy, guides decisions about where particular services should be provided. Here again the current system falls short because SGR only applies to certain services. It could influence where to provide a particular service. If it is provided in the physician's office, it is subject to the constraint. If it is moved to an ambulatory surgical center or hospital outpatient department, it is not.

Finally, we think that it is important for the Medicare Program, for the government to be a reliable and trustworthy partner to people who serve the Medicare population, and here again we think the current system falls short. The unpredictable and highly variable increases undermine confidence in the program. Yes, SGR controls spending, but only by compromising each of these other five important goals that we think should be included in the Medicare Program, and in our judgment that is a very high price to pay.

The CBO and Centers for Medicare and Medicaid Services (CMS) estimate that the cost of repealing SGR will be quite large. We have not had the opportunity to review those estimates in detail, the underlying assumptions, so I have no specific comment on the estimate. But we think it is important to keep in mind why the projected cost is large. The projected cost is large because the underlying baseline is so low.

The underlying baseline is based on the assumption that we will cut physician fees over the next several years by 17 percent. The underlying baseline assumes that the conversion factor for physicians, basically the price per unit of service, will be lower in the year 2005 than in 1993. It is because of this unrealistically low baseline that there is a large price tag for the policy that MedPAC recommends.

That cannot be a reason to avoid doing the right thing. The issue of volume in the Medicare Program is a critical issue. We think it is very important for the Committee to understand that the SGR system does not constrain volume per se.

The Sustained Growth Rate system controls total spending, but it fails to provide appropriate incentives at the level of the individual physician. Fees again are cut across the board as spending targets are exceeded. The individual physician is not rewarded in any way for exercising restraint in decisions about what to prescribe. The individual physician is not rewarded for being a conservative practitioner. That conservative practitioner of medicine is punished under the system just the same as the person that in-

creases volume inappropriately. That is a fundamental flaw in the system.

What will happen if SGR is not fixed? We think the initial signs may of trouble may be subtle. Initially we may see shorter, more rushed office visits for our seniors. Perhaps there will be an incentive to increase return visits or prescribe more procedures or tests. Eventually we might see a move to relocate certain services out of the physician office to other locations. If fees continue to remain very low or fall even further, we could begin to see access problems for Medicare beneficiaries. In the long run if Medicare fees stay out of whack, we could begin to see a fewer number of applicants to medical school, certainly fewer from our best or brightest young people or a shift away from specialties that are heavily dependent on Medicare.

All of these problems are serious problems and if they occur they will be difficult and costly to reverse in the future.

[The prepared statement of Mr. Hackbarth follows:]

Statement of Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission

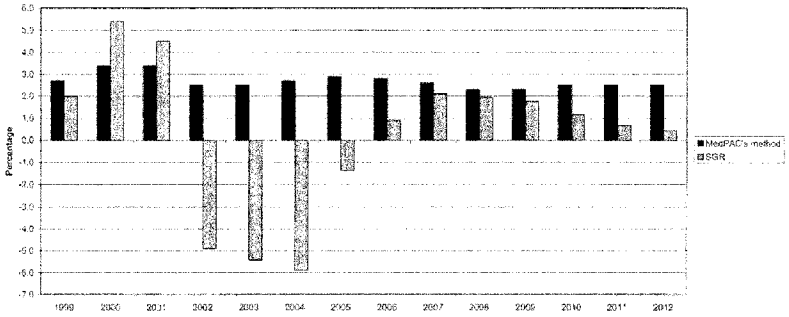
Chairman Johnson, Mr. Stark, Members of the Subcommittee. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss MedPAC's recommendations concerning payment for physician services in the Medicare program.

The current formula for updating physician payments, known as the sustainable growth rate system (SGR), should be repealed. We made this recommendation last year in our March report to Congress because the conceptual basis of the system is flawed and in June we warned of potentially large negative updates for 2002 and in the future. That future has arrived, and CMS now projects four years of negative updates. The basic problem is that in seeking to control spending, the SGR causes large swings in updates from year to year that are unrelated to changes in the cost of providing physician services. Although input price increases for physician services have been in the 2–3 percent range for the last few years, the SGR has produced payment updates of +5.4, +4.5, and −5.4 percent over the 2000–2002 period.

We recommend treating payment updates for physician services as we do payment updates for other services. Accordingly, we recommend that the Congress repeal the SGR and instead require that the Secretary update payments for physician services based on the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity. We also recommend that the Secretary revise the productivity adjustment currently used for physician services to make it a multifactor instead of a labor-only adjustment. Taking into account current estimates for input prices and productivity, we thus recommend that the Congress update payments for physician services by 2.5 percent for 2003.

Current estimates of updates using the SGR formula show three more years of negative updates for a total decrease of about 17 percent over the 2002–2005 period, a situation that is unsustainable (Figure 1). In addition, updates under the SGR will remain below estimated increases in the cost of providing physician services thereafter. Because the SGR is the current law, our recommendation—or any other action that corrects this problem—will show major budgetary costs. Nonetheless, maintaining access for Medicare beneficiaries and keeping physicians participating in the program and accepting new patients, will require that action be taken.

Figure 1: Updates under MedPAC's recommended method and the SGR, 1999-2012



Note: Updates based on MedPAC's recommended method are the MEI (excluding the labor-only productivity adjustment) less 0.5 percentage points for growth in multi-factor productivity.

Source: MedPAC analysis.

The problem with the current update system

Setting prices correctly in Medicare's payment systems is essential to maintain access to services for Medicare beneficiaries. The underlying problem with the current SGR system is that it attempts both to set individual prices accurately and to control total spending on physician services delivered to Medicare beneficiaries. These two goals can seldom be achieved simultaneously. The SGR attempted to achieve both goals and failed, as did the Volume Performance Standard system before it.

The SGR system causes payments to diverge from costs because, although the system accounts for inflation in input prices, productivity growth, and other factors affecting costs, it overrides these factors to achieve an expenditure target based on growth in real gross domestic product (GDP) per capita. If actual spending for physician services differs from the expenditure target, updates under the SGR system will diverge from costs. When this occurs, payments will be either too low, potentially jeopardizing beneficiaries' access to care, or too high, making spending higher than necessary. This is a particular concern given that the SGR system only applies to services paid for under the physician fee schedule. Services provided in physicians' offices are paid for entirely under the fee schedule, whereas when services are provided in other settings such as hospitals or ambulatory surgical centers, part of the payment is outside the fee schedule. Updates based on an expenditure target that fully applies to only one setting could create financial incentives that inappropriately influence clinical decisions about where services are provided.

An expenditure target approach, such as the SGR, assumes that increasing updates if overall volume is controlled, and decreasing updates if overall volume is not controlled, provides physicians a collective incentive to control the volume of services. However, this assumption is incorrect because people do not respond to collective incentives but individual incentives. An individual physician reducing volume does not realize a proportional increase in payments. Instead, the increase in payments is distributed among all physicians providing services to Medicare beneficiaries. If anything, in the short run an individual physician has an incentive to increase volume under such a system and the sum of those individual incentives will result in an increase in volume overall. In fact, CMS makes exactly that assumption when it estimates the so-called behavioral response of physicians to lower payments—which is an increase in volume of services provided.

Over a longer period, if payments were clearly less than physicians' marginal cost of providing a service, we might see physicians cut back their Medicare practice and concentrate on other patients, devote more time to other professional or leisure activities, or leave practice altogether. Ultimately, we could see fewer applicants to medical school or a shift in residency preferences away from those specialties most heavily dependent on Medicare. The result eventually would be decreased access for Medicare beneficiaries which would be very difficult to reverse.

Compounding the problem with the conceptual basis of the system, the SGR system produces volatile updates. Updates went from large increases in 2000 and 2001 of 5.4 percent and 4.5 percent, respectively, to an unexpected large reduction in 2002 of 5.4 percent. The recent volatility illustrates the problem of trying to control spending with an update formula. To control spending the update formula compares actual spending to an expenditure target. That target changed abruptly last year

because of two corrections. First, the Department of Commerce re-estimated historical GDP, which made prior physician spending growth too high by lowering the historical spending targets. Second, both actual and projected GDP went down since last spring, bringing down estimates of allowed future spending growth. In addition to corrections in the expenditure target, CMS found it had not counted some physician spending, correcting for that error increased actual expenditures and thus further increased the difference between actual and target expenditures. As a result of these corrections, CMS's estimates for the update in 2002 changed from −0.1 last March to −5.4 percent in November.

To address such problems, in our March 2002 report we recommend that the Congress replace the SGR system with an annual update based on factors influencing the unit costs of efficiently providing physician services (MedPAC 2002). The Commission's recommendation is based on a belief that getting the price right is important when making update decisions. If total spending for physician services needs to be controlled, it may be better to look outside the payment update mechanism, achieving appropriate use of services through outcomes and effectiveness research for example, as we suggested in our March 2001 report to the Congress (MedPAC 2001). If controlling total Medicare spending is the goal, then an approach that targets all of Medicare spending, not just physician spending, would be more appropriate. Below we describe how the Congress should replace the SGR system.

What should be done?

Replacing the SGR system would solve the fundamental problems of the current system and would allow updates to account more fully for factors affecting costs. The change also would uncouple payment updates from spending control and make updates for physician services similar to the updates for other services. This change would promote the goal of achieving consistent payment policies across ambulatory care settings, including physician offices, hospital outpatient departments, and ambulatory surgical centers. Accordingly, the Commission recommends that:

> **The Congress should repeal the sustainable growth rate system and instead require that the Secretary update payments for physician services based on the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity.**

To replace the SGR system, the Congress could repeal provisions in current law and replace them with language similar to that for other services. For example, the Social Security Act requires updates for inpatient hospital care to equal the increase in the hospital market basket index, except when the Congress chooses to make the update smaller or larger. The Congress generally makes these choices after considering advice from MedPAC and the Secretary. With a similar update method for physician services, the Commission intends to base its advice to the Congress on assessments of payment adequacy such as the one discussed later in this testimony.

Payment updates should take into account productivity improvements that enable physicians to provide care more efficiently. Revising the productivity adjustment to account for labor and nonlabor factors is consistent with the way physician services are produced. Labor accounts for most of the cost of providing physician services, but capital inputs are also important, including office space, medical materials and supplies, and equipment. The production of physician services, like the production of most other goods and services, is a joint effort that requires both labor and nonlabor inputs.[1] Therefore the Commission recommends that:

> **The Secretary should revise the productivity adjustment for physician services and make it a multifactor instead of labor-only adjustment.**

Productivity gains are certainly possible in physician services and should be taken into account. For example, research suggests that doubling the size of a physician practice (from the current average of about 2.5 physicians to 5 physicians) increases productivity by 9 percent with no increase in practice expense per physician (Pope and Burge 1996). Physicians apparently perceive the advantages of group practice: in 1990, 52 percent of self employed physicians were in solo practice, but by 1998, that percentage had dropped to 42 percent. Other gains might come from new technology, economies of scale, managerial skill, and changes in how production is organized.

In other health care delivery settings such as hospitals, MedPAC assumes that cost savings from improved productivity are usually offset by cost increasing factors such as scientific and technological advances or complexity changes within service

[1] The labor-only adjustment may simply be an artifact. It has been part of the MEI since the index was first used in paying for physician services in 1975, which was before the Bureau of Labor Statistics (BLS) began publishing measures of multifactor productivity in 1983.

categories. However, Medicare's payment system for physician services accounts for those cost increasing factors by either, creating new billing codes or revising existing codes in the physician fee schedule, or by recalibrating the fee schedule's relative weights every five years. Thus, those cost increases do not offset cost decreases from productivity and productivity must be accounted for separately.

Productivity growth is the ratio of growth in outputs to growth in inputs. Measuring productivity growth requires detailed information on the personnel, facilities, and other inputs used and on the quantity, quality, and mix of services (outputs) produced. Because such data are generally not available, MedPAC has adopted a policy standard, 0.5 percent, for achievable productivity growth that is based on growth in multifactor productivity in the national economy. Such a measure should be used in the physician update as well.

In making its update for physician services in 2003 MedPAC considered three things: the adequacy of Medicare physician payment in 2002, the inflation in input prices projected for 2003, and an adjustment for multifactor productivity. Although payments for physician services have not kept pace with the change in input prices since 1999, MedPAC recommends no adjustment for payment adequacy at this time, pending collection of further data. The other components of the update are the estimate of the change in input prices for 2003, which is 3.0 percent, and MedPAC's adjustment for growth in multifactor productivity, which is 0.5 percent. Therefore:

The Congress should update payments for physician services by 2.5 percent for 2003.

Our assessment of the first two components of our update, payment adequacy and inflation in input prices, is discussed briefly in the following sections.

Assessing payment adequacy

Is the current level of Medicare's payments for physician services adequate? The information available to answer this question is limited and better measures of payment adequacy are needed. We lack information on the cost of physician services, so we cannot compare Medicare's payments and costs the way we can for other services, such as hospital care. However, we do have information about several other factors that allow us to judge the adequacy of payments. This information includes data on the number of physicians furnishing services to Medicare beneficiaries, physicians' perceptions of the Medicare program and their willingness to furnish services to beneficiaries, and information from surveys of beneficiaries on their ability to obtain care and their satisfaction with the care received. However, because it takes some time for providers to respond to changes in payment, these indicators may lag behind payment changes and must be interpreted carefully. Additional measures of payment adequacy are needed that are sensitive to possible short-term effects of inadequate payments, such as the duration of office visits and changes in the volume of services.

Available information suggests that, as of 1999, payments were not too low. From 1999 onward, we have very limited data; we do know, however, that payments did not keep up with increases in input prices. This suggests that payments for 2002 could be too low, raising concerns about beneficiaries' access to care. We will not know if payments are too low until we have further information on payment adequacy. One source of that information will be MedPAC's newest survey of physicians which will be fielded this spring.

Entry and exit of providers

Data on provider entry and exit yield information regarding the adequacy of current payments. Rapid growth in the number of providers furnishing services to beneficiaries may indicate that Medicare's payment rates are too high. Conversely, widespread provider withdrawals from Medicare could suggest that the rates are too low.

Counts of physicians billing Medicare show that the number of physicians furnishing services to beneficiaries has kept pace with growth in the number of beneficiaries. From 1995 to 1999, the number of physicians per 1,000 beneficiaries grew slightly, from 12.9 to 13.1.

Physician willingness and ability to serve Medicare beneficiaries

MedPAC's 1999 survey of physicians suggests that physicians were willing and able to serve beneficiaries.

- Only about 10 percent of physicians reported any change between 1997 and 1999 in the priority given to Medicare patients seeking an appointment. Of those changing their appointment priorities, the percentage that reported giving Medicare patients a higher priority was almost the same as the percentage that assigned Medicare patients a lower priority.

- Only 4 percent of physicians said that it was very difficult to find suitable referrals for their fee-for-service Medicare patients, a finding comparable to the percent who reported problems referring their privately insured fee-for-service patients.

One of the most important findings of the survey was that, among physicians accepting all or some new patients, more than 95 percent said they were accepting new Medicare fee-for-service patients—a finding consistent with the results of another recent survey.

While these findings are positive, many doctors participating in MedPAC's survey expressed concerns about payment levels. About 45 percent said that reimbursement levels for their Medicare fee-for-service patients were a very serious problem although, even more, about 66 percent, said that HMO reimbursements were a very serious problem.

Beneficiaries' access to care

Another way to assess the adequacy of payment rates is to evaluate beneficiaries' access to and quality of care. Evidence of widespread access or quality problems for beneficiaries may indicate that Medicare's payment rates are too low. Access and quality measures are often difficult to interpret, however, because they are influenced by many factors. Access to care for specific services, for example, may be influenced by beneficiaries' incomes, secondary (medigap) insurance coverage, preferences, local population changes, or transportation barriers, all of which are unrelated to Medicare's payment policies.

Access to care was not a problem in 1999, according to data from the Medicare Current Beneficiary Survey. The percentage of beneficiaries reporting trouble getting care (4 percent) was low and essentially unchanged from previous years. The data also show that beneficiaries were overwhelmingly satisfied with the care they received. We will continue to track these indicators as newer data become available.

Accounting for cost changes in the coming year

Given the information about the adequacy of the current level of payments, the next step in determining payment updates is to ask how much costs will change in the coming year. Several factors will affect the cost of physician services, but the most important one is inflation in input prices. The available measure—the MEI—has two problems, but the Secretary can correct them. Other factors that may increase costs include scientific and technological advances and the regulatory burden of the Medicare program, including the burden of compliance with requirements of the Health Insurance Portability and Accountability Act of 1996. These other factors are likely to have small or unmeasurable effects on costs. The remaining factor—productivity growth—will reduce costs. Using appropriate measures of inflation and productivity growth, it appears that the cost of physician services will increase by 2.5 percent during the coming year.

Measuring inflation in input prices The MEI is the SGR system's measure of input price inflation. It is calculated by CMS as a weighted average of price changes for inputs used to provide physician services. Those inputs include physician time and effort, or work, and practice expense. Physician work, which accounts for the time, effort, skill and stress associated with providing the service, has a weight of 54.5 percent; the remaining 45.5 percent is allocated among categories of practice expense. Practice expense includes support staff wages and benefits, office expense, medical materials and supplies, professional liability insurance, medical equipment, and other professional expenses, such as private transportation.

Although the MEI is analogous to the market basket indexes used to update payments for inpatient hospital care, it currently differs from those indexes in that it includes an adjustment for productivity growth. Productivity growth is an important factor and MedPAC believes that it should be considered separately in update decisions. This would allow input price indexes to account only for changes in prices, not other changes in cost.

As used in the SGR system, the MEI also differs from the market basket indexes in that it is not a forecast of the change in input prices for a given year, but a measure of input price inflation for the previous year. To allow payment updates to anticipate changes in costs during the coming year CMS should use a forecast of the MEI when making payment updates for physician services.

By removing the productivity adjustment and making it a forecast, the MEI would become a better measure of input price inflation. So modified, the index shows that input prices for physician services are expected to increase by 3.0 percent in 2003.

Other cost-increasing factors

The cost of physician services may increase because of factors other than changes in input prices. The overall effect of these factors is likely to be small, however. As noted the costs of scientific and technological advances are already accounted for in the physician fee schedule when new billing codes are created or existing codes are revised.

Other factors increasing costs are difficult to measure. For example, the regulatory burden of the Medicare program is an important concern of physicians. Nevertheless, estimates of the cost of this burden are not available. One way to account for any measurable increases in cost due to these factors is to assess payment adequacy, as described earlier, and adjust payments accordingly in future updates.

Chairman JOHNSON. Thank you very much, Mr. Hackbarth. That was a very thorough explanation, I think, of the multiple goals that we have in our effort to reimburse physicians and of the depth of concern that we ought to have about the SGR formula and the impact it is having.

There are a couple of things I would like to bring up. The first one is a very brief question to Mr. Crippen. You say that spending on entitlement services Social Security, Medicare, and Medicaid will increase from 7 to 14 percent of the GDP. Do you have any idea what percentage of expected revenues that will be?

Mr. CRIPPEN. At the moment, we believe revenues will average about 19 percent of GDP during this decade and in the foreseeable future, given the way the Tax Code is constructed. Revenues can creep up over time, as they did in the recent past, to a little over 20 percent of GDP. The reduction in taxes that you all enacted last year will reduce that share to 19 percent over the current decade. So revenues will fluctuate somewhere between 19 percent and 20 percent of GDP for the very long term.

Chairman JOHNSON. So if this goes from 7 percent to 14 percent of GDP, what percentage of the expected revenues do you imagine that would be?

Mr. CRIPPEN. It would take 14 or 15 percentage points 19 percent. So it would be taking the lion's share, or three-quarters.

Chairman JOHNSON. So it would be taking 15 percent of the 19 percent of expected revenues?

Mr. CRIPPEN. Yes. About three-quarters.

Chairman JOHNSON. Leaving less than 25 percent for all other functions by the year 2030?

Mr. CRIPPEN. Right, if taxes were not raised or debt did not go up dramatically.

Chairman JOHNSON. Thank you.

Second, I wanted to ask whoever cares to comment on the following question. First of all, we do see that this formula has very different impacts on different physician groups, that some are receiving quite generous increases over time and some are receiving very steep reductions. The second thing that I see eclectically out there, and I wonder if you can look at this in your data, is that I see a very disparate impact on senior access to service, depending on how Medicare reimbursements interact with Medicaid policy and State decisions about whether or not to replace the 20 percent copayment, which is now a voluntary choice that States are making.

Let me be a little clearer. In some of the urban areas of Connecticut where the State is not replacing the 20 percent, urban physicians have large patient load being paid at the Medicaid rate, which is low, and then they have an unusually large number of Medicare patients now associated with a 5 percent cut in reimbursement rate and next year an additional cut. Most of these same physicians also have a suburban office. In their suburban office they are not seeing nearly as many Medicare patients and not nearly as many Medicaid patients.

So I am literally seeing before my very eyes public reimbursement policy driving care out of our inner cities, and I wonder whether any of your research into the impact of reimbursement rates is beginning to pick up this kind of data. I consider it probably the most serious impact of our reimbursement formulas on access to care for seniors and poor people, and yet I don't see it emerging from the materials that I am reading. Mr. Hackbarth.

Mr. HACKBARTH. None of the data I have seen is that refined that it would detect the sort of problem you have identified. The access data that we have reviewed at the Commission is at a higher level and shows in general good access to care for Medicare beneficiaries as 1999.

Those are the most recent data we have available. We will shortly be getting more up-to-date information, but in general access has been good.

Chairman JOHNSON. My understanding of that data that you have from 1999 is that there is a factor in it that shows that 45 percent of the physicians in 1999 are not happy with Medicare. Now, on average it is good but when you have 45 percent 2 years ago, unhappy, and now we are cutting their reimbursements in an environment in which their malpractice premiums are soaring, their nursing costs are going up and other factors affecting practice costs, including the need to invest in new technology for just office management, never mind for diagnosis. Do we have any way of getting at more current data about the real impact of the 5 percent cost on physicians and particularly on the physician decision as to where to practice?

Mr. HACKBARTH. Well, dissatisfaction among physicians about Medicare is certainly widespread, in particular in certain specialties. As you indicated, the impact of moving to the Resource Based Relative Value Scale (RBRVS) system has been differential across specialties. That was intentional, and certain specialties have experienced significant economic losses.

By the same token, though, many physicians are also dissatisfied with other payers. So Medicare is not unique in this regard by any stretch. The decision not to participate, not to see Medicare patients or not to accept new patients is different, though, from a decision whether to be dissatisfied or not. So there is not necessarily a direct correlation between that 45 percent or even an increase in dissatisfaction levels with an immediate decision not to see Medicare patients. There are two separate issues.

Chairman JOHNSON. Does your data allow us to look at the physician situation in those specialties that are most likely to serve elderly because it is not even across the specialties and of course there is going to be less dissatisfaction? If you are in a specialty

that has a relatively modest Medicare load, it is going to be different in not only a specialty that has a high Medicare load but for an older physician whose patient base has probably aged with him? Do we have the ability to look at the variable impact from those points of view?

Mr. HACKBARTH. We can look at it more specifically by specialty, and I would be happy to work with our staff on that. I think that is a legitimate and important question, but one of the dilemmas that you face if you are a physician practicing in a specialty dependent on Medicare is, well, where do I go if I don't see Medicare patients? If in fact it is a specialty that disproportionately cares for elements of the elderly, it is not like they can start seeing children as their alternative.

And so they are in a bit of a box in that sense, and that is a reason why we don't necessarily think the first order effect of these constraints will be for physicians to say, well, I am not going to see a Medicare patient. The first response might be in fact to say, well, to make up for lost income, I am going to have them come back more frequently or I am going to do an extra procedure or test, and again that is one of the critical failings of the SGR system.

All of the constraints are in the aggregate, not for the individual physician, and so perversely we could see that one of the indications that this series of cuts is doing real harm is an increase in volume for return visits, more procedures, more tests. The proponents of SGR will say, look, we told you so, we need this volume constraint, but in fact the increasing volume is a sign of distress.

Chairman JOHNSON. Thank you. I think that is a very important point. I think also we do need to pursue this issue of more detailed data because increasingly physicians are choosing to go to some other specialty or leave medicine at a remarkably young age, and while the data is small yet, depending on the specialty, that could have an enormous impact on senior access to critical physician services.

So we need to know a lot more about this because it is beginning to invade, in my estimation, senior access, and we are right on a point where we are going to see the interaction of the payment systems, the two publicly funded payment systems, really affect senior access. But I will not pursue this because my time has expired. Mr. Stark.

Mr. STARK. Dan, CBO estimated that the MedPAC recommendation would cost us $126 billion over 10 years, and did that include spending increases driven by volume? In other words, can you elaborate on that? When you did the $126 billion, did you just take the suggested increase and put it out or did you make any estimate as to change in aggregate spending?

Mr. CRIPPEN. I think we included volume increases. Let me consult my colleague. Yes, we did.

Mr. STARK. OK. Any idea of how much of that $126 billion would be due to volume and intensity as opposed to . . .?

Mr. CRIPPEN. It looks like what we added was about 1 percentage point-of-increase for each year, on average, as a result of volume and intensity.

Mr. STARK. And how much through——

Mr. CRIPPEN. The price increase?

Mr. STARK. The price increase?

Mr. CRIPPEN. Well, the total increase would have been the MEI. So we took the MEI plus 1 percent.

Mr. STARK. What is MEI averaging?

Mr. CRIPPEN. I am going to defer to my colleague here.

Mr. STARK. That is all right.

Mr. CRIPPEN. You have MEI data on

Mr. HACKBARTH. For what period?

Mr. CRIPPEN. The next 10 years. It has got to be 2.5 percent or 3——

Mr. HACKBARTH. Two to three percent.

Mr. STARK. Two to three percent. So you are talking maybe two for MEI and maybe another point on top for volume, and really isn't that what we have averaged over the last 10 years or so? Albeit we had a chart here somewhere, but it seems to me over the last 10 years we have paid 33 percent in increases, so the average annual in physician updates from 1992 up has been 2.6 percent. So I guess you guys are both talking, Mr. Hackbarth and Mr. Crippen, the same amount whether we pay it as we are currently doing it or whether we change it. Is that a fair assumption, that we are really not talking about great changes, although you suggest, Mr. Crippen, that it would be $126 billion more; so when you are dealing in these small percentages, a 10th of a percent here or there makes a major difference at least in your——

Mr. CRIPPEN. And part of the dilemma is that the current system—the SGR mechanism—would reduce payments for the next 2 or 3 years to catch up for the overpayments in 2000 and 2001. So if you just removed that effect of the current system and went back to roughly the increase in the MEI, then of course you would have something similar, but you would not recoup those payments that were made earlier.

Mr. STARK. Now, the President has proposed making these payment changes, whatever payment changes we make, on a budget neutral basis, so what I would call a zero sum game, as it were, and each year you give us savings options. Have you analyzed the options that we could use to provide this extra $126 billion? Quickly what are the—where would you tell us to go?

Mr. CRIPPEN. The physicians' fees are a component of Medicare part B Supplementary Medical Insurance, and there aren't many places to go here unless you change the underlying differential fee structure. In part B, 25 percent of costs will be paid by beneficiaries and 75 percent by general revenues, which leaves you part A if you are going to glean savings inside Medicare. You could in theory, cut hospital payments, but that hasn't been very successful either, so then you have to go outside of Medicare, into other entitlement programs. Presumably, under the current pay-as-you-go rules, you would go to other entitlement programs or raise taxes.

Mr. STARK. Just one question. I noticed in your testimony, Mr. Hackbarth, you got into the idea of incentives and not wanting a fee schedule to encourage one to use a procedure or not use a procedure. Now, I presume you practiced law at some point and shouldn't a lawyer, it may not always happen this way but at least according to the theory that you learned in law school, who takes a pro bono case, say, for the environment or criminal defense do

just as good a job as somebody who is getting a hundred bucks an hour for that same type of work?

Mr. HACKBARTH. Yes, sir.

Mr. STARK. And I have always felt it cuts both ways, that for a long time we tried to hold down overutilization. Now we have got managed care plans and we are sort of trying to prevent underutilization, where the pendulum swings. Don't you think that whatever we do, and I am taking issue with this idea of incentivizing, and I will just finish my question and then shut up, Madam Chair, that we ought to be sure there is no incentive one way or the other for a physician to make clinical decisions based on reimbursement, that that ought to be our goal, that the reimbursement ought to try to be as separated as possible from the clinical decisions the physician makes relative to his or her patients?

Mr. HACKBARTH. Yes, that should be the goal and it is one of the failures of SGR as we see it because it only applies to part of the system.

Mr. STARK. It is also a failure of the fee-for-service system in general, isn't it?

Chairman JOHNSON. Very important point.

Mr. HACKBARTH. It is an elusive goal.

Chairman JOHNSON. Mr. McCrery.

Mr. MCCRERY. Thank you. Mr. Crippen, in your data concerning the amount of GDP that we will consume with Medicare, Medicaid, and Social Security in 2030, you don't mention what percentage of GDP will be consumed by interest on the debt. Do you have some idea what that would be in 2030?

Mr. CRIPPEN. In our 10-year baseline, it would be pretty small because we don't increase debt by much; we have the current level of debt and then come 2005 or 2006, we start paying it down. So by 2010—again, in our baseline—we would have virtually no debt outstanding, so there would be no interest at that point and no interest payments.

Mr. MCCRERY. You have no debt outstanding in 2030?

Mr. CRIPPEN. Our baseline only goes for 10 years and as you well know, the precision of even that is questionable. But over that 10-year period, we return in the baseline to an era of surpluses, unified-budget surpluses, that will pay down debt held by the public. So sometime not long after 2010 in our baseline most of the debt held by the public will be redeemed.

Mr. MCCRERY. And you told Mrs. Johnson that we are spending about 19 percent of GDP. Actually that is down probably now to closer to 18 percent, isn't it, with the recession and——

Mr. CRIPPEN. It could well be. My guess is that we are going to end up collecting revenues and outlays equaling about 18.5 percent to 19 percent of GDP this year. It is going to be very close to balance, as you know. So the revenues are going to about equal what we are spending.

Mr. MCCRERY. And historically spending has been around 18 percent of GDP, hasn't it?

Mr. CRIPPEN. Revenues have been, since World War II, about 18 percent of GDP. Spending has fluctuated around that level in the past few years—sometimes up above it but then, in our most recent history of surpluses, slightly below revenues. But revenue

collections since World War II have averaged about 18 percent of GDP.

Mr. MCCRERY. So in 2030 we will have precious little left to spend on national defense, on roads, highways, transportation, environmental protection, justice, courts?

Mr. CRIPPEN. Exactly.

Mr. MCCRERY. Can you foresee a time when Congress would allow that to happen?

Mr. CRIPPEN. I don't know, Mr. McCrery.

Mr. MCCRERY. Can you foresee the Congress only spending about 3 or 4 percent of GDP on all the other priorities of the Federal Government?

Mr. CRIPPEN. No.

Mr. MCCRERY. No, of course not. So something is going to have to give.

Mr. CRIPPEN. Exactly.

Mr. MCCRERY. As you pointed out, we will either have to raise taxes or go into debt or I think more likely we will ration health care to control spending. I think that is where we are headed, is explicit rationing of health care, and it won't be just Medicare by the way. We will have a payroll tax for everybody's health care. Everybody will be on Medicare, I think, and we will limit explicitly the health care that people can receive. I think that that is where we are headed clearly and your numbers underscore that. Therefore, I am somewhat troubled by your statement that you don't mean to say there is a crisis and nothing that needs to be addressed today. Isn't it a fact that the sooner we impose some kind of solution to the ever growing increases for Medicare, the better off or the better chance we will have to control those costs over the long term?

Mr. CRIPPEN. Absolutely. What I was trying to do was not characterize this picture as in any way my opinion, but rather as a view of the facts as we understand them at this point. I also want to make sure that it is understood, and I know you understand—the Committee does, that there is no peril here for Medicare recipients in your consideration of changes to current benefits. Benefits of current beneficiaries—my parents' benefits—are not what we are talking about. We are talking about my benefits, paid by my children, so I don't want to leave anyone with the impression that there is a pending crisis that we need to solve today. Certainly, any action we take now will help much more than action we delay.

Mr. MCCRERY. Exactly. I mean I would hope we would look beyond the ends of our noses and consider the burden that our children will bear for us and their children for them if we don't do something today. So I think there is a crisis. I believe that we are fiddling while Rome is burning not only for Medicare but for Medicaid and for Social Security. We know it and shame on us for not proceeding with a solution that will give us some hope for controlling these costs in the future and continuing to provide the array of services the Federal Government always has and always will provide.

Chairman JOHNSON. Thank you, Mr. McCrery. Mr. Kleczka.

Mr. KLECZKA. Thank you, Madam Chairman. Madam Chair, I have a series of questions for Chairman Hackbarth and some are

specific, coming from physicians from Wisconsin, the district I represent. So if it is possible, what I would like to do is submit these in writing to you

Mr. HACKBARTH. Sure.

Mr. KLECZKA. And if you could review them and send back a response. Thank you very much. Thank you, Madam Chair.

Chairman JOHNSON. Would you like that response shared with the Committee?

Mr. KLECZKA. I will share it.

[The information follows:]

Medicare Payment Advisory Commission
Washington, DC 20006
March 18, 2002

Honorable Jerry Kleczka
U.S. House of Representatives
2301 Rayburn House Office Building
Washington, DC 20515–4572

Dear Congressman Kleczka:

Thank you for your letter concerning Medicare's payments for physician services. You asked us about payments for practice expense and professional liability insurance under the physician fee schedule. You also asked us about expenditure targets, the frequency of physician encounters, and the productivity adjustment in payment updates.

Question:

Medicare reimbursement for practice expense and malpractice insurance may be below the real costs physicians incur. For example, at St. Luke's Hospital in Wisconsin, heart surgeons often employ staff who assist them in the hospital. These local surgeons have told me that most of these costs are not reimbursed. Are you concerned that the reductions in practice expense payment will hurt quality as surgeons cut back on staff they can no longer afford? Why aren't hospitals providing this staff? Is this included in the hospital reimbursement rate? Or, is it reimbursed separately to the surgeon?

Your practice expense questions address the issue of whether payments for practice expense should account for the cost of support staff that surgeons bring to the hospital. These staff prepare patients for surgery, assist during procedures, and provide post-operative care.

The position of the Centers for Medicare and Medicaid Services (CMS) is that Medicare should not pay for the cost of these staff under the physician fee schedule because:

- Payments for the cost of these staff are included in payments to hospitals under the inpatient prospective payment system, and Medicare should not pay twice for these costs.
- It is not typical for most physicians to use their own staff in facility settings.
- Payment for these costs is inconsistent with the Medicare statute and regulations.

As you know, cardiothoracic and other surgeons contend that practice expense payments should cover the cost of support staff, when used in a facility, because hospitals are perceived as no longer providing the staff that are necessary.

It appears that this issue will be resolved soon. CMS has asked the Office of the Inspector General (OIG) to assess the staffing arrangements between cardiothoracic surgeons and hospitals, and the OIG is finishing its report now. We anticipate that CMS will use the report's findings to change current policy, if necessary.

Question:

Is MedPAC tracking the changes in costs of liability insurance that appear to be escalating this year (for at least some specialties)? How do you think the fee schedule should be adjusted in light of these changes in total costs and relative costs among specialties?

MedPAC agrees that the physician fee schedule should account for changes in input prices, including increases in professional liability insurance (PLI) premiums. That does not occur under the current method for updating payment rates, however. Instead, the sustainable growth rate (SGR) system overrides changes in input prices

to achieve an expenditure target. To solve this problem, the Commission recommends that the Congress repeal the SGR system. In its place, we recommend an update method based on the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity

Question:

In the past, there has been a presumption that expenditure targets would somehow influence individual physician behavior, and therefore, outlays. Does MedPAC believe that individual physician decisions can be affected by total expenditure targets?

Your question about expenditure targets and physician behavior addresses one reason why MedPAC recommends that the Congress replace the SGR system. The Commission believes that expenditure targets can influence the behavior of individual physicians but not in the way that those designing the targets intended. It was hoped that the targets would give physicians an incentive to control the volume of services. Instead, we believe that the reverse occurs. With expenditure targets, physicians have an incentive to increase volume, in the short run, to make up for lost income when payment rates are reduced. In fact, CMS makes exactly that assumption when it estimates the so-called behavioral response of physicians to lower payments—which is an increase in the volume of services provided. Over a longer period, expenditure targets can have other undesirable consequences. If payments fall below costs, we might see physicians cut back on their Medicare practice and focus on other patients. Alternatively, they could devote more time to other professional or leisure activities, or leave practice altogether.

Question:

Does MedPAC intend to analyze changes in frequency of physician encounters between specialties? Would these trends be important?

On your question about whether MedPAC intends to analyze changes in the frequency of physician encounters among physician specialties, we will continue to assess the adequacy of Medicare's payment rates for physician services with whatever data are available. Analyzing changes in the volume of services, including changes in volume by physician specialty, is one way to assess payment adequacy. In our March 2002 report to the Congress, we considered other factors—beneficiaries' access to care, physician willingness to furnish services to beneficiaries, and entry or exit of physicians from participation in the Medicare Program.

Question:

In regards to productivity, does the MedPAC recommendation assume that productivity changes are the same, or close to it, among all types of physicians, including surgeons, medical specialists, and primary care physicians?

You are correct that the productivity adjustment in payment updates applies to all services uniformly and, therefore, to all physician specialties. This is true of the current productivity adjustment for physician services and the adjustment that MedPAC recommends. The question is whether payment rates can account for any changes in productivity that are unique to specific specialties. We believe the answer to this question is yes because payment updates are not the only way that payment rates change. Payment rates also change when the fee schedule's relative weights are recalibrated. This occurs every year, if billing codes are revised, and every 5 years, when CMS reviews the accuracy of the relative weights. As long as recalibration is sensitive to changes in cost due to productivity growth, it accounts for changes in productivity that are unique to specific specialties. It is likely that recalibration is this sensitive because, by law, the process considers changes in medical practice, coding changes, new data, and the addition of new procedures.

If we can be of further assistance, please do not hesitate to contact us.

Sincerely,

Glenn M. Hackbarth, J.D.
Chairman

Chairman JOHNSON. Thank you. Mr. Crane.

Mr. CRANE. Thank you, Madam Chairman.

Mr. Crippen, the CBO projects nearly 20 percent in payment cuts over 4 years, a number that is greater if you count inflation, and I am sure I am not alone when I say that I have been hearing from

numerous providers in my district who are upset about the recent payment cuts in the physician fee schedule. I am hearing that many of them can no longer afford to participate in the program and are considering leaving if something isn't done. In fact, I just saw a recent survey released by the North American Spine Society that says 48 percent of physicians will be accepting fewer new Medicare patients, 35 percent will see fewer Medicare patients, and 6 percent will leave the Medicare Program altogether.

Does the CBO model cited in your prepared statement make any adjustments for the possibility that, as with Medicaid, many physicians will not continue to accept Medicare patients?

Mr. CRIPPEN. I think the answer, Mr. Crane, is no, or not to any great extent. Let me refer to Appendix D in your Committee's Green Book which has a lot of information on Medicare; as I recall it is Table D–121. The only reason I have a sense of which table it is because I looked at it over the last day or two. It shows assignment rates—both the number of physicians or percentage of physicians accepting assignment but also equally important, the number of dollars spent by Medicare part B under assignment. And those numbers, of course, as my colleague said earlier, were quite high in 1999, and one would expect they might go down.

But the point that this table makes is that we had much lower levels of assignment and participation even as recently as 5 years ago, or a few years ago, when payment rates were being cut. I don't know what to make of all of this other than to say that we had 99 percent assignment and in 1999 or thereabouts—or rather, 98 percent—and we have had 80 percent participation in the recent past.

I don't know what the right standard is. Do we want to shoot for 99 percent participation? That may be a little high, frankly, if you have to resort to the highest common denominator to pay for these services.

But I am not here to suggest what the right standard is. Rather, I am suggesting that these data and recent history say that at least for the next few years, we wouldn't anticipate that a fall-off in physician participation would change Medicare spending by much. That is, we don't think that patients, or beneficiaries, are going to be denied care because of the lack of physician participation. That is a long answer to your question.

The short answer is that CBO assumes that a sufficient number of physicians for all Medicare recipients will participate over the 10-year budget period and our projections will be based on that.

Mr. CRANE. Thank you. I yield back the balance of my time.

Chairman JOHNSON. Thank you, Mr. Crane. Congresswoman Thurman.

Mrs. THURMAN. Thank you, Madam Chairwoman. Let me follow up on his question, because that would generally be across the country and not necessarily State specific.

Mr. CRIPPEN. Right. As I recall, your tables also have State-by-State numbers on assignment rates and on assigned costs.

Mrs. THURMAN. But access.

Mr. CRIPPEN. Sure; it varies.

Mrs. THURMAN. That is one of the areas that, being from Florida, that I am getting very, very concerned about. And I had an op-

portunity similar to other Members who have talked to physicians as to what is going to happen in States like Florida. We are already understanding that we have got problems with even bringing people into Florida.

Their first question to a practice might be what is your percentage of Medicare? Because if they say it is high, then they are concerned that with these failing numbers for them, that what good is it to go there? We would rather go someplace, compete in Georgia or someplace else on the Sun Coast. What is the question to them? What do you say to them? What am I going to say to these constituents?

Many of us are on the bill that Mr. Dingell and Mr. Tauzin and others have put out there, but we are seeing long waits. We can't get people to come into Florida.

And then the second question that I would ask really has to do with the Medicare+Choice issue, too, because Dr. Ginsburg is going to testify, and he actually mentions now that doctors have an opportunity to negotiate with some of these Medicare+Choice programs, and in fact are getting higher or being able to get more dollars out of there. Are we then putting an imbalance into our Medicare program where some may just gravitate to those programs and may leave more other areas uncovered in some of our rural areas or areas where there are no Medicare+Choice programs? Either one of you.

Mr. CRIPPEN. I can start with the second one. At least by our lights and looking at future payments for Medicare+Choice, CBO anticipates, frankly, that there is going to be a fall-off in enrollment in those plans. Payment rates are going to be quite limited in most areas for the foreseeable future. So our projections certainly don't anticipate that we will have a migration from the fee-for-service program to Medicare+Choice. In fact, we assume quite the opposite.

Mr. HACKBARTH. On that particular issue, it is our belief that Medicare+Choice is not going to be a large and important part of the program in rural areas. The efforts to make it so through floor payments and the like have not succeeded and in our view will not succeed. In fact, managed care is not prevalent in rural areas in the non-Medicare population, and so there is little we can do in Medicare to alter that basic reality.

As for the overall Medicare+Choice program, whether it grows or not, certainly the recent trend, as Dan said, is down. Whether that reverses, in my view, will depend a lot on whether managed care organizations change how they do business. One of the reasons, in my view, that they are struggling is that they have stripped away a lot of their cost controls, expanded choice, and reduced the utilization controls to become more like fee-for-service. It is not surprising that they can't compete with Medicare.

Mrs. THURMAN. So let me just say this, then. If the $126 billion is what you said would bring us up to the right rates or at least bring us into line so we can actually take the dollars that we have put into the Medicare+Choice programs over the last couple of years to prop them up and move them over into the system, that would actually make us somewhat neutral in this budget, at least for this first year.

Mr. CRIPPEN. I think that we are still paying—and I say "think" because we have to look at the current formulations—but I think we are still paying Medicare+Choice less than we would pay under the equivalent fee-for-service program in a lot of areas in the country. So it may be a net cost from actually moving people from managed care

Mrs. THURMAN. Not necessarily moving them, but obviously that number has decreased. It went from 15 to 12 percent. We gave an additional amount of dollars over the last couple of years. I think there is some idea that we might do some more again this year. It just seems to me that we might be better off to keep physicians who are in Medicare fee-for-service at a level that they can continue to do their practices, not cutting off services, not have waiting lines for 3 months being able to bring people in, as versus putting it into Medicare+Choice.

Mr. CRIPPEN. One of the ways in which you and the country have tried to grapple with this incentive question for physicians on payment versus volume—how you get the incentives right—has been capitation, or something like the approach that you see inside some managed care systems, in which the decision to treat or not to treat is not based on physician income, or at least not on the price of that particular service; rather, the payment is for a year of "unlimited" service. So by raising more fee-for-service payments, you may exacerbate the dilemma that you are facing in the overall question here.

Chairman JOHNSON. Thank you, Congressman Camp? Congresswoman Dunn.

Ms. DUNN. Thank you very much, Madam Chairman. Gentlemen, I bring to the table the same complaints that I bring in all of these hearings that we have, and it is about the incentives in this program that result in a State like my State, Washington State, which is very efficient in the delivery of health care being penalized because of its strong history. So I have physicians at home not only worried about the 5.4-percent reduction in their reimbursements but in the reimbursement system as a whole.

So my question to both of you is, as we develop a new system, a new SGR, whatever we are going to call it, how are we going to begin to balance States like Washington, with States like New York?

Mr. HACKBARTH. Well, the reasons for different levels of spending in different parts of the country are quite complicated and, frankly, not all that well understood. Some are obvious. Some have to do with a different standard of living, different wage levels. And in the Medicare Program, as you know, we adjust using a wage index for all the different services to varying degrees. So if you happen to be in a State where wage levels tend to be lower than, say, New York, the Medicare payment formulas result in lower spending. But that is only part of the issue.

Perhaps an even bigger part of the problem might be differences in utilization patterns, which could be because of greater efficiency or could be because of differences in the underlying health status of the population, differences in tastes about medical care, different attitudes toward risk, and the like. It is a really complicated problem that has not been disentangled to this point.

If our goal were to equalize spending across States, across cities, whatever geographic unit you describe, we would need a very different health care system to produce that uniformity. One of the virtues of our system, at least in the eyes of many people, is the degree of freedom that gives both patients and providers, the autonomy it gives them. Such a system is very unlikely to produce uniform results. So if you want uniform results, you need a much more controlled, centrally controlled system than we have, and that brings with it its own potential problems.

Mr. CRIPPEN. I think, Congresswoman, you are absolutely right that there are some States that historically have had lower per capita costs—for example, in the Northwest, in Minnesota, and in others that in some sense early on had managed care. And so because we have no better basis, we have established payments based on historical expenditures. And those historical expenditures were lower in some States than in others.

Until we switch from a system that pays for inputs, based obviously on historical costs, to something that might pay for outcomes, or results, it is going to be hard and—and this is not a political matter—hard to figure out a system that would pay more to those States that have already established a more efficient delivery system without cracking down considerably on other States.

So all I can suggest is that because you were efficient in the past, you are being penalized now, as my colleague just said, because your cost structure is lower. So there is some basis for the sense of unfairness. It may not be "fair," but until we start paying for services differently—don't update payments inputs but rather on the basis of outputs or some other method—I don't see any magic in these formulas that will help.

Ms. DUNN. I will be waiting for such a system, hoping to take part in the development of such a system, and I appreciate your expressing the reality. Thanks.

Chairman JOHNSON. Just to conclude, I think your answer on those issues is inadequate. No offense. It is just that the historic base on which some of the States' payment systems were based and we have this problem in Iowa and a number of other States was very low. But those physicians are still having to buy the new technology and pay the higher malpractice cost. So, the disparity is declining, and the old differential is no longer as relevant.

And I am very concerned about their ability to attract physicians out of residency, because now our physicians coming out of residency have much higher debt loads. So it is a very hard decision to go to a State with lower reimbursement rates, because the cost of living isn't necessarily that much lower anymore. The original cost basis that was the foundation of this system is now not as relevant, because we have much more of a national system.

You talked to the hospitals. They are buying through national combines. So this whole issue, and I know Mr. Hackbarth and I talked about trying to review this. This Committee will be holding hearings on the whole wage area issue. But we have to evaluate these past fundamentals because they are no longer as relevant as they once were and they are going to create very disparate access to care in a decade or so if we don't do something about it.

It is like the baseline issue. The fact that you estimate your baseline to us on the basis of law will not prevail. Means that we have to raise lots more money just to stay where we are. So there are some things about the way that Congress has functioned in the past that make it hard to function in the future. This issue of the low paid States, I think, is going to be a much more significant problem for us as we go forward.

And in closing, I wanted to just remind you, and I know some of the next panel might help us on this issue of the differential impact of the 5 percent cut according to specialty and also place of care, which I think actually nobody has very good data on. And on your five goals, Mr. Hackbarth, one of the ones you didn't mention is how do we meet a future in which we need to encourage physicians to participate in disease management programs? Our whole reimbursement system doesn't look at care coordination. It looks at isolated care decisions. And that is not going to serve us as a nation as we move into an era where there are going to be people living much longer with multiple illnesses to manage. So our payment system is not only inadequate to next year and the year after, it is inadequate to the future of medicine. Mr. Stark.

Mr. STARK. Could I ask one brief question of Mr. Hackbarth, who may or may not have looked at this, but there has developed recently a phenomenon that I would refer to as boutique clinics or practices, wherein a primary care physician will charge somebody $1,500. There are some of us who are concerned that that may be extra billing or classified as that. Have you looked into that issue?

Mr. HACKBARTH. We have not, sir.

Mr. STARK. But you can understand how that might. When you charge a Medicare beneficiary an annual fee, do you spread that over some of the Medicare charges that that physician would collect from that patient? And if so, does that constitute extra billing? And you might—I would urge you to look into it because it is a question that will come up.

Mr. HACKBARTH. Thank you.

Mr. STARK. Thank you, Madam Chair.

Chairman JOHNSON. I thank the panel for their input and call forward the second panel. I welcome the panel. And I also want to acknowledge the presence of my colleague, Ben Cardin, a Member of the Committee on Ways and Means, one very, very interested in health. He often does join us, although not a Member of the Health Subcommittee, and works with us closely on much of the health care legislation that comes out of the Committee.

Dr. Ginsburg.

STATEMENT OF PAUL B. GINSBURG, PH.D., PRESIDENT, CENTER FOR STUDYING HEALTH SYSTEM CHANGE

Dr. GINSBURG. It is really a privilege to be invited to talk on this topic. The Center for Studying Health System Change is an independent nonpartisan research organization funded by the Robert Wood Johnson Foundation. It conducts research on how the health system is changing and the impact of those changes on people. Our research includes surveys and site visits that provide unique perspectives on health care in communities. We seek to in-

form policy with timely and objective analysis, but the Center does not advocate particular policy positions.

When the issue of the Medicare physician payment update developed late last year, I recognized that trend data from our surveys and data from our site visits could contribute to the debates.

We have information from household survey respondents about their experience in obtaining care in a timely fashion. We have information from physician respondents about their acceptance of new patients and the time spent in patient care. And we have information from site interviews with health plan executives about how much they pay physicians in relation to Medicare payment rates.

My testimony contains a lot of charts with data, but I would like to take you right to the bottom line. Many of the trends in the testimony point to a tightening of physician capacity in relation to demand that is leading to declines in peoples' ability to access care without delay. We see that more people are reporting delays in getting care. The time to get an appointment with a physician is increasing. Doctors are spending more hours per week in patient care and fewer doctors are accepting all new patients. A likely factor behind these trends is the recent growth in demand associated with the loosening of restrictions of managed care throughout the medical care system.

These trends are affecting Medicare beneficiaries, but they are also affecting those with private insurance. The relative financial attractiveness between Medicare and private insurance has probably not changed much in the last few years. Physician willingness to accept all Medicare patients is declining, but so is physician willingness to accept all new privately insured patients.

But this parallelism in trends could change over the next few years. The current law formula is expected to reduce Medicare payment rates a lot more. Also, physicians, particularly specialists, have been exerting greater leverage with managed care plans and are likely to get higher payment rates. The bottom line is that there are greater risks of deterioration and access to care from sharp cuts in Medicare physician payment rates today than in the past because of the stresses on physician capacity.

Thank you.

[The prepared statement of Dr. Ginsburg follows:]

Statement of Paul B. Ginsburg, Ph.D., President,
Center for Studying Health System Change

Thank you Madam Chairman, Congressman Stark, and members of the committee for inviting me to testify about Medicare physician payment. I am Paul Ginsburg, President of the Center for Studying Health System Change (HSC). HSC is an independent nonpartisan policy research organization funded solely by the Robert Wood Johnson Foundation. Our longitudinal surveys of households and physicians and site visits to 12 communities provide a unique perspective on the private health care market.[1] Although we seek to inform policy with timely and objective analyses, we do not lobby or advocate for any particular policy position.

Access for Medicare Beneficiaries

The goal of Medicare physician payment policy is to assure beneficiaries' access to high quality care while meeting federal budget objectives. Problems with the

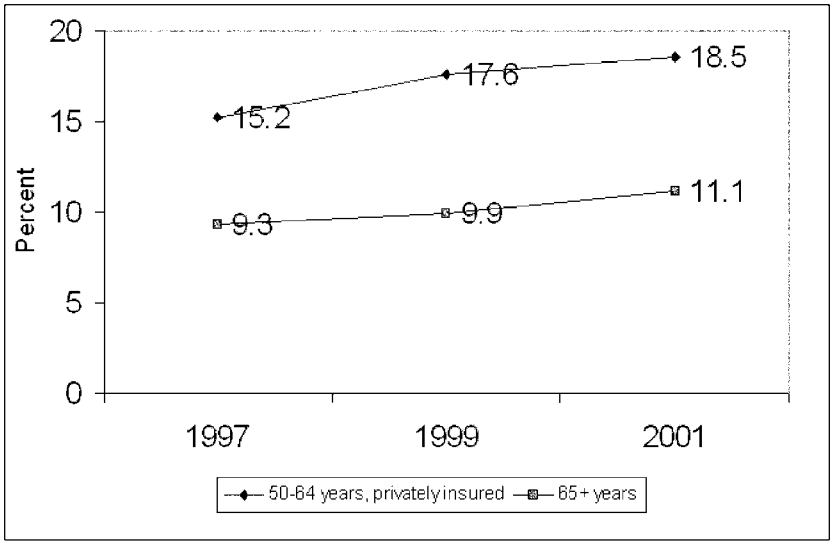
[1] "An Update on the Community Tracking Study: A Focus on the Changing Health System," HSC Issue Brief No. 18, February 1999.

Medicare physician payment update formula and the recent 5.4 percent fee cut have raised questions about the likely impact on access to care for Medicare beneficiaries. Our research suggests that Medicare beneficiaries' access to care over time may depend on physician capacity and local market conditions, factors that are difficult to capture within a budget-driven payment formula. By physician capacity, I mean the ability of physicians to provide services relative to the demand for those services. Capacity depends on a range of factors, including physician supply, the amount of time physicians are willing to devote to patient care, the mix of types of physicians and patients' demand for physician services.

The good news is that, overall, Medicare beneficiaries currently experience fewer problems of access than the near elderly covered by private insurance. In 2001, 11 percent of Medicare beneficiaries said they delayed or did not receive needed care compared with 18 percent of the privately insured who are 50–64 years of age. We have, however, recently seen slight declines in access to care for both groups.

Declines in access to care over time may reflect tightening of physician capacity in relation to demand. When asked the reasons for delaying or not obtaining care, respondents are increasingly reporting problems obtaining appointments. These problems are experienced by the privately insured near elderly as well as by Medicare beneficiaries. For example, in 1998–9, 16.3 percent of the Medicare beneficiaries who reported delaying or not obtaining care said they could not get an appointment soon enough compared with 20.9 percent of the privately-insured near elderly. By 2001, this had grown to 23.7 percent for Medicare beneficiaries and 25.0 percent of the privately insured near elderly (Exhibit 2).

Exhibit 1: Percent Reporting Delaying or Not Receiving Needed Care in Past Year, Comparison of Medicare Beneficiaries and Privately-Insured Near Elderly



Note: Data from the Community Tracking Study (CTS) Household Surveys, 1996–7, 1998–9 and 2000–1.

Exhibit 2: Percent of People Who Had Problems Obtaining Care, by Reason

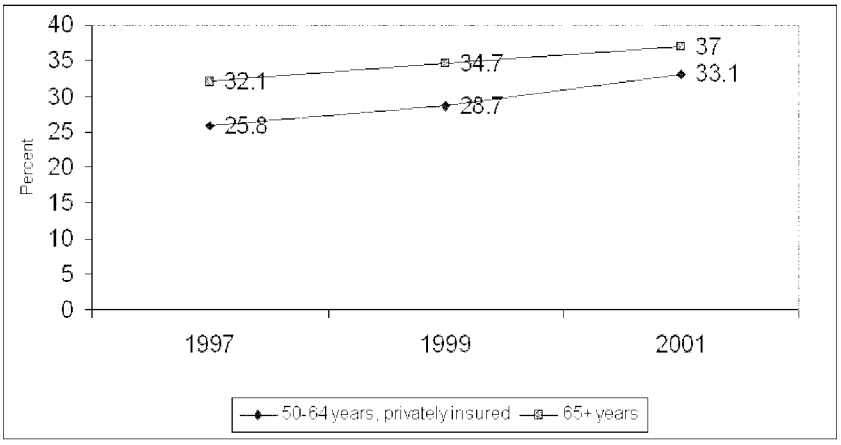
Reasons for Delaying/Not Obtaining Care	1996–7	1998–9	2000–1
Couldn't get appointment soon enough			
Age 50–64, privately insured	21.9	20.9	25.0
Age 65+	13.6	16.3	23.7
Couldn't get through on phone			
Age 50–64, privately insured	7.1	7.5	9.0
Age 65+	7.3	5.4	11.2
Couldn't be at office when open			
Age 50–64, privately insured	15.0	13.5	16.6
Age 65+	13.0	15.1	15.6

Note: Data from the Community Tracking Study (CTS) Household Surveys, 1996–7, 1998–9 and 2000–1.

A second indication of tightening capacity is that both the elderly and near elderly are facing longer waits for appointments with their physicians. Over a third of people aged 50 and older must wait more than three weeks for a checkup, while roughly 40 percent must wait for more than a week for an appointment for a specific illness. These increases in waiting times are occurring across all age groups.

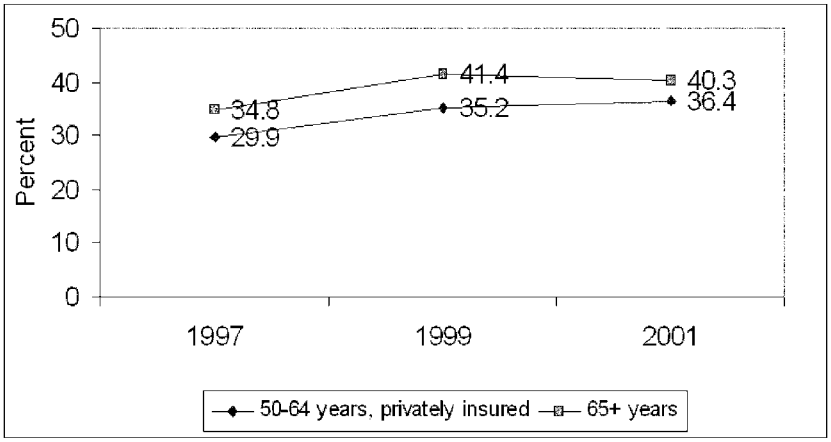
Exhibit 3: Percent Reporting Long Waits for Medical Check-ups,

Comparison of Medicare Beneficiaries and Privately-Insured Near Elderly



Note: Data from the Community Tracking Study (CTS) Household Surveys, 1996–7, 1998–9 and 2000–1.

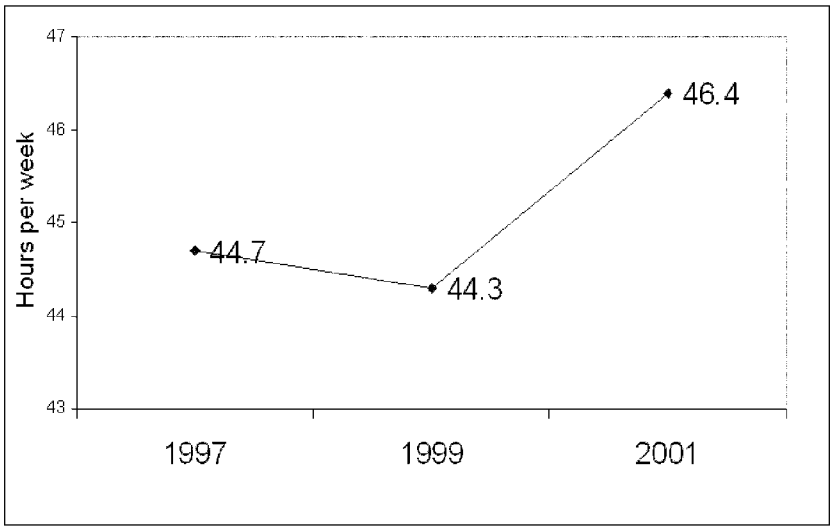
Exhibit 4: Percent Reporting Long Waits for Doctor Appointments When Ill, Comparison of Medicare Beneficiaries and Privately-Insured Near Elderly



Note: Data from the Community Tracking Study (CTS) Household Surveys, 1996–7, 1998–9 and 2000–1.

A third indication of tightening physician capacity is the increase in time that physicians are spending in patient care. Average hours per week increased sharply over the last two years. This may reflect a sharper increase in demand for services due in part the loosening restrictions in managed care. The increase in hours spent in patient care is also consistent with anecdotal reports that physicians are working harder to make up for lower fees—either meeting higher demand or creating it.

Exhibit 5: Average Hours Per Week Physicians Spend in Patient Care



Note: Data from the Community Tracking Study (CTS) Physician Surveys, 1996–7, 1998–9 and 2000–1, unweighted.

While there is considerable debate about the extent of a physician supply shortage, we do know that physicians have begun to exert increasing leverage with health plans to obtain higher payment rates.[2] As managed care plans have broadened their provider networks in response to demands for more choice and physicians are less eager to be included in all networks, physician leverage with managed care plans has increased. Physicians in some specialties have won substantial increases in payment rates.[3] If Medicare payment rates are falling, differentials between what physicians receive from Medicare and what they receive from private insurers would grow, putting beneficiaries' access to care at risk.

Physicians' Acceptance of New Medicare Patients

A key indicator of Medicare beneficiaries' access to care is the proportion of physicians who are accepting new Medicare patients into their practices. As part of our longitudinal physician survey, we ask physicians whether they are accepting new Medicare patients. Over the past 4 years, there has been a 4 percentage point drop in physicians' willingness to accept all new Medicare patients from 72 percent to 68 percent (Exhibit 6). The sharpest decline occurred for surgical specialists, while there was a modest increase for medical specialists. (For this analysis, pediatricians and physicians not accepting new privately insured patients are excluded.)

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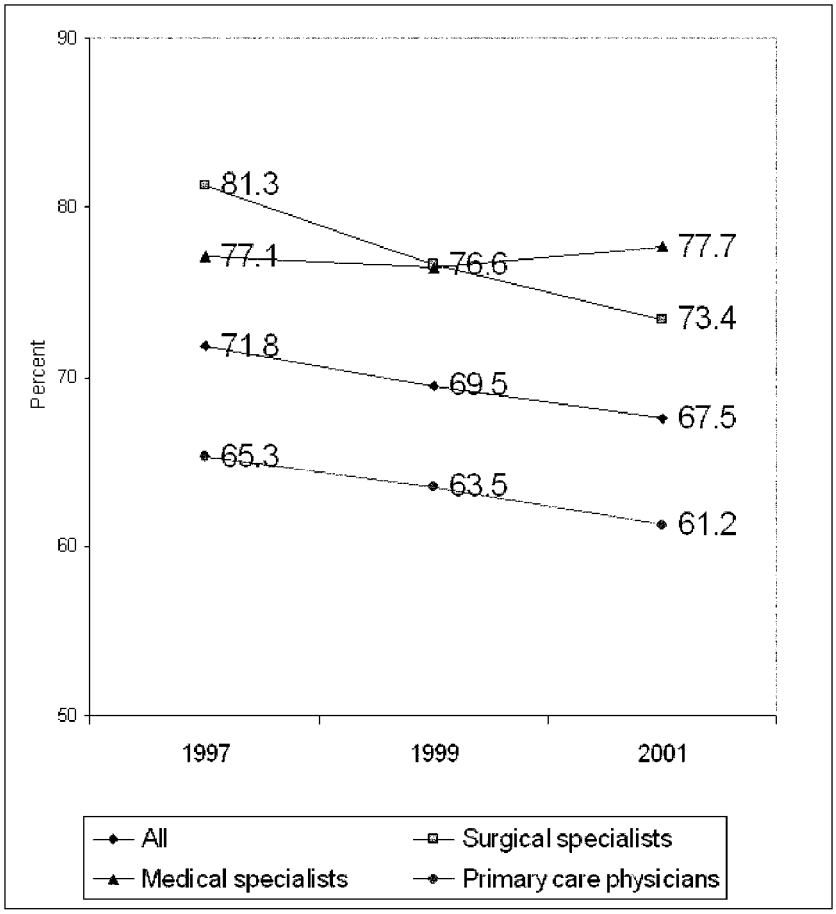
[2] Cooper, Richard A. and Thomas E. Getzen, Heather J. McKee and Prakash Laud, "Economic and Demographic Trends Signal an Impending Physician Shortage," *Health Affairs*, 21(1): 140–154, January/February 2002; Grumbach, Kevin, "The Ramifications of Specialty-Dominated Medicine," Health Affairs 21(1):155–157; and Mullan, Fitzhugh, "Some Thoughts on the White-Follows-Green Law," Health Affairs 21(1): 158–159.

[3] Strunk, Bradley C., Kelly Devers and Robert E. Hurley, "Health Plan-Provider Showdowns on the Rise, HSC Issue Brief No. 40, June 2001 and Short, Ashley C., Glen P. Mays and Timothy K. Lake, "Provider Network Instability: Implications for Choice, Costs and Continuity of Care, HSC Issue Brief No. 39, June 2001.

Exhibit 6: Percent of Physicians Accepting ALL New Medicare Patients, by Specialty



Note: Data from the Community Tracking Study (CTS) Physician Surveys, 1996–7, 1998–9 and 2000–1, unweighted.

The decline in accepting all new Medicare patients was the sharpest for physicians with the weakest connections to Medicare. That is, for physicians where Medicare revenues represent less than 10 percent of their practice revenue, acceptance of all new Medicare patients fell from 59 percent to 46 percent (Exhibit 7). In contrast, for physicians where Medicare revenues are over a half of their practice revenue, acceptance of new Medicare patients fell from 77 percent to 72 percent.

Exhibit 7: Percent of Physicians Accepting ALL New Medicare Patients by Medicare Revenue

Medicare revenue as percent of practice revenue	1996–7	1998–9	2000–1
Medicare revenue under 10 percent	59.1	55.8	45.9
Medicare revenue of 11 to 29 percent	71.4	69.1	64.8
Medicare revenue of 30 to 49 percent	75.3	74.1	71.5
Medicare revenue of 50 or more percent	76.6	73.2	71.9

Note: Data from the Community Tracking Study (CTS) Physician Surveys, 1996–7, 1998–9 and 2000–1, unweighted.

Similarly, physicians with the lowest revenue from Medicare were the most likely to report accepting no new Medicare patients. Among physicians who get less than 10 percent of their practice revenue from Medicare the number who now refuse to accept Medicare patients climbed from 12 percent to 21 percent in four years (Exhibit 8). In comparison, negligible changes occurred for physicians with higher Medicare revenues as a percent of their total practice revenue.

Exhibit 8: Percent of Physicians Accepting NO New Medicare Patients by Medicare Revenue

Medicare revenue as percent of practice revenue	1996–7	1998–9	2000–1
Medicare revenue under 10 percent	11.9	14.1	21.1
Medicare revenue of 11 to 29 percent	2.8	2.7	3.4
Medicare revenue of 30 to 49 percent	1.7	1.6	1.2
Medicare revenue of 50 or more percent	0.0	0.0	0.0

Note: Data from the Community Tracking Study (CTS) Physician Surveys, 1996–7, 1998–9 and 2000–1, unweighted.

Medicare Physician Payments Relative to Private Payers

The extent to which Medicare patients' access to care is compromised by Medicare physician payment cuts will depend on the community where beneficiaries live. This is because the relationship between Medicare payment rates and the rates paid by private insurers vary widely across communities. As part of our site visits to 12 communities, we conduct interviews with health plans and physician groups. From those interviews, we have found an extensive use of the Medicare relative value scale by private health plans and have also found that Medicare payment methods have had a large influence on the private sector. In fact, many health plans explicitly set their payments as a percentage of what Medicare pays.

There is considerable geographic variation in relative payments across the 12 communities we track. In Miami, Northern New Jersey and Orange County, California, private insurers' physician payment rates relative to Medicare are relatively low compared with other communities. For example, in Miami, private payments range from 80 to 108 percent of Medicare physician payments. In Northern New Jersey, private rates ranged from 95 to 105 percent of Medicare payments. In contrast, Boston, Cleveland, Greenville, Little Rock and Seattle have private rates that are much higher than Medicare. For example, private payments in Little Rock range from 120 to 180 percent of Medicare physician payments and from 100 to 150 percent in Boston.

This pattern of relative differences across markets has remained stable over time. Those markets that are typically more generous than Medicare have maintained these higher rates over the last 6 years of our study. Similarly, the communities with the lowest rates have consistently paid lower rates than other communities.

As a result of this variation in communities, a substantial decline in Medicare payments would pose the greatest risk to beneficiaries' access in those communities, such as Boston and Little Rock, where Medicare payment rates are the lowest relative to private rates. With the potential of "hot spots" of poor access developing in certain communities, new approaches for monitoring access in Medicare may be needed.

Implications

Since the Medicare program's inception in 1966, access to care for the elderly has not been a significant issue. This included the transition to the Medicare Fee Sched-

ule that began in 1992.[4] But our research raises concerns about access in the near future. Physician capacity to meet the demands of patients appears to be tightening and could tighten even further in the future. At the same time, payment rates in private insurance have been increasing, particularly for specialists.

Current policy established Medicare physician payment rates within the constraints of the federal budget. It also linked updates to the rate of growth of program spending and the growth of the economy. But attention also needs to be paid to Medicare beneficiaries' ability to command services in an environment of tightening capacity. MedPAC's recommendation of pegging updates in payment rates to trends in input prices would avoid cuts in the short term. However, given trends in the private markets, even under the MedPAC recommendation we would expect to see a widening gap between Medicare and private payment rates over the next few years. For this reason, just fixing the formula may not be enough to protect access to care for Medicare beneficiaries. At a minimum, more explicit attention to trends in Medicare beneficiaries' access nationally and within communities is advisable.

Chairman JOHNSON. Thank you very much, Dr. Ginsburg. Dr. Mayer.

STATEMENT OF JOHN E. MAYER, JR., M.D., PROFESSOR OF SURGERY, HARVARD MEDICAL SCHOOL, BOSTON, MASSACHUSETTS; PEDIATRIC HEART SURGEON, CHILDREN'S HOSPITAL BOSTON, BOSTON, MASSACHUSETTS; CHAIRMAN, COUNCIL ON HEALTH POLICY, SOCIETY OF THORACIC SURGEONS, CHICAGO, ILLINOIS; ON BEHALF OF THE AMERICAN ASSOCIATION FOR THORACIC SURGERY, MANCHESTER, MASSACHUSETTS

Dr. MAYER. Thank you, Madam Chairwoman. I am Dr. John Mayer. I am a Pediatric Heart Surgeon at the Children's Hospital in Boston and a Professor of Surgery at Harvard Medical School. I am also Chairman of the Council on Health Policy for the Society of Thoracic Surgeons (STS), and I represent both the STS and the American Association for Thoracic Surgery. We are among the Charter Members of the Coalition for Fair Medicare Payment and we support, as does this coalition, H.R. 3351 which would moderate the 2002 reductions in the physician fee schedule, as you have heard about previously.

We want to leave you with three basic points. First, we think this bill, H.R. 3551, has to come to the floor and that the SGR formula has to be revised along the lines recommended by MedPAC. Second we would also want you to recognize that the RBRVS system, the relative value system, is in our opinion on the verge of breaking down, and that will have an inevitable impact on the quality of the care that Medicare beneficiaries receive.

In announcing these hearings, Chairman Johnson said that Medicare's formula for paying physicians is completely irrational and must be reformed this year, and we 100 percent agree. This Congress should recognize that the 5.4 reduction this year in physician fee schedule across the board has been compounded for many specialties by inequities in reimbursement for practice expenses. More specifically in our case and other surgical subspecialties, CMS has refused to recognize the cost that cardio-thoracic surgeons

[4] Trude, Sally and David Colby, "Monitoring the Impact of the Medicare Fee Schedule on Access for Vulnerable Populations," *Journal of Health Politics, Policy and Law*, 22(1):49–71, 1997.

incur for staff who are on their payroll and who are essential to patient care in the hospital.

I really want to focus on some of the ways that this arcane system that has been devised for practice expense in particular has worked or not worked, and let me give you a few examples.

I also represent the Society of Thoracic Surgeons on the Relative Value Update Committee of the American Medical Association (AMA) which recommends physician work values but also reviews all the practice expense relative values. I believe we have gotten ourselves into an absurd reductionist approach trying to estimate the resources needed for each phase of each physician service. As a committee, we actually had to make a recommendation on whether 21 minutes or 23 minutes of clinical staff time were typical for a standard mid-level office visit. We were told that our decision would shift $100 million in the Medicare fee schedule. That is almost half as much as Medicare spends for the most common coronary artery bypass procedure that is done.

I have personally and perhaps this is as a scientist relatively little confidence in the ability of a Committee of physicians sitting in a room to reliably distinguish between 21 minutes and 23 minutes. As I said, the reductions in allowed charges for cardiac surgery are not 5.4 percent but, on average, are 10 percent; and for some of the procedures they are as high as 15 percent.

Since 1994, for cardiac surgery, reductions in practice expense component of the fee schedule have been 47 percent. There are in the written materials submitted to you graphs that demonstrate the overall impact of this system over the last 10 to 15 years and I think they are self-explanatory.

Congress in 1997 instructed Health Care Financing Administration (HCFA) in revising the practice expense system to recognize all staff, equipment, supplies and expenses. And subsequently under section 212 of the BBRA, Congress instructed the U.S. Department of Health and Human Services (HHS) to utilize valid data from outside organizations in addition to HHS itself. We have submitted that data, but HCFA has nonetheless deleted from practice expense all costs our Members incur for clinical staff who actually help provide services in the hospital.

In some States, some of these costs can be partially offset, but only for certain kinds of staff and only for certain kinds of activities. There is no reimbursement for any of the clinical staff for their services in intensive care units or on the wards postoperatively.

You may ask, why it is that cardiothoracic surgeons employ these staff? Very simply, cardiothoracic surgeons have, at their local community levels found that these staff are essential to improving quality. The Institute of Medicine, IOM, report very clearly noted that in complicated situations like cardiac surgery, that a well-functioning consistent team is essential to quality. Our overall mortality rates for coronary surgery in the United States are down 40 percent in the last 10 years and we think that these teams are essential to that improvement.

I actually gave a talk last week in Florida to a group of 75 cardiothoracic surgeons, and I asked them how many of them employed clinical staff that they took with them to the hospital. Es-

sentially everyone raised their hand. We don't want to go backward. And I think that the current course that we are on is one that will progressively deteriorate the quality of care that cardiac patients will receive in this country.

I can tell you that for the last several years we have failed to fill cardiothoracic surgery training positions in this country with American medical school graduates, and this year we did not fill the positions at all. That is, there were positions that were left unfilled. I think this bodes poorly for the future, and if the baby boomers don't have some other health catastrophe befall them, we are going to need more and more cardiac surgical procedures in the future. And if the shortages continue in applicants, it will take years to turn this around.

The decisions that are made this year will have an impact, and the impact is going to be felt not only tomorrow but in the future. We hope that we are looking ahead.

Thank you.

Chairman JOHNSON. Thank you very much for your excellent testimony. Anyone speaking out there with thoracic surgeons knows that this has been a specialty that has not been able to survive the automatic formula that governs reimbursement.

Dr. Palmisano.

[The prepared statement of Dr. Mayer follows:]

Statement of John E. Mayer, Jr., M.D., Professor of Surgery, Harvard Medical School, Boston, Massachusetts; Pediatric Heart Surgeon, Children's Hospital Boston, Boston, Massachusetts; Chairman, Council on Health Policy, Society of Thoracic Surgeons, Chicago, Illinois; on behalf of the American Association for Thoracic Surgery, Manchester, Massachusetts

Madam Chairwoman, I am John Mayer, M.D., chairman of the Council on Health Policy of the Society of Thoracic Surgeons. In practice I am a pediatric heart surgeon at Children's Hospital in Boston and Professor of Surgery at Harvard Medical School. I am here to represent both the Society of Thoracic Surgeons and the American Association for Thoracic Surgery; together these organizations represent essentially all of the surgeons providing heart, lung, esophageal, and other thoracic surgery in the United States. These two organizations are among the charter members of the Coalition for Fair Medicare Payment, formed last year in response to the crisis created by the across the board reduction of 5.4 percent in the Medicare conversion factor. The effects of this across the board reduction are compounded for our specialty and many others by continued reductions in the practice expense component of the Medicare fee schedule.

We support, as does the coalition, H.R. 3351, which would moderate these 2002 reductions. It is essential that this bill, which has over 300 co-sponsors, be brought to the House floor in time to limit the damage that is being done.

In announcing these hearings, Chairwoman Johnson said that "Medicare's formula for paying physicians is completely irrational and must be reformed this year." We fully agree. The "Resource-Based Relative Value System (RBRVS)" and the related "Sustainable Growth Rate" formula amount to a very complicated administered price control system. Administered price control systems sometimes work in the short run, but the lesson of history is that they end by breaking down. The RBRVS is now breaking down, and this will have an inevitable impact on the quality of care that Medicare beneficiaries receive.

The first sentence of the Institute of Medicine's 2001 report, "Crossing the Quality Chasm: A New Health System for the 21st Century," reads: "The American health care delivery system is in need of fundamental change." One of the IOM's principle recommendations is:

"Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement."

Our discussions of a rational reimbursement system should bear this closely in mind.

Let me explain why a surgeon from a children's hospital is here to talk about Medicare. For the last six years, I have represented the Society of Thoracic Surgeons on the Relative Value Update Committee of the American Medical Association. This committee has been charged by CMS to advise it on changes in the fee schedule—originally, the work values, more recently on some aspects of the practice expense values. I do need to emphasize that all of the basic payment policy decisions on practice expense reimbursement were made by the CMS (formerly HCFA) staff. The Practice Expense Advisory Committee has only been asked to advise on some details, but the entire process for determining the components of practice expense is fundamentally flawed.

Let me give you an example The PEAC was asked to give its opinion on the amount of clinical staff time (nurses, nurse assistants) involved in a typical mid-level office visit (99213). The committee considered 21 vs. 23 minutes of clinical staff time, and we were told that this two-minute difference would shift over $100 million in the Medicare fee schedule. This is over half as much as Medicare paid for the most common open heart procedure. I have no confidence that the committee could make any reliable distinction between 21 and 23 minutes, yet this is the process that is being used to determine the practice expense component of the Medicare Fee Schedule.

This is not the way to set fee schedules that are either 1) equitable to physicians or 2) in the best interests of patients. One fact this story illustrates is this: the "relative value" system is not about value—certainly not about value to the nation or to the patient. There is no attempt to base reimbursement on benefit—value—to the patient. The name RBRVS is a misnomer. It is a relative *cost* system, not a relative *value* system. It does not reward experience, it does not reward quality, and it does not even (despite the original recommendation of Professor Hsiao) recognize the "opportunity cost" of extended training (seven to eight years after medical school for cardiothoracic surgeons).

You have heard in detail about how the SGR system has evolved and the relationship between the fee schedule and the conversion factor. A system tied to gross domestic product is inherently unstable; even more important, the need for physician services is not dependent on the rate of growth of the economy. An economic downturn may even increase the need for some services. The issue of growth in volume and intensity of physician services is more complex, but I am uncomfortable with the proposition that there must be an absolute cap on growth. Any arbitrary formula will fail to recognize the growth of medical technology and our ability to offer life saving interventions to a greater proportion of the population. As a consequence, there is the potential for denying Medicare patients treatments that will prolong life and reduce disability.

The steadily lengthening American life spans and the clear evidence that rates of disability in old age are diminishing should show that we should encourage, not penalize growth in medical services—so long as these services are indeed contributing to the health of our citizens. I suggest that the Administration and Congress look closely at where the growth in medical services has occurred in recent years. It is not in heart surgery. The recent report of John Wennberg and his associates from Dartmouth on "supply/sensitive services" is relevant. His suggestions for creation of centers of health care that will encourage necessary but discourage unnecessary services deserve consideration.

In the short run, pending major system reforms, we basically support the draft recommendations of the Medicare Payment Advisory Committee. This would eliminate the SGR and base updates primarily on a revised Medical Economic Index. The productivity factor used in setting the MEI should be examined carefully; it probably does not realistically measure changes in physician productivity (for example, the learning curve in adopting new technologies) and certainly does not accommodate the current escalation in malpractice insurance costs. MedPAC also suggests that it be asked to make annual recommendations on the update formula, so that the system would not be on automatic pilot; Congress therefore would have the option of adopting higher or lower updates. There should be a default formula, to set the update if Congress does not act; for example, the default update could be the revised MEI with a productivity adjustment of -0.5 percent.

Let's turn back to the RBRVS. The reductions in allowed charges for cardiac surgery this year are not 5.4 percent but, on average, ten percent. For some procedures it's as high as 15 percent. Since 1994, for cardiac surgery, the reductions in the practice expense component of the fee schedule alone have been 47 percent (see attached chart). How this has happened, and the consequences, will illustrate the problems with this administrative pricing system.

Congress in 1997, under the leadership of this committee, instructed HCFA, in revising practice expense RVUs, "to recognize all staff, equipment, supplies, and expenses." Congress said all expenses, not "some expenses." Two years later, under Section 212 of the Balanced Budget Revisions Act, Congress instructed HHS, in computing practice expense, to utilize statistically valid data from outside organizations in addition to data from HHS itself.

In recognition of the need for better data, the Society of Thoracic Surgeons contracted with the American Medical Association to conduct an enlarged sample of thoracic surgeons in its annual socioeconomic survey. The work was done by the AMA, through its own subcontractor, not by the STS. HCFA agreed that the survey met its very rigid standards for statistical validity and used some of this data in its 1999 revisions of the practice expense RVUs. But that same year, despite the clear evidence in this survey that cardiac surgeons are incurring major costs for staff who assist in both operative and post-operative care in the hospital, HCFA deleted from its practice expense equation all costs our members incur for clinical staff who help them in the hospital. This payment policy decision deleted more than 80 percent of our clinical staff costs from the practice expense equation.

We have subsequently done yet another survey, which showed that 74 percent of cardiothoracic surgeons incur these costs for staff who assist in the hospital. In some states, these costs may be partially—but only partially—compensated for by limited billing for some—but not all—of these staff when they assist at surgery. There is no reimbursement for any of the clinical staff on our members' payrolls for their services in the ICU or the wards post-surgery, and reimbursement even for assistance at surgery is inconsistent.

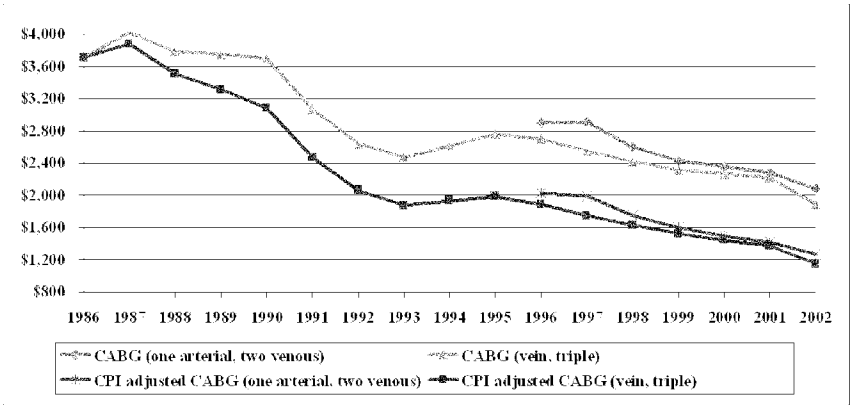
Why do cardiothoracic surgeons employ this staff? Very simply, the cardiothoracic surgeons working at the grassroots level have made decisions that these staff are essential to quality outcomes. Only in the largest, mostly academic hospitals, is the hospital staff adequately specialized and trained to assist at heart surgery and care properly for these patients in the hospital post-surgery. Heart surgery is very complex. As the IOM has noted in regard to complicated procedures, quality outcomes require a team that works together consistently, both in the operating room and in post-operative care. Cardiothoracic surgeons have stepped up and incurred these costs as the practice of heart surgery has evolved over the last ten years. Risk-adjusted mortality has dropped 40 percent in the last ten years. The team approach is one of the reasons for this quality improvement. That is what cardiac surgeons have done by incurring these costs themselves. I gave a talk to a statewide meeting of cardiothoracic surgeons in Florida last weekend, and I asked for a show of hands for how many of them employed clinical staff that helped them to care for patients in the hospital. Every one of them raised their hand.

We do not want to go backwards. But if the RBRVS ignores these costs, cardiothoracic surgeons are no longer going to be able to maintain staff of the same quality.

Also at the direction of Congress, the General Accounting Office is studying HCFA/CMS implementation of practice expense and its effects on all specialties. A preliminary report was submitted last year, entitled "Practice Expense Payments to Oncologists Indicate Need for Overall Refinements." The GAO in this study concluded that on average, practice expense reimbursement under the RBRVS meets only 70 percent of average physician costs. For cardiothoracic surgery, reimbursement was only 53 percent. That was under the 2001 fee schedule; adjusting the GAO study to 2002, the PE reimbursement for cardiac surgery would be less than 50 percent of costs.

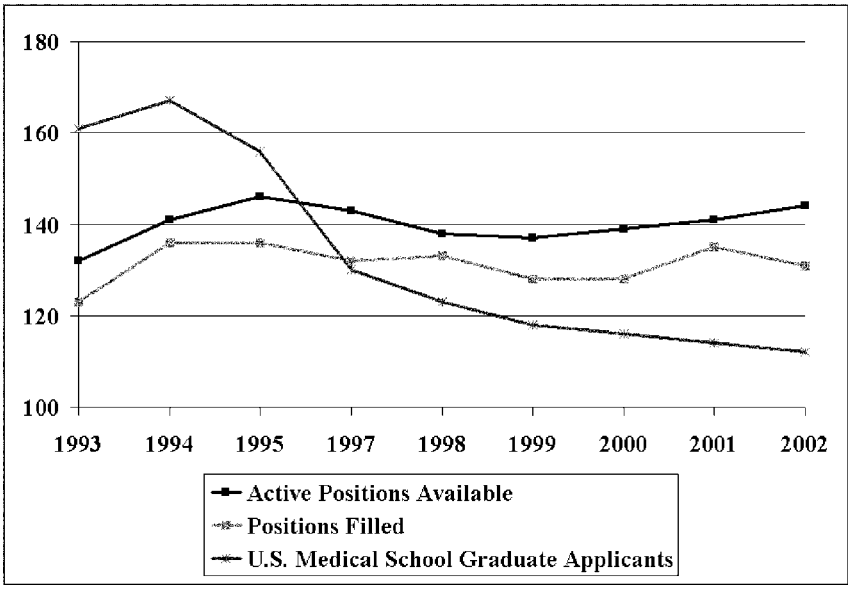
I noted at the beginning that the reimbursement system is broken. Physician morale is poor. In our own specialty, applications from graduates of U.S. medical schools for the 144 residency training positions offered annually in cardiothoracic surgery have dropped well below the positions available: this year, there were only 112 applications from graduates of U.S. medical schools for these 144 positions (chart attached). The total training period for a cardiothoracic surgeon, post medical school, is seven years. Most are in their mid-thirties before they begin practice. This drop off in applications does not bode well for the medical care the baby boomer generation will need as this large group enters the age in which cardiac disease is prevalent. If major shortages of cardiothoracic surgeons, or a decline in quality appears five or ten years from now, there will be no way to turn the situation around on a dime. The decisions Congress and CMS make this year will have their impact, and the impact will be felt much more in the future than the day after tomorrow. I hope we are looking ahead.

Cumulative Reductions in Medicare "Allowed Charges" for Coronary Artery Bypass Surgery, 1986–2001 (with & without CPI adjustment)



◊ △ **Current Dollars**
∗ □ **Adjusted to 1986 Dollars to reflect changes in the Consumer Price Index (buying power)**

Positions Filled and Applications To Thoracic Surgery Resident Programs 1993–2002



STATEMENT OF DONALD J. PALMISANO, M.D., J.D., SECRETARY–TREASURER, AMERICAN MEDICAL ASSOCIATION

Dr. PALMISANO. My name is Dr. Donald Palmisano. I serve as Secretary-Treasurer of the American Medical Association and am a Member of the AMA Board of trustees. I am a practicing General and Vascular Surgeon from New Orleans.

We thank Madam Chairman Johnson and the Subcommittee for your leadership efforts in the commitment to providing a remedy for the 5.4 percent Medicare payments to physicians and other health care professionals. This deep cut is threatening access for all Medicare beneficiaries. We urge this Subcommittee and Congress to immediately halt this cut and replace the Medicare payment update system.

Last June, MedPAC warned that a significant cut in the payment update could raise concerns about beneficiary access to care. Clearly, 5.4 percent is significant and it comes on top of sharp increases in professional liability premiums as well as a host of costly regulatory burdens. Many physicians as a result are being forced to make difficult choices, such as stop accepting new Medicare patients, discontinue the provision of some medical services, limit or discontinue investments in new technology, lay off staff or leave the practice of medicine. These are not choices that physicians want to make. In each case, our patients lose.

In response to these access concerns, MedPAC recommended a new framework for Medicare physician updates. We support the MedPAC general framework and look forward to working with the Committee on the specific details of a new update system.

The current system does not work for several reasons. First, the sustainable growth rate, SGR, requires the use of estimates that are nearly impossible to predict accurately. Chart 2 shows that inaccurate SGR predictions have shortchanged physicians and other health professionals by over $20 billion since fiscal 1998. Inaccurate enrollment projections mean that every year physicians care for nearly 1 million Medicare patients whose costs are not counted in the update. Under the formula, these errors are compounded annually.

Further, physician updates, unlike any other category of providers, are linked to changes in the GDP, even though the medical needs of Medicare patients do not wane when the American economy falls into a recession.

Chart No. 1 clearly illustrates the growing gap between the Medicare Economic Index and annual physician updates. Since 1991, physicians have received an average annual increase of 1.1 percent, as shown in the red line, versus the 2.4 percent increase in practice costs, as shown in the blue line. This trend cannot be sustained. Finally, the SGR is highly unpredictable and allows severe payment cuts to be imposed without any warning or opportunity for action by Congress.

In March 2001, CMS predicted a 1.8-percent increase in the 2002 payment update, and 10 days later predicted that the update would be a negative 0.1 percent. Not until November, with only a few weeks left in the congressional session, did CMS announce the 5.4

percent cut in the update. Like any small business, medical practices need to plan their expenses in order to remain financially sound. If practices continue to lose money due to low Medicare payments, patient access is threatened.

In conclusion, we strongly urge Congress to enact an immediate halt to the 5.4 percent cut and repeal the SGR system. We also ask the full Committee to ensure that its views and estimates submitted to the House Budget Committee include necessary funds to implement the MedPAC recommendations. Again, we thank the Subcommittee for your strong efforts on this important matter, and I am happy to answer any questions.

Chairman JOHNSON. Thank you. I am going to have to suspend a hearing while we complete the vote. I will run over and be back quick as we can. I will suspend for 5 minutes.

[The prepared statement of Dr. Palmisano follows:]

Statement of Donald J. Palmisano, M.D., J.D.,
Secretary–Treasurer, American Medical Association

Madam Chairman, Ranking Member Stark and Member of the Subcommittee, my name is Donald J. Palmisano, MD, JD, and I serve as the Secretary-Treasurer of the American Medical Association (AMA). I am a practicing surgeon in New Orleans. The AMA is grateful to you and the Subcommittee for the opportunity to provide our views concerning the Medicare physician payment update formula, as well as the 2002 Medicare payment cut of 5.4 percent. This steep payment cut is alarming. It is critical that Congress take steps to immediately halt this cut before it further jeopardizes the success of the Medicare program and patient access to care.

We thank Chairman Johnson for your leadership efforts and commitment to providing a remedy for the 5.4 percent cut that became effective on January 1, 2002. We especially appreciate your leadership on H.R. 3511. The AMA is eager to work on legislation with you and Representative Stark to address this important matter and appreciates the various efforts of several Subcommittee Members on both sides of the aisle to assist America's physicians in this regard.

CONGRESSIONAL ACTION NEEDED TO REMEDY ACCESS PROBLEMS

As of January 1, 2002, Medicare implemented a 5.4 percent payment cut that applies to Medicare services provided by physicians and other health professionals, including, but not limited to, physical therapists, speech pathologists, optometrists, advanced practice nurses and podiatrists.

This is the largest payment cut since the Medicare physician fee schedule was developed more than a decade ago, and is the fourth cut over the last eleven years. Since 1991, Medicare payments to physicians averaged only a 1.1 percent annual increase, or 13 percent less than the annual increase in practice costs, as measured by the Medicare Economic Index (MEI). (See attached Chart 1, *Medicare Payments vs. MEI*, which compares Medicare physician payment updates to increases in inflation.)

The Administration argues that total spending for physicians' services by the Medicare program is increasing. This assertion misses the more important point—spending per physician service is being cut significantly. Increases in total Medicare spending are due in large part to such factors as the increasing Medicare population, greater longevity in lifespan, expensive technological innovations and greater demand for medical services. All of these factors contribute to spending, and all are beyond physicians' control. Increased spending resulting from these factors cannot be curbed simply by cutting payments to physicians. A global cap on physician payments cannot successfully control the health care utilization of individual patients.

The current 5.4 percent cut is forcing many doctors to make difficult choices about their ability to continue accepting new Medicare patients, or even whether to retire or change to a career that does not involve patient care. If the pay cut is not immediately halted, it could soon become difficult to prevent serious access problems for elderly and disabled Medicare patients.

For example, the National Committee to Preserve Social Security and Medicare has stated that their members are having difficulty finding a physician who accepts Medicare because physicians cannot afford to keep their offices open. A family practitioner in an underserved part of Kentucky says she now cannot take any new Medicare patients and, if the situation does not improve, she will have to close her

practice in a couple years. A cardiology group in Colorado is being forced to lay off employees and, in Texas, spine surgeons at Baylor University plan to stop taking Medicare patients.

The American College of Nurse Practitioners warns that the pay cut is also forcing physicians and nurse practitioners to restrict their Medicare patient loads and cut back on the services they provide. One nurse practitioner in New York described a couple for whom she provides care (the husband is 91 and the wife is 82), and she stated that the cut "will devastate the care received by the neediest segments of our society."

Because of these growing access problems, immediate action is needed. We appreciate the Subcommittee's bipartisan commitment to addressing in a timely manner the significant problems resulting from the 5.4 percent cut and the payment update formula. We urge the full Committee to report, and the Congress to enact, legislation that would—

- **Immediately halt the 5.4 percent Medicare payment cut;**
- **Repeal the sustainable growth rate (SGR) system; and**
- **Replace the flawed Medicare payment update formula with a new system that appropriately reflects increases in practice costs, including changes in patient need for medical services, changes in technology, and other relevant information and factors.**

It is critical that Congress not defer legislative action to halt the current payment cut or repeal the SGR. The Centers for Medicare and Medicaid Services (CMS) is projecting that the SGR system will continue to produce additional steep payment cuts in 2003, 2004, and 2005.

We ask the Committee to ensure that its "views and estimates" letter on budgetary and legislative matters, to be submitted to the House Budget Committee, includes a request that appropriate funds be set aside in the budget resolution to replace the Medicare physician payment update formula beginning in calendar year 2003.

MEDPAC'S RECOMMENDATIONS TO REPLACE THE FLAWED MEDICARE PHYSICIAN UPDATE FORMULA

The Medicare Payment Advisory Commission (MedPAC) warned in June 2001 that if the 2002 update was lower than the CMS estimate, which at that time was—0.1 percent, it "could raise concerns about the adequacy of payments and beneficiary access to care." MedPAC adopted a recommendation that Congress replace the current Medicare payment formula with one that more fully accounts for increases in practice costs. Specifically, MedPAC advised Congress to repeal the SGR system because an expenditure target system, like the SGR, does not appropriately reflect increases in practice costs. MedPAC further recommended that future updates be based on inflation in physicians' practice costs, less an adjustment for multi-factor productivity.

We strongly agree with MedPAC's assessment and support the general framework of MedPAC's recommendations. We look forward to working with the Subcommittee and the Full Committee on the specific details of a new update system consistent with the MedPAC's framework.

MEDICARE PAYMENT CUTS SERIOUSLY THREATEN MEDICARE PATIENT ACCESS

The current 5.4 percent Medicare cut for physicians' services has a broad impact well beyond the physician community and Medicare program. Since Medicare payments for numerous health professionals are directly tied to the physician payment schedule, these practitioners also are experiencing large payment cuts. In fact, nearly one million physicians and other health care professionals are immediately affected by the cut. In addition, many private health insurance plans base their rates and updates on Medicare payment rates, which mean an additional loss of revenue from non-Medicare sources.

Most significantly, the payment cut jeopardizes access for elderly and disabled patients. Two-thirds of all physician offices are small businesses. If a business, especially a small business, continues to lose revenue and operate at a loss, the business cannot be sustained. Thus, when medical practices experience a Medicare cut of the magnitude being incurred in 2002, as small businesses, they may not survive. This means that physicians and non-physician practitioners and their staff are left with very few alternatives for maintaining a financially sound medical practice. These alternatives include:

- Discontinue seeing new Medicare patients;

- Opt out of the Medicare program;
- Move from being a participating to a non-participating Medicare provider;
- Balance bill patients (subject to Medicare charge limits);
- Lay off administrative staff;
- Relocate to an area with a smaller Medicare patient population;
- Discontinue certain low-payment/high-cost Medicare services;
- Shift services into the hospital outpatient setting, which increases costs to Medicare and to patients;
- Limit or discontinue charity care;
- Retire early;
- Reduce hours of practice Change career;
- Shift into a position which involves reduced or no patient care responsibilities; and
- Postpone or discontinue necessary investments in new technology.

It is clear from the foregoing that the current Medicare payment cut likely will result in patients having difficulty finding a physician. Indeed, concerns about patient access, due to payment cuts and excessive rate fluctuations, were raised by the General Accounting Office in testimony recently presented to Congress.

Further, recent press reports in many states have documented the access problems resulting from the Medicare payment cut. Excerpts from these reports are as follows:

- "As a result (of the 5.4% cut), doctors around the country are finding themselves pinched. If you continue to lose and lose, there may be a time when we will have to limit services or close one of our sites,' says Susan Turney, medical director of reimbursement at Marshfield Clinic, of Marshfield, Wis., which operates about 40 sites with 600 physicians. In some areas of Wisconsin, we're the only provider,' she adds." The *Wall Street Journal*, Jan. 20, 2002 (*Some Doctors Say They May Stop Seeing Medicare Patients After Cuts*);
- "Washington's health-care system is in serious decline, and the prognosis is guarded. Tests show the severity of the problem,' said Tom Curry, executive director of the Washington State Medical Association, which released a gloomy report in Olympia. Responding to an informal poll of members in November, 57 percent of physicians said they are limiting the number or dropping all Medicare patients from their practices. . . . The report says that for many years the state's health-care delivery system has been in decline, characterized by a slow erosion of funding for public health, growing administrative expenses for practitioners and mounting frustrations of physicians trying to cope with myriad regulations. A growing number of patients, even those with private insurance, are having trouble finding a physician because increasing numbers of doctors have been leaving the state or retiring early since the late 1990s, the report says." *Seattle Times*, Jan. 30, 2002;
- "Medicare reimbursement to doctors was cut 5.4 percent the first of the month, worsening an already tight financial situation for rural hospitals. . . . One result likely will be a harder time recruiting doctors to rural areas. . . . Medical equipment purchases can suffer, staff cuts are more likely and doctors sometimes will leave for better conditions elsewhere, Bruning said (Dr. Gary Bruning of the Flandreau, South Dakota Medical Clinic)," Associated Press, Jan. 22, 2002 (*Medicare Cuts Strain Rural Health*);
- "*Other West Virginia doctors fear their peers will stop treating patients who have Medicare* . . . And some wonder how they will recruit doctors to a medical environment marred by the recent struggles over malpractice insurance. . . . At Madison Medical PLLC in Boone County, three doctors treat at least 80 patients a day. About 65 percent of them have Medicare, said office management Phyllis Huffman. The cut in Medicare reimbursement does not come at a good time, she said. In the last two years, for example, the physician group's malpractice insurance doubled. Huffman said she fears that in the long run, the practice will not be able to afford to replace a departing employee. Or they may have to stop offering services for which they get little or no reimbursement from Medicare." *The Charleston Gazette*, Jan. 23, 2002.
- Patients are reporting having great difficulty finding a physician that takes new Medicare patients in North Carolina, where many physician practices have had to stop accepting new Medicare patients due to low Medicare payments. Dr. Conrad Flick, a vice president of the North Carolina Academy

of Family Physicians, stated that "until [Medicare] payments improve, medical practices will continue to cap the number of Medicare patients they see, causing many practices to refuse new patients." *News & Observer*, by Jean P. Fisher, on website of American Association of Retired Persons (AARP).

In order to ensure that the 85 percent of Medicare patients enrolled in the fee-for-service program will maintain access to physicians and health care services, this payment crisis must be addressed immediately.

VARIABLES COMPOUNDING MEDICARE PAYMENT CUTS

Several variables compound the current 5.4 percent Medicare payment cut. First, this cut occurs at a time when premiums for physicians' professional liability insurance (PLI) are increasing at an alarming rate. For example, the *Las Vegas Sun* recently reported that a Minnesota company's decision to get out of the PLI business could force nearly 40 percent of Nevada's physicians to pay painfully high premiums for new coverage or close their office doors. This trend is occurring across the country. The *Miami Herald* reported that South Florida physicians' will see PLI premium increases between 25 and 350 percent this year, if any insurance is available at all. In Pennsylvania, rising PLI premiums threaten to close trauma centers and emergency rooms.

The effects of the payment cut also are compounded by requirements under the Medicare and Medicaid programs that physicians take on expensive new responsibilities without any additional compensation. For example, program integrity activities have led to demands for reams of documentation, expensive new compliance programs and the proliferation of time-consuming certificates of medical necessity that force physicians to police other providers, such as home health agencies and medical suppliers. Patient safety, quality improvement, privacy protection, interpreters for non-English-speaking patients and a host of other well-intentioned requirements also are pushing medical practice costs ever upward.

The magnitude of regulatory burdens on physician is not lost on this Committee. Last year you passed legislation to assist us in this regard. We thank you and look forward to working with you to ensure that it passes the Senate.

Finally, the costs associated with PLI insurance premiums and the continually increasing amount of government-imposed regulatory requirements are not properly reflected in the Medicare payment update for physicians' services.

MEDICARE PHYSICIAN PAYMENT UPDATE FORMULA

Medicare payments to physicians are annually adjusted through the use of a legislated "payment update formula" that is based on the SGR and the MEI, which measures increases in practice costs. These costs include, among others, such factors as payroll, physician time, office equipment, supplies and expenses.

This update formula originally was intended to cap increases in practice costs. It has several flaws that create inequitable and inappropriate payment updates that do not reflect the actual costs of providing medical services to Medicare patients.

The Sustainable Growth Rate System

Under the SGR system, CMS annually establishes an expenditure target for physicians' services based on a number of factors set forth in the law. CMS then compares actual expenditures to the target. If actual expenditures exceed the target, the Medicare payment update may be as much as 7 percent below the MEI. Conversely, if allowed expenditures are less than actual expenditures, the update may be up to 3 percent above the MEI.

The target is based on changes in expenditures for physicians' services due to changes in (i) inflation, (ii) fee-for-service enrollment, (iii) gross domestic product (GDP), and (iv) laws and regulations. It is a highly unpredictable and unstable system that has a number of critical flaws:

GDP Does Not Measure Health Care Needs: The SGR system permits beneficiary Medicare spending for physicians' services to increase by only as much as real per capita GDP growth—a measure of the economy that bears little relationship to the health needs of Medicare beneficiaries. Incidence of disease did not lessen with recent downturns in the economy.

Specifically, GDP does not take into account health status, the aging of the Medicare population or the costs of technological innovations. Thus, the artificial link between medical care spending and GDP growth under the SGR system creates a system that is seriously deficient. Unlike any other segment of the health care industry, physicians are being penalized with a steep Medicare cut this year largely because the economy has slowed. Yet, the health needs of patients continue, the number of beneficiaries continues to grow and the use of new medical services approved by Medicare increases.

SGR Requires Unreliable Economic Forecasts: To calculate the SGR, CMS must make projections of GDP, enrollment and other factors. It is nearly impossible to make accurate predictions about these factors and thus it is equally impossible to predict future payment updates. When the resource-based physician payment system was first enacted in 1989, it was intended to provide predictability over time. Yet, the current update formula has created payment updates that are unpredictable and subject to sharp swings as economic circumstances, beyond physicians' control, change.

Further, because the update system is unpredictable, severe payment cuts may be imposed without any warning or opportunity for action by Congress. In March 2001, for example, CMS predicted that the Medicare payment update for 2002 would be a 1.8 percent increase. Ten days later, CMS recanted and stated that the 2002 update would likely be a 0.1 percent decrease. Finally, not until November, only eight weeks before the effective date of the 2002 update and with only a few weeks left in the Congressional session, CMS announced that the 2002 physician payment update would be a 5.4 percent cut. Like any small business, medical practices need to plan their expenses in order to remain financially sound. Small businesses are the engine of the U.S. economy.

For these reasons, as MedPAC has recognized, the current physician payment update system should be replaced.

Problems with SGR Projections: In annually calculating the SGR, CMS estimates of GDP growth and enrollment changes in 1998 and 1999 have shortchanged funding for physicians' services by $20 billion to date. (See attached Chart 2, *CMS Errors in SGR: Impact on Funding for Physician Services.*) CMS projected that Medicare+Choice enrollment would rise by 29 percent in 1999, even though many HMOs were abandoning Medicare. In fact, as accurate data later showed, managed care enrollment increased only 11 percent in 1999, a difference of about 1 million beneficiaries. This means that when CMS determined the fee-for-service spending target for 1999, it did not include in the costs of treating about 1 million beneficiaries. Nevertheless, these patients were and will continue to be treated, and since the SGR is a cumulative system, each year since 1999, the costs of treating these 1 million patients have been and will continue to be included in actual Medicare program expenditures, but not in the SGR target. Clearly, this disparity should be remedied.

CMS acknowledged its mistakes in calculating the 1998 and 1999 SGR estimates at that time, but concluded it did not have the authority under the law to correct its mistakes. We disagreed then, and were further shocked by CMS' announcement in the 2002 final physician fee schedule rule that not only do they have the legal authority, but the legal imperative, to change 1998 and 1999 SGR projections relating to spending for certain CPT codes overlooked by the agency. CMS' interpretation of the law is perplexing and seems to allow the agency to make SGR changes only when they result in Medicare payment cuts, but not when the same changes would increase payments.

The full magnitude of this problem has only recently become apparent. Information supplied by CMS suggests that the total amount of this latest "missing code" error was nearly $5 billion. Recent predictions by CMS of continued payment cuts for several more years show that its decision to continue using bad data in the target while correcting the errors in actual spending will ultimately have a devastating impact on payments for physician services.

Flawed Productivity Adjustment under the Medicare Economic Index

In the early 1970s, pursuant to congressional directive, CMS developed the MEI to measure increases in physician practice costs. A key component of the MEI has been a "productivity adjustment," which offsets practice cost increases. Over the last eleven years, CMS estimates of productivity gains have reduced annual increases in the MEI by 27 percent. Such estimates contrast with MedPAC estimates of the degree to which productivity gains offset hospitals' cost increases. In fact, in 2001, MedPAC's estimate for hospitals was −0.5 percent, while CMS' estimate for physicians was −1.4 percent. It is highly improbable that physician practices could achieve such substantial productivity gains in comparison to hospitals, which arguably have a much greater opportunity to utilize economies of scale.

We continue to believe that the productivity adjustment in the MEI is overstated. First, it is widely recognized that productivity growth in service industries is typically lower than that in other types of industries. Indeed, productivity data from the Bureau of Labor Statistics show productivity growth in the general non-farm economy of 2 percent per year from 1991 to 2000, compared to 4 percent annual productivity growth for manufacturing.

Second, we believe that productivity growth in physician practices is likely to be low in comparison to other service industries due to the previously-mentioned massive regulatory burden imposed on physicians. The cost of these requirements is absorbed by physicians with no offset paid by the Medicare program. In establishing the annual update for hospitals, however, MedPAC includes a category for these costs, and in its recommended update for 2000, for example, the Commission included a 0.2 percent increase to help cover hospitals' Y2K conversion costs. None of these government-mandated costs are presently captured in the MEI.

In recommending a framework for future payment updates, MedPAC is advising that the MEI should simply measure inflation in practice costs and that productivity should be separately reported. MedPAC further recommends that the productivity adjustment be based on multi-factor productivity instead of labor productivity, and estimates that this would significantly reduce the productivity adjustment that CMS currently uses in updating the Medicare fee schedule.

Cost of New Technology Not Taken Into Account

Unlike most other Medicare payment methodologies, the Medicare physician update system does not make appropriate adjustments to accommodate new technology, and thus physicians essentially are required to absorb much of the cost of technological innovations.

Congress has demonstrated its interest in fostering advances in medical technology and making these advances available to Medicare beneficiaries through FDA modernization, increases in the National Institutes of Health budget, and efforts to improve Medicare's coverage policy decision process. The benefits of these efforts could be seriously undermined if physicians continue to face disincentives to invest in important medical technologies as a result of reliance on a defective expenditure target system. New technologies, including ever-improving diagnostic tools such as magnetic resonance imaging, new surgical techniques including laparoscopy and other minimally-invasive approaches, have significantly contributed to quality of life for Medicare beneficiaries. For example, a paper published by the National Academy of Sciences indicated that from 1982–1994 the rates of chronic disability among the elderly declined 1.5 percent annually.

Technological change in medicine shows no sign of abating, and the physician payment update system should take technology into account to assure Medicare beneficiaries continued access to mainstream, quality medical care.

All of the foregoing factors contribute to a payment update system that does not adequately reflect increases in the costs of caring for Medicare patients and is already undermining Medicare patients' access to necessary medical services provided by physicians and other health professionals.

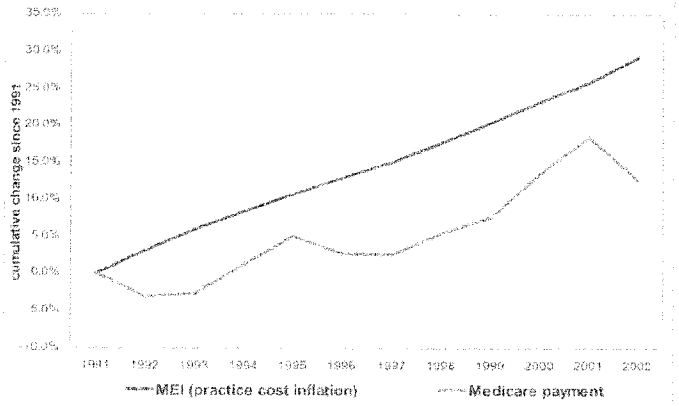
Again, we thank the Subcommittee for its continued support and commitment towards mitigating the ongoing problems resulting from the Medicare physician payment update formula.

We urge the full Committee and Congress to (i) immediately halt the 5.4 percent Medicare payment cut; and (ii) replace the Medicare payment update formula with a new system that appropriately reflects increases in practice costs.

We further ask the full Committee to include in its "views and estimates" letter of budgetary and legislative matters submitted to the House Budget Committee that appropriate funds be set aside to replace the Medicare physician payment update formula beginning in calendar year 2003.

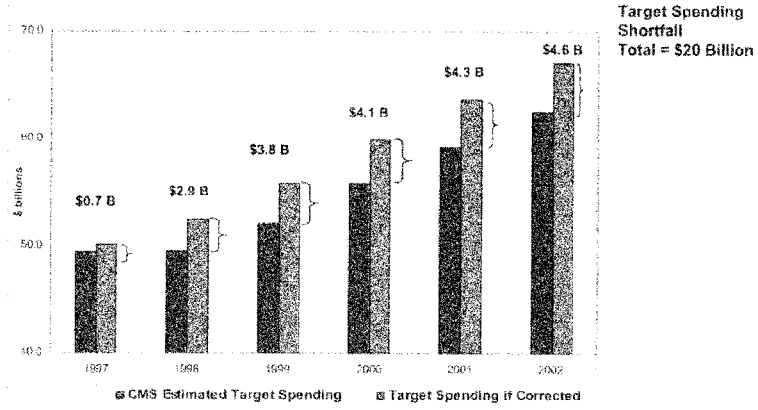
We appreciate the opportunity to provide our views about Medicare's physician payment update formula, and we look forward to working with the Subcommittee to quickly reach a satisfactory resolution to this critical problem.

Chart 1
Medicare Payments vs. MEI



Source: 1992-1997 pay change data, Physician Payment Review Commission; 1998-2002, AMA.

Chart 2
CMS Errors in SGR:
Impact on Funding for Physician Services



Brackets } indicate CMS errors in GDP and enrollment factors in SGR. Data on GDP growth is from U.S. Department of Commerce; enrollment data is from CMS.

[Recess.]

Chairman JOHNSON. We will resume with the presentations. Mr. Levine.

STATEMENT OF STEPHEN M. LEVINE, CO–OWNER AND ADMINISTRATOR, SPINE AND SPORTS REHABILITATION CENTER, TIMONIUM, MARYLAND, ON BEHALF OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Mr. LEVINE. Thank you, Madam Chairwoman and the Members of the Subcommittee on Health. The American Physical Therapy Association (ATPA) is grateful for the opportunity to provide testimony today concerning the need to reform the update formula of the resource based relative value fee schedule. This issue is of great significance to physical therapists who bill their services to the Medicare program under part B.

My name is Steve Levine and I am a practicing Physical Therapist and owner of Spine and Sports Rehabilitation Center in Timonium and Falston, Maryland. My practice specializes in the evaluation and management of the musculoskeletal dysfunction involving the spine. Physical therapists provide services to patients who have impairments, functional limitations, disabilities, or changes in health status resulting from injury, disease, or other causes. As clinicians, physical therapists are involved in the evaluation, diagnosis, prognosis, intervention, and prevention of musculoskeletal and neuromuscular disorders in the acute chronic and rehabilitative settings.

Please allow me to express my appreciation for the commitment of the Members of the Committee and Madam Chairwoman to address the problems that exist in the update formula for the part B fee schedule. The APTA is hopeful that Congress can work to ensure the fee schedule is modified appropriately before the end of this year.

Many health professionals, including physical therapists, utilize the RBRVS fee schedule to bill for their services. By inviting APTA to testify today, you are helping to dispel the myth that this is solely a physician concern. The APTA urges the Committee to consider the following immediate actions to address the problem.

First, immediately stop implementation of the 5.4 percent cut to the Medicare fee schedule; and second, adopt MedPAC's recommendations which would eliminate the SGR and replace it with a system that would more appropriately account for the changes in the cost of providing services. It is important that Congress acts this year, as CMS has projected that the formula will produce further significant negative fee schedule updates in the aggregate 19.6 percent by 2005. Should Congress fail to act, physical therapists and other health care professionals will experience Draconian cuts in reimbursement over the next 4 years. We are concerned that this downward projection will hinder the ability of physical therapists to care for Medicare beneficiaries needing rehabilitative services.

Because the SGR system is flawed, updates under the system do not reflect the cost of providing services. Our recommendation is to

eliminate the SGR methodology. Furthermore, the MEI, which accounts only for growth in labor productivity, overstates productivity gains in services and should be revised.

The APTA takes issue with the administration's assertion that reform of the update formula must happen in a budget-neutral environment. Clearly, additional financial resources are necessary to address this fundamental problem. APTA feels strongly that to correctly remedy this situation, the Committee should seek appropriate resources through the Budget Committee to meet this and other challenges. A short-term fix is nothing more than simply moving the furniture around on the deck of a ship that continues to speed toward an iceberg. The ship must change its course to avoid certain disaster. The impact of the Medicare cuts needs to be viewed in the context of significant legislative and regulatory changes affecting physical therapists.

As you know, the BBA also imposed a $1,500 cap on outpatient therapy services in all settings except for hospitals. In 1999, and again in 2000, due to concerns raced by beneficiaries, Congress placed a moratorium on enforcement of the $1,500 cap. The present moratorium will expire at the end of this year unless Congress acts. If the cap goes back into effect, it will compound the Medicare payment cuts.

In addition to the cap, physical therapists continue to deal with increased documentation requirements, conflicting Medicare rules, nonuniform application of Medicare requirements among its contractors and impending privacy requirements under the Health Insurance Portability and Accountability Act of 1996 or HIPAA. These issues further compound an already alarming problem.

During the past few months, The APTA has heard numerous reports from its Members concerned about the impact of the 2002 cut and future CMS projections. As an illustration, this year, for a typical 45- to 60-minute skilled visit with a physical therapist, Medicare will allow approximately $85.78. Currently my cost to provide this visit is $79.57. Next year for the same visit and using the current formula, Medicare's allowable rate will drop to $80.89. Considering a cost-of-living adjustment to both salaries and expenses, my cost to provide this visit is projected to increase to $81.95 in 2003. Therefore, next year if Congress does not act to change this formula, my practice will lose over a dollar on each physical therapy visit under Medicare. The only choice for survival is to reduce my cost, which will ultimately reduce the quality of services that can be provided to Medicare beneficiaries.

In conclusion, as the older adult population continues to rapidly grow, prompt and coordinated quality health care services will be necessary to avoid hospitalization, decrease the length of institutional stay, reduce the amount of care required after discharge, prevent complications, and improve the individual's level of function. The health of older Americans will be at risk if access to and appropriate payment for health care services does not keep pace with the growing number of Medicare beneficiaries.

Madam Chairwoman, I would like to thank you for submitting this testimony before the Subcommittee.

[The prepared statement of Mr. Levine follows:]

Statement of Stephen M. Levine, Co-Owner and Administrator, Spine and Sports Rehabilitation Center, Timonium, Maryland, on behalf of the American Physical Therapy Association

Medicare Part B Fee Schedule Payment Update Formula

Madam Chairwoman and members of the Subcommittee on Health, the American Physical Therapy Association (APTA) is grateful for the opportunity to provide testimony today concerning the need to reform the update formula of the Resource-Based Relative Value Fee Schedule (RBRVS). This issue is of great significance to health professionals who bill their services to the Medicare program under Part B, including physical therapists.

It is an honor to testify today on behalf of the APTA's 64,000 member physical therapists, physical therapist assistants, and students of physical therapy. My name is Stephen Levine, PT, MSHA. I am presently co-owner and administrator of the Spine and Sports Rehabilitation Center, with offices in Timonium and Fallston, Maryland. My practice specializes in the evaluation and management of musculoskeletal dysfunction involving the spine.

I have also served nationally within the APTA as a former member of the Board of Directors and Vice Speaker of APTA's House of Delegates. From 1992 to 1999, I was APTA's appointee to the American Medical Association's (AMA) Health Care Professional's Advisory Committee of the Relative Value Update Committee, a multi-specialty committee which advises the AMA and the Centers for Medicare and Medicaid Services (CMS) on appropriate relative values of medical services provided by a broad range of licensed providers.

First, I would like to thank you for holding this hearing today and for the commitment of Committee members to address the outstanding problems that exist in the update formula for the Part B fee schedule. Many health professionals, including physical therapists, utilize the RBRVS fee schedule to bill for services. By inviting APTA to testify today, you are helping to dispel the myth that this is solely a physician concern.

Physical therapists provide services to patients who have impairments, functional limitations, disabilities, or changes in health status resulting from injury, disease or other causes. As clinicians, physical therapists are involved in the evaluation, diagnosis, prognosis, intervention, and prevention of musculoskeletal and neuromuscular disorders. On a daily basis, physical therapists provide care for Medicare patients with acute, chronic, and rehabilitative conditions. Physical therapy is a dynamic profession whose goal is to preserve, develop, and restore optimal physical function.

APTA was pleased with the strong support members of the House gave to legislation last year that would have forestalled a 5.4 percent cut in payments that took effect January 1st. Some 316 members of the House cosponsored H.R. 3351, a bill to promote payment fairness under the RBRVS fee schedule. Unfortunately, Congress failed to act last year. APTA is hopeful the Congress can work to ensure the fee schedule is modified appropriately before the end of this year.

Congressional Action Necessary

APTA urges the Committee to consider the following immediate actions to address the problem:

- Immediately stop implementation of the 5.4% cut to the Medicare fee schedule;
- Adopt MedPAC's framework for updating the Part B provider fee schedule, which includes eliminating the sustainable growth rate (SGR) and replacing it with a factor which will more appropriately account for changes in the cost of providing services. MedPAC's framework was highlighted in its March 2001 report to Congress and will be part of its March 2002 report.

It is important that Congress act this year as CMS has projected that the formula will produce significant negative payment updates of 5.7% in 2003, 5.7% in 2004, and 2.8% in 2005. Should Congress fail to act, physical therapists and other health care professionals will experience draconian cuts in reimbursement over the next four years.

APTA takes issue with the Administration's assertion that reform of the RBRVS update formula must happen in a budget neutral environment. Clearly, additional resources are necessary to address this fundamental problem. Moving the furniture around on the deck of the ship will not slow it from sinking. APTA feels strongly that remedying this issue must not be a budget neutral exercise. We recommend the Committee seek appropriate resources through the Budget Committee to meet this challenge and other necessary Medicare reforms.

Patient Access Problems Will Result from Flawed Update Formula

APTA is concerned that the negative payment updates to the RBRVS fee schedule will hinder the ability of physical therapists to care for Medicare beneficiaries needing rehabilitation services. It is important that these individuals continue to receive the rehabilitation and other services that they need in order to achieve their maximum level of functional independence. Because rehabilitation enables beneficiaries to function more independently, rehabilitation will save the Medicare program dollars in the long run.

The impact of the Medicare cuts needs to be viewed in the context of significant legislative and regulatory changes affecting physical therapists that have occurred over the past few years. Since 1992, physical therapists in private practice have been reimbursed under the RBRVS fee schedule. Prior to 1999, all other outpatient therapy settings were reimbursed under a cost-based system. The 1997 Balanced Budget Act (BBA) required that outpatient therapy services in all settings be reimbursed under the RBRVS fee schedule, beginning in January 1999. Thus, in addition to impacting physical therapists who own and operate private physical therapy practices, the 5.4% cut in payment and the flawed update methodology also impacts the provision of outpatient therapy services in outpatient hospitals departments, skilled nursing facilities (Part B), home health agencies (Part B), rehabilitation agencies, and comprehensive outpatient rehabilitation facilities (CORF).

The BBA also imposed a $1500 cap on outpatient therapy services in all settings except for hospitals. In 1999 and again in 2000, due to concerns raised by beneficiaries, Congress placed a moratorium on enforcement of the $1500 cap. The present moratorium will expire at the end of this year unless Congress acts. If the cap goes back into effect, it will compound the Medicare payment cuts.

In addition to the cap, physical therapists continue to deal with increased documentation requirements, conflicting Medicare rules, non-uniform application of Medicare requirements among Medicare contractors, and impending privacy requirements under HIPAA. When combined with the current and impending cuts you can begin to understand how difficult it is and will be for health professionals to continue providing services within the Medicare program.

The majority of physical therapists in private practice are small businesses. As small business, their ability to operate is in jeopardy when they lose necessary revenue or cannot forecast revenue accurately from year to year. As a result, maintaining access to providers like these, that play such an important role in health care delivery, cannot be sustained without immediate reform of the payment update formula.

During the past few months, APTA has heard numerous reports from its members regarding the impact of the 2002 cut. Speaking from my own experience, the Medicare allowable amount per visit, as projected over the next two years, will cause Medicare reimbursement to fall below my actual cost to provide physical therapy services (in 2002 dollars), particularly as costs increase due to inflation. As a result, we may be forced to become non-participating providers in the Medicare program, which will result in a decreased ability for patients to access skilled physical therapy services from our office.

Flawed Medicare Payment Update Formula

Medicare payments are updated annually based on the SGR system. Because the SGR system is flawed, updates under the system do not reflect the cost of providing services. The flaw in the system is apparent in 2002 as the SGR resulted in a 5.4 percent reduction in payment rates, despite an estimated 2.6 percent increase in the costs of inputs used to provide services.

The SGR system sets spending targets for services reimbursed under the RBRVS fee schedule and adjust payment rates to ensure that spending remains in line with those targets. If spending equals the targeted amount, payment rates are updated in accordance with the percentage change in input prices, which is determined by the MEI. If the spending for that year exceeds the target, the increase in payment rates is smaller than the increase in input prices (MEI). If spending for that year is less than the target rate, payment rates are allowed to be increased by a greater amount than the rise in input prices.

The annual target is a function of projected changes in four factors: input costs, enrollment in traditional Medicare, real gross domestic product (GDP) per capita, and spending attributable to changes in law and regulations. Revisions to any of these four factors or to estimates of prior spending can change the spending estimate significantly.

One of the problems with this methodology is the use of changes in GDP as a factor. Linking annual changes in the targets to annual changes in GDP ties the target to the business cycle. During times of prosperity, GDP growth rates would be high-

er; yet, during periods of downturn, such as the past year, the GDP rates are lower. Health care needs of Medicare beneficiaries do not follow the same cycle. Beneficiaries do not need fewer services and the cost of providing care to these beneficiaries does not lessen when the economy is in a downturn.

Another problem with the methodology is that the SGR is highly volatile. In March 1, 2001 rule, CMS estimated that that the 2002 update would be around negative 0.1 percent. However, in November 1, 2001, just 7 months later, the SGR was at negative 0.7 percent, which caused the fee schedule update to be reduced by 5.4 percent. This was due, in part, to a predicted slower economy, and changes in spending estimates. These excessive and unpredictable rate fluctuations make it very difficult for providers to continue to participate in the Medicare program.

Still another problem relates to errors in estimating beneficiary enrollment. According to CMS, Medicare+Choice enrollment would rise 29 percent in 1999. In actuality, the projection was off by 10 percent and nearly 1 million enrollees. The corresponding projected drop in fee for service enrollment was erroneous and has negatively influenced the SGR ever since.

Changes Needed in the Medicare Economic Index (MEI)

In addition to eliminating the SGR, the MEI, which is calculated by CMS and used to measure practice cost inflation, also needs to be improved. The MEI is a weighted average of price changes for inputs, which include physician time and effort (work, non-physician employees, and office expenses) used to provide care. The MEI, which was developed in 1972, also includes an adjustment for productivity growth, which affects the cost of providing services. Currently, the MEI, which only accounts for growth in labor productivity, overstates productivity gains in services.

In its framework, MedPAC recommends that the MEI measure inflation in practice costs and that productivity be separate from the MEI. In addition, MedPAC recommends that the productivity adjustment be based on multi-factor productivity (which would include both labor and capital inputs), instead of labor productivity. Making this change would ensure that it would account for changes in productivity for all relevant inputs used to provide services. According to MedPAC, this would significantly reduce the productivity adjustment that CMS uses currently in updating the Medicare fee schedule. APTA urges Congress to adopt MedPAC's recommendation regarding MEI.

Conclusion

As the older adult segment of our population continues to rapidly grow, it will be paramount that they have access to qualified health care professionals who are able to serve their health care needs. Prompt and coordinated services provided by health professionals can help to avoid hospitalization, decrease the length of institutional stay, reduce the amount of care required after discharge, prevent complications, and improve the individual's level of function. The health of older Americans will be at risk if access to and payment of health care providers does not keep pace with the growing number of Medicare beneficiaries.

Thank you for the opportunity to submit this testimony before the Subcommittee.

Chairman JOHNSON. I thank you very much for your testimony. It was very interesting.

I wonder if any of the practicing physicians at the table have seen any effect on their practices of payment issues driving access? In other words, have you seen any referrals from people that normally would have provided care but for the payment structures, and are there any ways in which you are seeing any impact on access of the payment system. Dr. Mayer?

Dr. MAYER. Well, you know, I don't spend any time taking care of Medicare patients, since I am a pediatric heart surgeon. But I can tell you that similar sorts of things that are affecting Medicare are also affecting both private insurers who are now using the Medicare fee schedule to a large extent, and also affects Medicaid. I can certainly tell you that there have been patients covered under Medicaid programs and referred to our center who have essentially been told that they can't come to a center like ours and that they

have to stay locally. So these are children with complicated forms of congenital heart disease who are basically being told they have to stay closer to home and perhaps be cared for in centers that don't have as much experience as we do. So it is having an effect even in a non-Medicare population.

Chairman JOHNSON. Thank you. Do any of you have any comment or information about Dr. Ginsburg, I think there was a chart in your testimony that really went to the heart of the matter of the impact of our reimbursement policies on different types of practices. Would you go through that a little bit more?

Dr. GINSBURG. Yes, certainly. There was a chart in my testimony on trends of the proportion of physicians who accept all Medicare patients by specialty. Whereas for all physicians, the percent that are accepting all the new Medicare patients declined from 71.8 percent to 67.5 percent over this 4-year period, the decline was steepest among surgeons, from 81.3 percent to 73.4 percent. In contrast, medical specialists actually slightly increased the proportion that are accepting all new Medicare patients over this period. The differences in these trends probably are related to Medicare payment policy; in going to a common conversion factor, it reduced payments to surgeons, and increased payments to medical specialists.

Chairman JOHNSON. Thank you very much. Dr. Palmisano?

Dr. PALMISANO. Thank you, Madam Chairperson. If I may, I would like to respond to your first question. We have gathered information from around the country in the area where I am of New Orleans. I will give you an example. A group of clinic-based colon and rectal surgeons in New Orleans, Louisiana, first reduced from four to one the number of days each month that they would test and treat elderly women with fecal incontinence. Later they scaled back these services to once every 3 months. Now they have reached the point where they will no longer accept new patients who need these services.

Colon and rectal surgery is a very small specialty. There are only about 1,250 who are board-certified and in active practice nationwide. It makes a difference to a community when one of them ceases to provide a service. There are few others to meet that need.

And we have other examples around the country that we will be glad to submit to you, again, from New Orleans and Pine Bluff, Arkansas, Pensacola, Florida. Physicians report to us they are having a difficult time identifying primary care physicians to provide follow-up care for elderly surgical patients who do not have a regular doctor. They are hearing that these practices simply are not accepting new Medicare patients.

We have other stories that we can put into evidence. Thank you.

Chairman JOHNSON. Thank you. I hope you will all of you who have any access to contemporary data that reflects the difficulty of access for seniors to care, share that information with us, because anecdotally I am seeing that in a way that I have never seen it, being out there in the real world, and I don't know to what degree it is driven by the Medicare reimbursement problems, both administrative and cuts, and to what degree it is an interactive consequence of the problems in Medicaid.

And if you could begin also to help us identify where these problems are the most acute, we can begin to look at those interactions.

The other thing that we need to know is how are these cuts affecting physicians of different ages? And are we going—do we see an increase in early retirement amongst physicians because of the complexity of the reimbursement problems and this erratic cut. Dr. Mayer?

Dr. MAYER. I would like to speak, I think, to two points. One is I think it is important to recognize that the access problem is not just a straight numeric one. It also has embedded in it quality. Certainly what we are hearing, and I don't mean to beat this practice expense issue to death, but what is happening is that surgeons are laying off the clinical staff that are part of their teams that are taking care of these cardio patients. I think that is inevitably going to have an impact on quality. So I would expand the access issue, and I would say it is an access to quality care issue, not just fundamental access to get in the door.

Chairman JOHNSON. The other thing I would be interested in hearing is, more and more physicians are actually involved in care management. They are using their nurses. We don't give any reimbursement for that. How do we get physicians into disease management protocols and using them with the reimbursement structure we have, or what reimbursement structure—what adjustments need to be made to the reimbursement structure so we can help physicians through their practices actually follow patients? Because it is having a very significant impact on the reuse of appointments and reuse use of hospital facilities. And while we had hoped that the Medicare+Choice plans would lead us in this direction more rapidly, clearly if it is going to lead in this direction, it is going to be slowly, so we cannot have a physician reimbursement that is blind to the need for disease management.

Dr. GINSBURG. Yes, I agree very strongly with you, Madam Chair, about the importance of changing our payment system so that it can be supportive rather than discouraging toward physicians engaging in disease management. I believe you are right that we realize that the fee-for-service Medicare Program is going to be responsible for the overwhelming majority of beneficiaries for some time.

It was very encouraging that in the past week the CMS announced a large demonstration of to encourage disease management. We need a lot more initiatives to experiment with this within our fee-for-service system.

In Medicare, we have a fee-for-service system. It has some strengths, but it has limitations as far as ability to control volume. A key weakness is that when the services of professionals other than physicians are very important to disease management, we need to quickly find a way where the system can through payment, if not encourage disease management, at least avoid discouraging it.

Dr. MAYER. We actually have a group in the State of Virginia, all of the cardiothoracic surgeons and all the hospitals that provide cardiac surgical care in the State of Virginia, and they have actually given to CMS a proposal in which all of them would get together, globally contract, and there would be global pricing. So one

would include hospital services as well as physician, surgeon, anesthesiologist, cardiologist as well as cardiac surgeon fees all together. The CMS has said they can't do it somehow, which we found particularly disappointing, because one of the things that our sort of an approach allows is an alignment of incentives. It then becomes to everyone's advantage to make the care both more cost effective and efficient.

Chairman JOHNSON. I would like to have copies of that information, if I may. I do think that at this time when we are clearly going to rewrite the way we pay physicians, we can simply ill afford to be blind to the most promising approach to reducing overuse of extensive services and at the same time improving quality of care. So I look forward to working with you on that.

That was my amendment in the last bill on the disease management, and I am pleased to see it going forward. But as is often the case, the real world is far ahead of us, and a demonstration at this point is almost pathetic. We can't afford this opportunity to think about it either.

Let me recognize my colleague, Mr. McCrery.

Mr. MCCRERY. Go ahead, Dr. Palmisano. You had a comment?

Dr. PALMISANO. Thank you, Representative McCrery. I just wanted to make one point. Thank you very much for that courtesy. Two things I also wanted to add on the record. the physician's ethical obligation to do the very best for the patient. Last week my partner, Jim Brown, and I operated on a patient who had a very difficult problem with his thyroid. He had a mass. He previously had hyperthyroidism. The operation took 5 hours using magnification to make sure we didn't cut the nerves of the voice box, to make sure we kept the parathyroid gland so he wouldn't go into tetani at the operation. And we weren't thinking of whether or not we were going to stop the operation after 3 hours because we weren't paid beyond 3 hours or whatever. We are going to do the very best for the patient.

But as my partner tells me repeatedly, and told me again this morning, when I called to check on the practice, he said, just remember you can't make it up on volume if everything else escalates and the fees for your services continue to decrease.

And I think going back to the disease management question, there is the old Louisiana saying about it is hard to remember you came here to drain the swamp when you had so many different alligators, and the different alligators biting at you are the unfunded mandates or the decreasing payment for your services and just the increased burdens of the Emergency Medical Treatment and Active Labor Act, EMTALA, and all of these things I know you are working on and have done a wonderful job to get that out of the House to ease the burden.

There are so many factors here that this really is the perfect storm, to use that analogy, and we are going to act like the weather person and say there will be an access problem if we don't fix these things. Regardless of how we do the long-term fix, right now we have to stop the 5.4-percent cut.

Mr. MCCRERY. One of the other elements of your perfect storm that you mention in your testimony was medical malpractice premiums going up. You know what causes those premiums to go up?

Dr. PALMISANO. Well, yes, sir. I am quite familiar with how premiums go up. In an ideal world, it is based on severity and frequency; frequency of claims and severity. And it is outrageous awards that have no relationship to the damages.

And before you ask me the next question, is that in your State, my State, beloved State of Louisiana, we have one of the best tort reform laws in the Nation. And we think it is equal to California and Indiana and New Mexico. We think ours is really perhaps a little better. The AMA has the California model. So those are increases, and yet we are seeing physicians retiring early in New Orleans even though we have a very effective tort reform compared to West Virginia, Florida, Pennsylvania, and Nevada and all of these places that are in severe distress.

Mr. MCCRERY. We do have a good tort reform or medical malpractice reform in Louisiana and have had for a number of years. Do you think it would be helpful to the Nation's health care system if we had a nationwide medical malpractice reform that would model, or that would go after the model in Louisiana?

Dr. PALMISANO. The AMA's position for many years has been that we need effective tort reform. The particular model that we picked was the model in California, which is the micromodel, and it is a cap of $250,000, periodic payments, collateral source and those types of issues.

So we do definitely believe that it would be good to have that nationwide, at the same time protecting States like Louisiana and Indiana, who might have substantially similar laws but slightly different so as not to upset their jurisprudence that has accumulated over the years. Our act has been upheld by the Louisiana Supreme Court, and the U.S. Supreme Court says there is no Federal question on it.

Mr. MCCRERY. So the AMA supports nationwide medical malpractice?

Dr. PALMISANO. Yes, sir. The AMA supports, and in our December meeting, the AMA said this is a top priority for the Association to get nationwide tort reform and help States if we are not able to get it effectively because that is another access problem, physicians going out of practice.

Mr. MCCRERY. So you would now support having medical malpractice reform passed as a part of the Patients' Bill of Rights?

Dr. PALMISANO. Well, that question comes up all the time but we have said, we will always look. We certainly want to sit down and reason and would love to be at the table on the Patients' Bill of Rights issue and the tort reform issue. AMA's position in the past, we think these are both an effective Patients' Bill of Rights is an important issue. Tort reform is an important issue. And we think that they can stand alone. If you want to put them together in a bill, let us look at it together. But what we don't want to do is have everything get killed based on those two being put together. We would like to get one thing out that is effective and then continue to work on the other than get nothing.

Mr. MCCRERY. Perhaps if you would help us underscore the importance of medical malpractice reform, we could attach it to some vehicle like the Patient's Bill of Rights that is popular in the ele-

ment that doesn't like medical malpractice reform, and we might get them both done. I would submit that the AMA ought to——

Dr. PALMISANO. Mr. McCrery, I am sorry. Just repeat that a little bit. I lost one of my hearing aids coming up here and I am having a little trouble with it, I am sorry.

Mr. MCCRERY. My point is that we may never pass medical malpractice reform if the AMA doesn't stand squarely behind it on any vehicle that we might get through the Congress, and if we could get solid support from the AMA for what to many of us seems to be a commonsense reform for the benefit of our society and for the preservation our private health care system, we could maybe get it done. But if we get mixed signals like don't put it on this vehicle or that vehicle, it is not that important, go ahead and pass this, then it is going to be impossible to pass medical malpractice reform.

Dr. PALMISANO. Sure. And if I might respond to that for the record, the AMA would like to see any language in any bill that would give us nationwide tort reform because it is a top priority of the American Medical Association.

Mr. MCCRERY. Thank you. The only other thing I would add to the list that Mrs. Johnson asked you to provide some evidence for is medical school applications. Is there any evidence that medical school applications are going down because of the best and the brightest changing their minds as to what career path to pursue because of all these problems?

Chairman JOHNSON. Dr. Mayer, did you want to respond?

Dr. MAYER. Yes. I think there are data now that the number of applicants is going down. The applications are still in excess of the number of positions available. I would only reemphasize when you weren't here to point out, though, that in cardiothoracic surgery we had fewer applicants than we had available positions. It has never happened in our specialty before. It was sort of the creme de la creme who made it through general surgery and then went on to cardiothoracic surgery. For the last 3 or 4 years, we have not filled with American medical school graduates. Those applicant positions are going to overseas folks, and many of them are high-quality people, but I think it is symptomatic of the problem. And this year, even with the non-U.S. medical school graduates, we didn't fill the programs.

So, you know, I think these things are all having an impact, and, you know, as I said in my formal comments, I think once this train goes off the edge of the cliff, it is going to take 10 years to turn it around, because that is how long it takes, post medical school, to mint a new cardiothoracic surgeon.

Chairman JOHNSON. Mr. Levine.

Mr. LEVINE. Madam Chair, if I may just regress for one minute and go back to your comment on disease management and access, I think that is a very significant concern. Physical therapists focus on functional restoration with patients, and prevention is a key to disease management. One of the other things that I hope the Committee will look at is not only the impact of the fee schedule cuts but the other regulatory restrictions that limit Medicare beneficiaries' access to those health care providers that do impact disease management.

In my practice in the State of Maryland, physical therapists have had direct access for physical therapy services since 1979. However, the Medicare beneficiary does not have that ability to seek physical therapists and oftentimes it is the physician who is not familiar with the fact that the physical therapist can be an integral component of the disease management process.

So I would only urge the Committee to look at the other regulatory issues in combination as you look to navigate this.

Chairman JOHNSON. I would just like to add to Mr. McCrery's comments that it is truly bizarre for Congress to consider capping the liability of plans without capping the liability, at least at those same levels, of physicians. So I consider it imperative to have some malpractice reform in the Patient's Bill of Rights in order to simply have a level playingfield, and was very disappointed with the lukewarm support we got on that issue. And I recently sat down with insurance companies in my district, physician-owned insurance companies, where the issues of utilization and quality have been rigorously addressed, and they had a 20-percent cost increase last year, they will have a 25-percent cost increase this year. It is not because there are more cases being brought. It is specifically because the awards have gone absolutely through the ceiling. So this is a very big issue, and you can't talk about cost control in Medicare or anywhere else unless you are willing to confront it. Congresswoman Thurman.

Mrs. THURMAN. Thank you, Madam Chairman. Although, Madam Chairman, I would also say that in some of the instances with the insurance and I don't want us to get too caught up in all of this it is also the interest payments that they are receiving on their investments which is also not helping them. And for some of those doctors who are doing their own insurance, and through the reinsurance because of September 11, they are also having an increase in their reinsurance which is also creating a part of the problem.

Chairman JOHNSON. If the gentlelady will yield, I asked those questions of this particular company. They do not use reinsurance and they are invested in ways that are not affected by Wall Street. So we need to get into this in a way that demonstrates, because here is kind of a creme de la creme plan and it is strictly award size.

Mrs. THURMAN. And I have talked to others that say differently. So I would agree with you that we probably need to sit down and talk about that overall, so that we have a better idea of what is going on here.

I just want to tell you all thank you very much for being here. I am sorry I missed your testimony, and so at this time I don't have any questions, but we certainly appreciate it and hopefully we will be able to help our constituents by making sure they have access to physicians without long waits and without the loss of physicians in areas that are underserved today. So we thank you for being here.

Chairman JOHNSON. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Madam Chair. I am sorry that the Congress is trying to do everything in 2 days a week, so that some of us are running between committees. I was just up listening

to Secretary Thompson talk about all of this, and I had to kind of decide whether I would go there or stay here. What he is saying up there isn't going to make you folks very happy, I am sure.

But let me ask you a question, first of all. I think, Dr. Ginsburg, you were here when we put in the RBRVS system?

Dr. GINSBURG. Yes.

Mr. MCDERMOTT. And I had just come to the Congress. That was in 1989, so I wasn't on this Committee yet. And I thought there was a lot of discussion at the time that one of the goals of putting in the RBRVS system was to increase payments to primary care people and to make additional access, to actually increase the volume of things; is that correct?

Dr. GINSBURG. Certainly we felt, and many people felt at that time, that Medicare had an imbalance, that we were paying too little for primary care and really were concerned that this would discourage the use of primary care in the Medicare program—and encourage too much specialty care. When this fee schedule, RBRVS, was put in, there also were concerns about the total volume and about the trends in total volume of Medicare physician services; although recognizing that this is a fee-for-service payment system, the incentives to the individual physicians are to increase volume, and this is what led to the Volume Performance Standards. This mechanism was attempting to engage the medical profession as a whole in professional attempts to limit volume through better information about effectiveness of care.

Mr. MCDERMOTT. How did that fail? I mean, we have gotten better payments for primary care physicians. And why is it that we can't control volume? I mean, we knew it. There was all this discussion about it. It should be no big surprise to anybody around here that the volume has gone up.

Dr. GINSBURG. I don't know that we should say we failed, because actually——

Mr. MCDERMOTT. I don't think we did. We hit the goal.

Dr. GINSBURG. Volume trends in the nineties were far more benign than they were in the eighties, although I am not sure that it was Medicare policy that was driving this, you know. Throughout the nineties we had a dramatic change in our system toward managed care. Most people in private insurance went from traditional plans to managed care plans. The managed care plans I suspect did have some effects on volume, and I believe that the effects of managed care on physician behavior, such as from requiring authorizations for admission to a hospital or referral to a specialist, probably spilled over into the fee-for-service Medicare Program. When physicians learn how to treat some of their patients differently, it is going to spill over to how they treat other patients.

So it is really hard to say whether the mechanism to control volume succeeded or failed, but the nineties were a period of low cost trends both for privately insured patients and for Medicare patients; but you know, I wouldn't—attribute it to the policy that the Congress passed in 1989.

Mr. MCDERMOTT. Now, I know you can't make recommendations, but I would like to ask you an option. We are not going to pass a bill for $126 billion, like MedPAC suggests, but how about letting the Secretary make a volume adjustment each year in the

fee update, maybe 1 or 2 percent, and just give them a little flexibility? How would you feel about that as a public policy?

Dr. GINSBURG. Yes. Drawing on the research, my biggest concern is with a formula that locks us into a very large decrease in rates over time. So to the degree to which people would make better judgments making annual decisions as opposed to having a lockstep formula, I would say that would be a positive. Policymakers would be in a better position to respond to the various data on physicians' costs and access to care for Medicare beneficiaries.

Mr. MCDERMOTT. I have one final question for the panel and I am sorry I also didn't hear all the testimony. We decided we are going to save a lot of money by turning the U.S. Department of Justice (DOJ) loose on medical providers, and I would like to know how many places you know about, or if you can provide a list to me after the hearing or whatever of those places where the DOJ has gone in on criminal charges on doctors and hospitals for their forums.

Where is that happening? I happen to know it is going on in Seattle, and I don't know where else it is going on, but what I know about it there; makes me really concerned about what you are doing to the health care and the practice of medicine. So I would like to know where else; so I have got to figure out which of my colleagues is having this same thing that is going on in Seattle.

Does anybody know the answer to that or have a list?

Dr. MAYER. Well, I think the University of Pennsylvania certainly was affected. The University of Pennsylvania hospitals took a significant financial hit based on a Department of Justice investigation. I know in Boston there was the threat of a Department of Justice inquiry at the Beth Israel Medical Center.

Mr. MCDERMOTT. How did they abort it?

Dr. MAYER. I am not sure that I know the answer to that. But it may be that the Beth Israel is sort of teetering financially, and maybe they didn't want to to be honest with you, I just don't know, but I do know that this threat existed.

Mr. MCDERMOTT. Were those both criminal? Pennsylvania was criminal and Beth Israel was criminal?

Dr. MAYER. I don't know the answer to whether it was criminal or civil. I know that the University of Pennsylvania had to pay $30 million and, you know, the method they used is actually quite interesting. You know, they will take 200 charts and find some percentage rate of failure to comply or something, and then they will extrapolate it to the entire volume at that institution and then come up with a number times 3, because it is treble damages sort of thing, and it can add up to a lot of money in a big hurry. And I think that is exactly what is going on in Seattle, too, at least from what I read on my e-mail.

Mr. MCDERMOTT. Is there anybody else that has any information about this? My colleague say the University of Florida has been going through is there anybody else?

Chairman JOHNSON. If the gentleman would yield, this is a very big issue. We have worked on this a little bit in the regulatory reform bill to deal with some of the extrapolation problems. But one of the big problems in the Pennsylvania situation was that originally the Inspector General was completely ignoring HCFA's

own directives to that institution about how to pay, and they were ignoring the portion of the law that allowed indirect supervision of residents, and a number of us got into that and suspended that whole process for a number of months, but when the Secretary allowed it to go ahead, there was not clarity on those issues.

Since that time we have had some better compliance by the Inspector General's Office, with the fundamental principle of recognizing the law and the directives that these organizations must comply with under other provisions of the law, because too often the Inspector General was not acknowledging the orders from HCFA themselves but was interpreting the law according to their own judgment and leaving the providers in a terrible bind. So we do have work to do on that issue, and I appreciate the gentleman from Washington bringing up, as he always does, very difficult but extremely important issues.

Mr. MCDERMOTT. Madam Chair, just for a second, I would hope that we could have a hearing on this issue so that we could understand what actually is going on because what I know about the Seattle situation is that they are crushing either the number one or number two neurosurgery program in the United States by this criminal investigation, and I think there is a real question about whether or not what is happening there is what we intended. And it has happened to me first, but I think other people are going to get the same treatment.

Chairman JOHNSON. I will be very happy to explore this with you, because I thought after the Pennsylvania thing that we had brought some greater rationality to the process. But we have seen in many parts of the Medicare system a total lack of respect for the law and justice, in my estimation, and we will, Mr. McDermott, look into this and see if we can put it into our schedule.

We do have a very tight schedule on some portions of our work, but there will be lots of opportunity to fold in things learned, perhaps even after floor action, so we will look into this.

Thank you very much. I thank the panel for their input, and I thank the Members for their attendance. The hearing is adjourned.

[Whereupon, at 11:46 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of the American Academy of Family Physicians

Congress Must Fix the Medicare Physician Fee Schedule

Physicians and other health practitioners have experienced a sharp (5.4 percent) across-the-board reduction in their Medicare payments beginning January 1st. These cuts apply to all services and to more than one million health professionals. The Medicare Payment Advisory Commission (MedPAC) has called for the elimination of the current update formula and warned that cuts of the magnitude expected under this formula could raise concerns about the adequacy of payments and beneficiary access to care. AAFP agrees with that assessment and joins in urging Congress to take immediate steps to "freeze and revise"; that is, freeze the conversion factor (payment rate) at the 2001 level and work to revise the update formula as recommended by MedPAC.

Currently, Medicare officials are required to use a seriously flawed [because it's tied to business cycle not patient need], statutory formula to calculate physician conversion factor updates which take effect each January 1 and which apply to chiropractors, optometrists, nurse practitioners, therapists and many other practitioners

in addition to doctors of medicine and osteopathy. This formula known as the sustainable growth rate (SGR) restrains aggregate Part B spending and ties this spending target to the business cycle rather than patient need. Despite 1999 legislation that attempted to stem volatility, large and unpredictable payment swings with potential cuts of more than 5 percent a year are still occurring.

The cut experienced this year makes the fourth time in 11 years that Medicare physician payment rates have been reduced. During that time, physicians and other practitioners have been inundated with expensive new government regulations requiring physicians to provide interpreters, dedicate staff to documenting and overseeing compliance plans and supply unnecessary and duplicative documentation. Yet, Medicare payments during the same 11 years have risen by an average of just 1.1 percent a year or 13 percent less than the government's own estimate of practice cost inflation.

The gap between cost inflation and Medicare's payment updates is already starting to take its toll and a negative update could greatly exacerbate the situation. In the last year or so, access problems have been reported in Atlanta, Phoenix, Albuquerque, Annapolis, Denver, Austin, Spokane, northern California and Idaho. AAFP data reveals that 17 percent of family physicians are not taking new Medicare fee-for-service patients.

Perhaps the most striking example of the payment rate cut can be illustrated by the experience of Dr. Baretta Casey:

Dr. Casey has done what the government wants many physicians to do: set up practice in an underserved area, taking care of many patients on Medicare and Medicaid. She came to medicine later in life than many do, as a wife with two children—three by the time she graduated. She wanted to become a family doctor and practice in her Appalachian hometown of Pikeville, Ky.

Her business background stood her in good stead. She bought an office building at an auction, rented out the top floor to offset the cost of her first-floor office, computerized her practice from the start and opened her doors as a solo practitioner eight years ago.

Thanks to the booming practice and conservative living, Casey significantly paid down her $145,000 in student loans her first full year. But that was as good as it got. Ensuing years didn't get better. In fact, they got worse.

On her computer Dr. Casey watched while medical expenses continued to grow but payment rates failed to keep pace. Dr. Casey says: "As a solo practitioner, I pay for everything. And the increase in expenses hasn't been the measly little percentage you hear forecasted by the government. I've tracked it on my computer. It has gone up 10 to 15 percent every year."

"It took about six years, but at the six-year mark, expenses and income literally met in the middle," she says. "This past year, they crossed over. And now, I have to dip into my savings to cover the extra expense. I'm basically subsidizing my own practice out of a savings account."

And now, in 2002, the worst blow of all—the 5.4 percent cut in the Medicare conversion factor. "I've had to make some decisions," Dr. Casey says. "I won't take any new Medicare patients or any new patients with any insurance company that follows suit and drops payment." And ultimately, she says, "If things don't change, I probably couldn't stay in practice any more than two more years."

Dr. Casey has a message for Washington:

"If our reimbursement rates continue to go down and our expenses continue to go up," she says, "you will see an exodus of physicians out of rural areas like Moses out of Egypt. It's not because doctors don't care about their patients. They do, tremendously."

"It's because nobody is going to continue in a field or in a business when they're losing 10 to 15 percent per year. The practice of medicine is like any other business: If you can't pay your bills, you can't survive."

Experience has already shown the danger of unrealistic payment rates in Medicaid, where twenty years of studies have consistently concluded that fee levels affect both access and outcomes. Medicare is not immune from similar problems as has been made abundantly clear by the continued exodus of Medicare+Choice plans from the program despite a guaranteed pay increase of at least 2 percent a year. Some 85 percent of elderly and disabled Americans rely on fee-for-service Medicare and for an ever-increasing number, there is no other option available.

The American Academy of Family Physicians and its 93,500 members urge Congress to act now to freeze the conversion factor at last year's rate as we all work to revise the flawed formula that causes volatile swings and insufficient reimbursement for physicians. Your action will ensure that Medicare patients can continue to receive the care they depend on and deserve.

Statement of the American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG), an organization representing nearly 45,000 physicians dedicated to improving women's health, strongly urges Congress to repeal the 5.4% cut in Medicare payment and to replace the current, flawed Medicare payment formula.

The Medicare Physician Payment Fairness Act of 2001 (S 1707 and HR 3351) enjoys a supermajority in both Houses, with over 300 co-sponsors in the House and 69 in the Senate pledging their support. Yet, in 2001, no floor action occurred to prevent the 5.4% cut from going into effect January 1, 2002. This legislation is the critical first step in solving the inherent problems in the annual Medicare Physician Payment updates.

The 5.4% cut implemented by the Centers for Medicare and Medicaid Services (CMS) stems from a fatally-flawed formula that penalizes physicians for economic downturns and from CMS data errors that have short-changed physicians by $15 billion since 1998 and 1999. Services provided by physicians are subject to an aggregate Medicare spending limit that does not include any adjustment for new technology and that is tied to the gross domestic product.

This cut is the fourth broad-scale reduction in physicians' fees since 1992, bringing the average increase in Medicare fees between 1991 and 2002 to just 1.1% a year—13% less than the government's estimate of practice cost inflation. This cut is especially hard on ob-gyns, whose professional liability premiums have skyrocketed in the last six months. Ob-gyns face these increases, combined with decreases in federal payments and expanding regulatory burdens.

Medicaid and private payers often base their payments on the Medicare payment update as well. Medicare beneficiaries make up 13% of ACOG Fellows' patients. Twenty percent of their patients are Medicaid beneficiaries. Already, compromises in access to care have been reported in Atlanta, Phoenix, Albuquerque, Annapolis, Denver, Austin, Spokane, northern California, and Idaho. We cannot allow this to continue.

The Medicare Physician Payment Fairness Act would provide an immediate legislative halt to the 5.4% Medicare Payment cut, and give Congress the opportunity to make systemic changes in the physician update system next year. In addition, it would direct the Medicare Payment Advisory Commission (MedPAC) to recommend ways to eliminate or fix the expenditure target or Sustainable Growth Rate (SGR), which now helps determine annual Medicare Physician Payment updates.

ACOG urges Congress to act today to restore fair payments to physicians and ensure patients' access to quality care.

Statement of the American College of Physicians-American Society of Internal Medicine

The American College of Physicians-American Society of Internal Medicine (ACP–ASIM)—representing 115,000 physicians and medical students—is the largest medical specialty society and the second largest medical organization in the United States. Internists provide care for more Medicare patients than any other medical specialty. We congratulate the Subcommittee on Health for holding this important hearing. Of the College's top priorities for 2002, addressing the inadequacies of physician payment by the Medicare program is the most critical to our members. ACP–ASIM thanks Congresswoman Nancy Johnson, chair of the Subcommittee, Congressman Pete Stark, ranking member of the Subcommittee, and other members, for convening this important hearing. We also want to extend special appreciation to Chairwoman Johnson for her extensive efforts to seek stability in the physician payment system.

Background

Beginning January 1, 2002, Medicare reimbursement payments to physicians and other health care professionals fell an average 5.4 percent. Despite serious concerns raised by ACP–ASIM and other medical associations, and warnings from the Medicare Payment Advisory Commission (MedPAC), medicine is having to endure the fourth physician payment cut in ten years. Because of flaws in the formula used by Medicare to determine annual updates, the CMS is projecting that Medicare payments will continue to decline over the next four years—*by a grand total of 18.3*

percent from 2002–2005. This is an *absolute* reduction in payments; it does not take into account the impact of inflation in the costs of providing services. Using a very conservative inflation assumption of 3 percent per year, *Medicare payments per service in constant dollars will be cut by 28.1% over the 2002–2005 period.*

This is not a problem that was created overnight. Congress adopted the current physician payment methodology (known as the Sustainable Growth Rate or SGR) in the Balanced Budget Act of 1997. Even then, ACP–ASIM recognized the serious flaws inherent in the SGR payment system and voiced our concern. Congress attempted to make corrections to the payment formula in 1999 with the Balanced Budget Refinement Act, however, it was not sufficient enough to correct the intrinsic problems. The recent economic downturn the country is now facing has only exacerbated the problem.

Recognizing the unfairness of the SGR methodology and the tremendous hardship it has placed on physicians across the country, a super-majority of members of Congress cosponsored legislation that would stymie the magnitude of the 5.4 percent cut. Introduced in the waning days of the first session of the 107th Congress, "the Medicare Physician Payment Fairness Act of 2001," (H.R. 3351 and S. 1707) would have cut the SGR reduction to physicians to 0.9 percent, rather than the current 5.4 percent cut. ACP–ASIM continues to strongly support this legislation. Unfortunately, Congress failed to act prior to adjournment and physicians are consequently now beginning to feel the effects of an across-the-board reduction in their medical practices.

Flawed Data Used in Formula

The 5.4 percent across-the-board reduction in Medicare payment is primarily due to the flawed SGR system that governs the annual payment for physician services. The SGR system errantly ties physician payment to the Gross Domestic Product (GDP). There is no other segment of the health care industry that uses such a methodology to update payment. What is most unfortunate is that this method of tying physician payment to the health of the overall economy bears absolutely no relation to the cost of providing actual physician services. In the years where the economy is facing a downturn, such as has been the case in the recent past, a reduction in physician payment is significant.

In its March 2002 report to the Congress, MedPAC expresses grave concern about the underlying problem of tying the SGR to the economy. MedPAC reports that the current SGR system may even cause payments to deviate from physician costs because it does not fully account for factors affecting the actual cost of providing services. Specifically, while the current SGR payment system accounts for input price inflation and productivity growth, it provides no opportunity to account for other factors, such as an increase in the regulatory burden of the Medicare program.

In addition to the flawed SGR payment system, physicians have repeatedly been penalized for inaccurate estimates in the past. Since the SGR payment formula was first utilized in 1998 and 1999, Medicare officials have consistently relied upon flawed data for the annual update. Because the SGR formula is cumulative (i.e., it relies on previous years' estimates), these errors that were never corrected are compounded, further exacerbating the problem year after year. Due to these successive errors, the spending target is about $15 billion lower than it actually should be.

Effect on Physicians and Their Patients

A physician payment cut of this proportion is a tremendous blow to physicians, particularly internists. According to a 2001 Medical Group Management Association study, Medicare payments account for nearly 50 percent more of the average internists revenue than the average primary care physician. The 5.4 percent physician payment cut comes at a time when malpractice premiums are at their highest levels, the amount of regulatory burden it at its peak (such as costs associated with complying with HIPAA), and the cost of other overhead expenses is dramatically increasing. This culmination of events may force physicians to make difficult choices in order to continue to operate.

Physicians have a strong sense of commitment to their Medicare patients. They will do everything within reason to continue to provide their Medicare patients with high quality, accessible health care, even in the face of rising costs and declining reimbursement. *However, there is a point where the economics of running a practice will force physicians to institute changes to limit the damage from continued Medicare payment cuts.* Like any small business, revenue must exceed the costs of providing services in order for a practice to remain financially viable. For practices that are heavily dependent on Medicare revenue, such as a typical internal medicine practice, an after-inflation payment reduction of 28.1 percent over the 2002–2005

period will dictate that they take preventive steps to cut their losses from seeing large numbers of Medicare patients.

Physicians will have essentially only four options available to them to offset the losses from declining Medicare payments and rising costs. They can reduce their reliance on Medicare revenue, by restructuring their practices to decrease the share of their practice revenue that comes from Medicare while increasing the share that comes from more reliable (non-Medicare) payers. This would be accomplished by putting limits on how many Medicare patients will be seen while marketing the practice to non-Medicare populations. They can cut costs—eliminating beneficial services *and* technology. They can do both: cut beneficial services and reduce their reliance on Medicare. Or they can go out of business, by closing their practices entirely.

We believe that it is extremely probable physicians will be forced to limit the number of Medicare patients in their practice; lay off staff that help Medicare patients with appointments or medications; relocate to areas with a younger, non-Medicare eligible patients; spend less time with Medicare patients; discontinue participation in the Medicare program; limit or discontinue investment in new technology; limit or discontinue charitable care; or in some cases, retire or close their practices. Physicians will make such changes reluctantly, but the laws of economics will leave them no choice but to do so.

The effects of the most recent and projected cuts in reimbursement will most likely be hardest felt in rural and other areas that are already underserved. The problems that we see today will certainly only get worse unless the severely flawed methodology utilized by Medicare to compute physician payments is immediately addressed.

Physicians' efforts to reduce their reliance on an unstable and unreliable Medicare payment system will make it even more difficult for patients to gain access to an increasingly under-funded health care system, particularly as the number of Medicare patients increases from 34 million today, to 40 million in 2010, to 60 million in 2030. More Medicare beneficiaries will be seeking care, yet fewer and fewer physicians may be able and willing to provide care to Medicare patients. As Medicare is increasingly viewed as an unreliable payer whose reimbursement does not cover the costs of providing services, young physicians will be disinclined to go into specialties that are viewed as being heavily dependent on Medicare—particularly internal medicine and geriatrics—at the time when those specialties should be most in demand to provide care to an aging population.

A recent American Academy of Family Physicians study confirmed that physicians are already making tough decisions, citing that nearly 30 percent of family physicians are not taking new Medicare patients. Other recent studies confirm doctor frustration with inadequate reimbursement from all areas of physician payment. In Washington State, for example, a Washington State Medical Association poll of members in November 2001 revealed that 57 percent of physicians said that they are limiting the number of or dropping all Medicare patients from their practices. The report blames the many years of decline of the state's health care delivery system, characterized by a slow erosion of funding for public health, growing administrative expenses for practitioners and mounting frustrations of physicians trying to cope with myriad of regulations.

The subcommittee will be hearing testimony today from Dr. Paul Ginsburg, Director, Center for Studying Health System Changes, which provides further evidence to support the view that the availability of care for Medicare patients has already deteriorated over the past four years. He reports that the percentage of Medicare patients who did not receive or delayed needed care increased from 9.27 percent in 1997 to 11.1 percent in 2001. The percentage of primary care physicians accepting all new Medicare patients declined steadily over the 1997–2001 period. These changes were occurring even before the impact of the 5.4 cut went into effect, and before most physicians have become fully aware that they will have to cope with an after-inflation cut of 28.1% over the 2002–2005 calendar period.

In December 2001, the American Medical Association conducted a state-by-state analysis of the impact of the 5.4% Medicare cut, which revealed a tremendous blow to the states. In Connecticut, for example, physicians' Medicare losses will total $33.8 million. In California, physicians are expected to lose more than $205 million. New York physicians stand to lose more than $207 million, the highest physician payment reduction total of any state.

MedPAC Recommendations to Congress

In its March 2001 report to the Congress, MedPAC recommended that the Congress replace the SGR system with an annual update methodology based on factors influencing the unit costs of efficiently providing physician services. According to

MedPAC, getting the price right is more important than controlling spending through the payment mechanism. The Commission noted that the main problems with the SGR were that it failed to account for all relevant factors that affect the cost of providing services, and the system exacerbates Medicare's problem of paying different amounts for the same service depending on where it is provided (physician's office, hospital outpatient department, ambulatory surgical center). The Commission added that other inherent problems with the SGR system stem from its volatility and unpredictability. These problems are as true today as ever.

In MedPAC's March 2002 Report to Congress, the Commission will once again recommend that Congress repeal the SGR system due to these same concerns. This time, however, MedPAC offers more concrete recommendations for Congress to direct the Secretary of HHS to implement for the year 2003 and beyond.

MedPAC's proposed payment method would make updates to physician services similar to the updates for other services and promote the goal of "achieving consistent payment polices" across ambulatory care settings, including physician offices, hospital outpatient departments, and ambulatory surgical centers. MedPAC's recommendations are as follows:

1. The Congress Should Repeal the Sustainable Growth Rate System and Instead Require that the Secretary Update Payments for Physician Services Based on the Estimated Change in Input Prices for the Coming Year, Less an Adjustment for Growth in Multifactor Productivity;
2. The Secretary Should Revise the Productivity Adjustment for Physician Services and Make it a Multifactor Instead of a Labor-Only Adjustment; and
3. The Congress Should Update Payments for Physician Services by 2.5 Percent for 2003.

The Congress Should Require the Secretary to Update Payments for Physician Services Based on the Estimated Change in Input Prices, Less an Adjustment for Growth in Multifactor Productivity

In MedPAC's first recommendation to repeal the SGR system, the Commission states, "Replacing the SGR system in this way would solve the fundamental problems of the SGR system." The adjustment the Commission recommends would change the current measure of input price inflation for physician services—the Medicare Economic Index (MEI)—to make it a forecast of input price growth for the coming year. Further, the productivity adjustment from the MEI would also be removed so the MEI would only be a price measure. Productivity would be considered separately in update decisions.

The Secretary Should Revise the Productivity Adjustment for Physician Services and Make it a Multifactor Instead of a Labor Only Adjustment

MedPAC's second recommendation to revise the productivity adjustment to account for labor and nonlabor factors is consistent with the way physician services are produced. While labor accounts for the majority of the costs for providing physician services, other inputs, such as office space, medical materials and supplies, and equipment, are also important to consider. This adjustment would more accurately measure growth in productivity by considering all inputs. However, ACP–ASIM cautions that factoring in physician productivity in order to lower the physician payment update may be problematic. Increased compliance with federal regulations, such as Medicare paperwork and HIPAA mandates, may be what is contributing to the lower productivity, and may therefore skew the update. MedPAC acknowledges this problem, but admits that it has little or no data to support compensating for this issue.

The first two recommendations in physician payment methodology would allow the updates to more fully and accurately account for factors affecting costs, and it would decouple payment updates from spending control. Further, the revision to the productivity adjustment will make payment of physician services consistent with modern methods of measuring productivity, and make payments stable and predictable from year to year.

Congress Should Update Payments for Physician Services by 2.5 Percent for 2003

MedPAC's third recommendation to update physician services by 2.5 percent for January 2003 is the application of the first two recommendations. Since input prices are expected to rise 3 percent in 2003, when combined with a 0.5 percent productivity adjustment, the result yields a 2.5 percent payment increase.

Solution

ACP–ASIM strongly supports the MedPAC's goal of "achieving consistent payment polices" for physicians and their practices. Therefore, ACP–ASIM supports the

Commission's recommendation to replace the SGR system and to require Medicare to update payments for physician services based on the estimated change in input prices for the coming year as measured by the Medicare Economic Index (MEI). We agree that any productivity adjustment for physician services should be based on several factors instead of being based on labor costs alone, and that this should be applied as a separate adjustment to the update, rather than being included in the MEI itself. Further, ACP–ASIM supports the Commission's recommendation to update the physician fee schedule by 2.5 percent for 2003.

We are recommending one addition to the MedPAC's recommendations, however. Legislation to eliminate the SGR formula and replace it with the MedPAC update framework should specify that **if Congress declines in any given year to enact legislation to establish the physician fee schedule update based upon recommendations of the MedPAC a default update equal to the modified MEI, i.e., the MEI excluding the productivity factor, MINUS a separate .5% productivity adjustment, shall apply.** This adjustment would, at the very least, assure some predictability and stability in the update in the coming years, notwithstanding our reservations about applying an automatic productivity adjustment to the update.

Finally, ACP–ASIM continues to seek a halt to the 5.4% cut that went into effect in January 2002 and calls on Congress to enact immediate relief. Correcting the problem in 2003, by replacing the SGR formula with the MedPAC framework, will not be sufficient to undo the harm created by the 5.4% cut. We are concerned that Congress may delay action on halting the 5.4% cut by bundling this relief into other Medicare reforms that may not be acted upon until late in the congressional session.

We urge the Committee to report legislation to (1) put an immediate halt to the 5.4% reduction (2) replace the SGR formula with the MedPAC framework, with the addition of the above default mechanism recommended by ACP–ASIM and (3) establish the 2003 update at 2.5% and (4) urge the House Budget Committee to include money in the budget resolution to accomplish these changes. Such measures should be reported and acted upon by Congress prior to, and independent of, other needed Medicare reforms.

Conclusion

ACP–ASIM is pleased that the Subcommittee is addressing the serious problems associated with the current SGR based physician payment system. Our organization stands ready to assist the Subcommittee in resolving this pressing issue in any way we can.

Statement of the Association of American Medical Colleges

The Association of American Medical Colleges (AAMC) is pleased to submit for the record testimony to the House Ways and Means 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 providers and Medicare beneficiaries. 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 ensure that Medicare beneficiaries have access to the complex and specialized care provided by academic physicians.

The AAMC represents the country's 125 accredited medical schools and nearly 400 major teaching hospitals and health systems, 90 academic/professional societies representing approximately 100,000 faculty members ("academic physicians"), and the nation's medical students and residents.

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 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.

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 can not be 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 (which account for just 6 percent of the nation's hospitals) deliver geriatric care (e.g., treatment for Parkinson's or Alzheimer's disease) and operate certified trauma centers in conjunction with academic physician partners.

In addition, faculty practices partner with AAMC's teaching hospital members to provide nearly 45 percent 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. According to 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.

Update Methodology (SGR)

The Balanced Budget Act of 1997 (BBA) established a formula to calculate the SGR—the "target growth rate" for Medicare spending on physician services—that would control overall Medicare spending while simultaneously accounting for changes in the cost of providing care. The AAMC is concerned that the SGR has not achieved an equitable balance between fiscal management of the Medicare program and the actual cost of caring for Medicare patients, including the cost of medical inflation. Various analyses have shown that, since implementation of the SGR, updates in physician payments have failed to rise in proportion with increases in input prices.

Additionally, as was the case this year, the SGR's link to the country's gross domestic product (GDP) is problematic and volatile. While payment updates in 2000 and 2001 were relatively large (5.4 percent and 4.5 percent respectively), the 2002 payment update of negative 5.4 percent is not only a dramatic decline, but also contrasts sharply with the previous two years.

In its March 2001 report, the Medicare Payment Advisory Commission (MedPAC) identified similar concerns with the SGR and unanimously called to replace the methodology, stating that it "neither adequately accounts for changes in cost nor controls total spending." MedPAC members reiterated their concerns at their January 2002 meeting and announced in their January 16–17 *Meeting Brief* that their March 2002 report will recommend "replacing the SGR system, updating payments for 2003, accounting for productivity growth outside the MEI, and revising the productivity adjustment. . . ." The AAMC strongly supports MedPAC's conclusion regarding the need to develop a new update methodology that produces stable and adequate payments for physicians.

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 total about $2.5 billion each year and represent up to one-third of faculty practice revenues. In light of the fact that faculty practice revenues, on average, represent about 35 percent 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 providing charity care.

A sample analysis of the impact of the 2002 Medicare fee schedule on faculty practice plans identified that a vast majority of faculty practices will lose more than minus 5.4 percent of Medicare revenue. In fact, Medicare revenue for some plans will decline by as much as 7.5 percent. Because faculty practices provide multispecialty and complex care for Medicare patients, the negative payment update, when

combined with recent changes in Relative Value Units (RVUs)[1], will drive payment reductions that exceed minus 5.4 percent in many Medicare-related clinical specialties (as illustrated in the table below). It is important to note that while some specialties included in the analysis will experience less than 5.4 percent decline, no specialties will experience an *increase* in Medicare revenue under the 2002 payment schedule.

Medicare Payment Forecast Analysis Impact of Change in 2002 Conversion Factor and RVU Values Across Faculty Practice Plans

Specialty	Percent Change
Cardiology: Invasive	–13.21%
Cardiology: Noninvasive	–9.7%
Critical Care	–5.6%
Emergency Medicine	–7.7%
Gastroenterology	–7.3%
Neurosurgery	–8.4%
Ophthalmology	–6.9%
Physical Medicine	–5.9%
Psychiatry	–6.2%
Pulmonary	–6.3%
Radiology: Interventional	–7.1%
Radiology: Nuclear Medicine	–8.5%
Surgery: Cardiovascular	–10.1%
Urology	–7.3%

Source: University HealthSystem Consortium (UHC)/AAMC Faculty Practice Solutions Center

Since private payers often tie their reimbursement rates to those set by Medicare, reductions in Medicare payments will further increase the disparity between the costs of care and the rates at which payers reimburse for those costs. For example, one large faculty practice (nearly 900 physicians) anticipates a loss of $4.8 million in managed care reimbursement because the contracts are linked to the Medicare fee schedule. Note that this does not include Medicaid and Tricare, which would also be affected by cuts in the Medicare fee schedule.

The growing disparity between costs and reimbursement will make it increasingly difficult for medical schools and teaching hospitals to maintain their patient care, education, research, and community service missions. Because of their revenue losses, the practice described above is implementing a policy to limit its appointments for indigent patients to no more than 10 percent of patient visits.

A Legislative Solution to the SGR Problem

Last fall, bipartisan, bicameral legislation, "The Medicare Physician Payment Fairness Act of 2001" (H.R. 3351/S. 1707), was introduced to provide short- and long-term relief from unstable Medicare physician payment updates. The bills provide short-term relief by reducing the cut to the Medicare physician payment update from minus 5.4 percent to minus 0.9 percent and long-term relief by directing MedPAC to develop a replacement for the SGR.

The AAMC strongly endorses these bills, and is pleased that a majority of Representatives and Senators have cosponsored the bill. The AAMC urges the Sub-

[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.

committee to support this legislation and ensure that the losses currently experienced by physicians are mitigated as quickly as possible.

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. Passage of H.R.3351/S. 1707 is a vital first step toward mitigating the losses currently experienced by all physicians. The AAMC looks forward to working with Subcommittee members in accomplishing the second step—devising a long-term solution to replace the current SGR methodology and assure adequate and stable Medicare physician payment updates.

Association of Maternal and Child Health Programs
Washington, DC 20036
February 27, 2002

The Honorable Nancy Johnson
Subcommittee on Health of the Committee on Ways and Means
United States House of Representative
Washington, DC 20515

Re: Committee Hearing on Medicare Physician Payments

Dear Representative Johnson:

The Association of Maternal and Child Health Programs (AMCHP) represents state public health leaders and others working to improve the health and well being of women, children and youth, including those with special health care needs, and families. We are very concerned about the Centers for Medicare & Medicaid Services' (CMS) decision to publish only the practice and physician liability expense values for the two vaccine administration codes (90471 and 90472), without publishing any values for the physician work involved in the administration of vaccines. As a result of this under-valuation, we fear that many Medicaid programs and other insurers that base payments on the Medicare fee schedule will reduce reimbursement for this service to levels well below the actual costs incurred by providers. Undercompensating private physicians for vaccine administration, thereby discouraging them from providing this valuable service in their offices, could have a significant detrimental impact on the viability of our nation's immunization efforts.

State health programs across the nation alongside federal partners CDC, HRSA, and CMS, and the private medical community have worked hard to reach the current high rate of immunization and low rate of vaccine-preventable diseases in the United States. The Vaccines for Children (VFC) program has been remarkably effective in moving vaccine delivery for low-income families into the setting of a medical home, where children receive the benefit of comprehensive health services as well as immunizations. This effort to increase vaccine availability and utilization by increasing family awareness and encouraging families to seek primary, preventive care supports national health status goals reflected in the Healthy People 2010 initiative. Now is a particularly inopportune time to weaken that system, as it is already being severely stressed. Shortages of varicella, measles, mumps, rubella, DtaP and pneumococcal vaccines mean providers must recall the child, thus, increasing their financial burden and workload. In some cases, physicians' offices vaccine shortages mean that patients seek immunizations in already overburdened public health clinics.

The rationale guiding CMS' values for vaccine administration does not reflect what actually happens at an administration site, since there is, in fact, physician work involved in the administration of childhood vaccines. The American Medical Association's Related Value Update Committee (RUC) recently reaffirmed their recommendation to include specific vaccine administration physician work values. At the time each dose is administered, the physician must explain the vaccine's benefits and possible adverse reactions to the patient's parents or guardians. Provision of this information is requirement of the National Childhood Vaccine Injury Act. With the increases in disseminating misinformation, the time that physicians spend on education and cognitive discussion has increased. Some children receive vaccines from a variety of sources (e.g., public health departments, community health centers) further complicating the physician's task of forming a comprehensive vaccine history using scattered records. Finally, physicians make every effort to avoid any "missed opportunities" to immunize a patient, so they administer vaccines in contexts other than preventive health care visits.

For these reasons, AMCHP strongly recommends that the committee correct this problem, either through working with the administration on rewriting the rule or through legislative action if necessary, so that physicians are adequately compensated for administering vaccines to our nation's children.

The goal of public health and its partner organizations is to foster a healthy society. This goal will be significantly and negatively affected if private physicians are not adequately compensated for administration of vaccines. The result would be increasing the burden on public health clinics and reducing the likelihood that a child will receive comprehensive care in a medical home. If CMS does not change the Medicare fee schedule for vaccine administration, the result could be a decrease in the number of immunized children and a concomitant increase in preventable—and sometimes fatal—infectious diseases. We urge the committee, on behalf of our nation's women, children, and their families, to address this issue as you look at the broader issues involved with the physician payment rule put forth by CMS.

Sincerely,

Deborah F. Dietrich
Acting Executive Director

Statement of the College of American Pathologists

The College of American Pathologists (CAP) is pleased to submit this statement for the record of the Subcommittee on Health's hearing on the Medicare physician fee schedule formula and physician payments. The College is a medical specialty society representing more than 16,000 board-certified physicians who practice clinical or anatomic pathology, or both, in community hospitals, independent clinical laboratories, academic medical centers and federal and state health facilities.

The CAP first would like to applaud Subcommittee Chair Nancy Johnson for her support of improved Medicare payments for physicians and her strong statement last week regarding the flawed formula now used to calculate annual updates to the Medicare physician fee schedule. The CAP also would like to express its appreciation to Ways and Means Chair William Thomas and other members of the full committee who have voiced the need to address the important issue of Medicare physician payments. We look forward to working with all of you so that Congress can act quickly to lessen the damage caused by this year's precipitous decline in Medicare physician payments and replace the current update formula with one that more accurately reflects true practice costs.

The 5.4 percent reduction in physician payments that began January 1, 2002, affects pathologists profoundly and exacerbates existing financial pressures brought on by increasingly complex and costly regulatory requirements and rising liability insurance rates.

The January 1 reduction in payments is the fourth payment cut—and the largest—since Medicare instituted its physician fee schedule a decade ago. Since 1991, Medicare physician payment rates have risen an average of only 1.1 percent annually, or 13 percent less than the annual increase in practice costs, as measured by the Medicare Economic Index. Further, the Jan. 1 reduction comes on top of cuts to pathology services made in the transition to resource-based practice expenses, such as an 11.5 percent drop in payment over four years for the diagnosis of breast cancer, prostate cancer and malignant melanoma.

Pathologists and other physicians cannot continue to sustain the financial pressures the Medicare program has placed upon them. Compounding the current problem of falling payment rates are numerous new administrative requirements imposed on Medicare providers in recent years. For example, documentation requirements necessitated by Medicare program integrity initiatives and various provisions of the Health Insurance Portability and Accountability Act of 1996 have created substantial new paperwork burdens in laboratories and physician offices, and more are expected in coming years. These requirements raise the cost and complexity of providing care, but come with no additional compensation. Further adding to the burden on providers are rising professional liability insurance rates and the cost of technological advances critical to maintaining state-of-the-art medical care.

The 2002 payment cut stems from a flawed Medicare update formula—the "sustainable growth rate," or SGR. This system inappropriately reflects downturns in the general economy and that, along with data errors by the Centers for Medicare and Medicaid Services, have short-changed physicians by $15 million since 1998. The Medicare Payment Advisory Commission (MedPAC) warned last year that significant cuts in 2002 "could raise concerns about the adequacy of payments and ben-

eficiary access to care." MedPAC adopted a recommendation that Medicare replace the SGR with a system based on estimated changes in physician practice costs less an adjustment for growth in multi-factor productivity (labor, supplies and equipment—not just labor, as is now the case).

MedPAC's concerns regarding access must not be taken lightly. Experiences with Medicare+Choice disenrollment and Medicaid patient access give ample evidence of the need to maintain adequate payment to ensure adequate access. This year's reduction and future cuts that are likely absent immediate changes to the update system will force some physicians to discontinue accepting new Medicare patients, switch from participating to non-participating provider status, reduce administrative staff, retire early or take other actions to limit their Medicare liability. It is unfortunate that those same actions likely will jeopardize Medicare patients' access to care.

The CAP urges Congress to act this year to mitigate the 5.4 percent reduction to the Medicare physician fee schedule, repeal the sustainable growth rate system and replace it with an update formula that accurately reflects increases in practice costs.

The College thanks the Subcommittee for the opportunity to present its views on this important issue and offers its support and continued assistance as Congress moves toward remedying the flawed SGR formula and restoring equity to Medicare physician payments.

Colorado Otolaryngology Associates
Colorado Springs, Colorado 80909
February 26, 2002

The Honorable Nancy L Johnson
Chairwoman, House Ways and Means Committee, Health Subcommittee
2113 Rayburn H.O.B.
Washington, DC 20515

Dear Representative Johnson;

I recently learned of the February 28, 2002, hearing on 2002 physician payments. I would like to offer this written comment for consideration during this hearing.

Physicians are very concerned about the 5.4% decrease in Medicare payments. This year this decrease in payment is linked to most if not all-commercial third-party payers. Since 1997 the commercial third parties have been trying to control their costs and increase their profits by changing the way they develop their fee schedules. Fees used to be based on standard unit values by McGraw Hill (now called St. Anthony) but are now based on RBRVU's (Resource Based Relative Value Units). The sole purpose of this change was to reduce their physician payments. This move has been very successful for the health plans but has left the physicians with less money to run their practices.

As of January 2, 2002, most health plans had completed their conversion to RBRVU's. Physicians have had no input into this change. Health plans have also changed computer systems to comply with other government regulations and now the systems support only one fee schedule, as I understand it.

My physicians have not received an increase in salary in 7 years. This is far longer than most people in this country have gone without a salary increase. Therefore, you can see that a 5.4% decrease in payment is a deep cut into the physician budget; and you expect this decrease to continue through 2006. I can foresee many physicians having to give up their practices because they cannot afford to run an office at that level of payment.

To add to our problems, over the past two years commercial third-party payers have increased their premiums to employers by 50–60% per year. Health plans have not only increased their premiums but also now get a windfall profit of 5.4%.

In concrete terms the cost to run our practice has increased 6% in the past year. Coupled with this new 5.4% decrease in payments, we are now faced with an increased cost of 11% this year. We cannot sustain increased costs and decreased payments. If this only affected Medicare patients, a solution would be to stop seeing Medicare patients. As it is, our patient mix includes only 10% Medicare patients.

I hope this helps you understand the plight of all physicians in the United States. I need you to understand this issue and develop a formula for the Medicare conversion factor that will be fair and allow physicians to provide quality care to patients and at the same time let the medical business grow.

If you have questions or need clarification, I can be reached at (719) 867–7850. Thank you in advance for your consideration.

Sincerely

Judy Boesen, *RN, BGS, MAM*
Administrator

J. Lewis Romett, *MD*
Neiland Olson, *MD*
Joel Ernster, *MD, FACS*
Barton Knox, *MD, FACS*
J. Christopher Pruitt, *MD*
John Hohengarten, *MD*
Edgar B Galloway, *MD*

Statement of the Hon. J.D. Hayworth,
a Representative in Congress from the State of Arizona

Thank you Madam Chairwoman for holding today's hearing on the Medicare payment formula for physicians. I commend your leadership in addressing this pressing issue that will impact not only physician payment levels, but also beneficiary access to quality health care.

I have heard from many physicians in Arizona who have serious concerns about the physician payment update, which has resulted in a negative 5.4 percent update in 2002. I share their concerns because this significant cut could exacerbate existing access problems for Medicare beneficiaries, particularly in rural communities. Unfortunately, the current flawed formula has nothing to do with the cost of providing health care. I am concerned that the physician payment cut in 2002 and the expectation of similar significant reductions in the next several years may have the potential to sway physicians to retire early or simply choose not to participate in the Medicare program, which would have a serious effect on patient access to care.

As you know, the current physician payment formula links physician updates to the Sustainable Growth Rate (SGR) and changes in the Gross Domestic Product (GDP). The Medicare Payment Advisory Commission (MedPAC) and others have recommended replacing the SGR because it fails to account adequately for changes in physicians' costs by tying updates to the growth in the economy and exacerbating different payments to different groups for the same services.

I strongly believe that this critical issue must be addressed this year and I again commend your leadership in holding this hearing today. With the input of the physician community, MedPAC, the General Accounting Office, and the Administration, our committee can improve the existing physician reimbursement system. I look forward to continuing to work with you on a new payment methodology that will yield more fair, stable, and predictable updates for physicians.

Statement of the Hon. Joe Knollenberg,
a Representative of Congress from the State of Michigan

Mr. Chairman, I applaud the committee for holding this hearing as Congress continues to work with the Bush Administration to modernize and improve the Medicare system. As Congress addresses the issue of broad Medicare reform, it is essential to consider the impact of reducing Medicare payments to physicians. After all, physicians and other health care professionals are critical components of the Medicare system, serving on the front lines to provide quality health care to all Americans.

I commend the efforts made already by many Congressional Members and the Bush Administration to implement administrative reforms to make the Medicare program work better for physicians. Programs such as the Physicians' Open Door Initiative and the Physicians Issues Project have helped improve the flow of information, reduce regulatory burdens and ease paperwork requirements. As a result, doctors will be able to spend more of their time providing health care and less of their time wading through pages of rules and regulations. It is my hope that we will build on these improvements.

I appreciate the opportunity today to raise concerns expressed by many doctors in my home district in southeastern Michigan. I believe these issues have been

echoed by health providers throughout the country as well. My constituents have brought to my attention the devastating consequences of the final payment policies and payment rates for 2002 under the Medicare Physician Fee Schedule announced by CMS on November 1, 2001. Reducing Medicare's physician payments by 5.4% would significantly restrict their ability to provide the necessary services to our seniors.

In addition to physicians being discouraged by the enormous amount of federally required paperwork, our area has seen a significant decrease in the number of physicians financially able to care for Medicare beneficiaries, subsequently closing their practice to them. Moreover, some doctors are simply leaving medicine altogether because of the financial impossibility of providing services under Medicare.

Emergency physicians will be particularly adversely affected given payment cuts in other areas. The role of emergency departments is becoming even more important as our country prepares to respond to bioterrorism and it is essential that their physicians be able to effectively carry out their responsibilities.

A Medicare payment cut could also effect the entire health sector as numerous private sector plans and state Medicaid programs tie their physician fee schedules to Medicare rates. At a time when we are concerned with healthcare workforce shortages, we must identify strategies to increase recruitment, retention and development of qualified health care providers. I look forward to working with the Committee and the rest of my colleagues and the Bush Administration to enact comprehensive Medicare reform that will include strengthening the Medicare payment system.

Professional Radiology Inc.
Cincinnati, Ohio 45223
February 27, 2002

Ms. Allison Giles
Chief of Staff
US House of Representatives
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Ms. Giles:

Attached is a submission for the record to be included in the February 28, 2002 Subcommittee on Health Hearing on Physician Payments. This letter represents the views of the President Elect of the Alliance Physicians and Surgeons, speaking for 1250 Cincinnati physicians, the Ohio State Radiological Society representing 150 Diagnostic Radiologists and Radiation Oncologists, as well as the members of Professional Radiology, Inc., a 21-physician radiology group from the Christ and Jewish Hospitals in Cincinnati, Ohio, who are also members of the Health Alliance.

Sincerely,

Frank E. McWilliams, *M.D.*

Professional Radiology Inc.
Cincinnati, Ohio 45223
February 27, 2002

The Honorable Rob Portman
Member of Congress
238 Gannon Building
Washington, D.C. 20515
FAX: c/o Mr. Tim Miller
(202) 225–1992

Dear Rob:

Thank you very much for inviting me to attend the Medicare information meeting with Mr. Tom Scully on February 22, 2002. I found the exchange positive and Mr. Scully an eminently reasonable, intelligent man with a good grasp of CMS services, as one would expect. I was interested in the comments of all that spoke, and wanted to supplement what was stated at the meeting with some of my own comments, particularly in regards to physician reimbursement and mammography screening, as these issues were not perhaps as definitively explained by the participants as I think they should be. It is my understanding that the Health Services Sub-

committee in the House is meeting this week, according to Mr. Miller, and hopefully these comments, if helpful, could be forwarded.

PHYSICIAN REIMBURSEMENT:

CMS indicated that between 1998 and 2001, the cumulative update for physicians was 15.9%, compared to a 9.3% increase in medical inflation. This calculation ignores certain technical adjustments that reduce the conversion factor by a total of about one percentage point between 1998 and 2001. Furthermore, and more importantly, it focuses on the most positive four-year period in the target's history, and completely ignores six of the ten years that physicians have been under an expenditure target. The physician payments were cut in three of the missing years, 1992, 1996 and 1997, and were well below medical inflation in a fourth, 1993. Therefore, over the full ten years under an expenditure target, the cumulative change in physician payment was 18.5% compared to a 26% increase in medical inflation. Average annual increase in payments was 1.7% per year for physicians, while medical inflation averaged 2.3% per year. If one includes inflation, adjusted physician's reimbursement over that period of time is minus 13%, with all hospital and institutional reimbursement staying at 0% with no increase or decrease relative to inflation.

MS also claimed that over the long haul, physician payments and the CPI have risen by nearly identical rates, with one going up on the average of 3.2% and the other by 3.3%. To understand this assertion, it is important to understand that Medicare officials essentially issue two different conversion factor updates every year. The first (−4.8% in 2002) is based just on the Medical Economic Index. The second conversion factor as required by the expenditure target (−5.4% in 2002) makes additional negative budget neutrality adjustments, including one to offset volume increases that CMS assumes will occur as physicians attempt to make up for the reductions in the relative values for some services. This significantly impacts physicians in the service area, such as Radiology, where examinations are requested by other physicians, and there is no control by the radiologist over the volume. This results in a skewing of the relative value units, which we have all previously negotiated and agreed to in past years, and places an undue burden on those physicians who do not control the service demand. It also does not take into account the growing Medicare population or patient demands.

The 5.4% across the board reduction in Medicare physician payments is indefensible and will create a political fire storm. The practice policies that are beyond the control of physicians have increased dramatically. Medicare has imposed excessive administrative burdens and unfunded mandates on physicians in the past, and is now going to compound the situation with and an across the board cut. In fact, in some services such as Radiology, the cut is not 5.4%, but is estimated between 12 and 14%.

In Cincinnati, this Medicare fee schedule impacts dramatically the reimbursement climate. As Mr. Scully pointed out, the average Medicare recipient receives $6,800 in benefits across the country, whereas in Cincinnati it is $4,800, and in other areas it is $8,400, representing a significant discrepancy. This discrepancy is compounded by the fact that the high HMO penetration in the Greater Cincinnati area utilizes Medicare as a benchmark. Therefore, Cincinnati physicians, again at a reimbursement rate that is 25% below the national average for Medicare, are penalized further by the insistence of the HMO's on utilizing those figures as the baseline.

In Cincinnati, there are numerous physicians that are leaving the community. In particular, we note that cardiovascular surgery is significantly understaffed in the community, as well as neurosurgery. In Radiology, we are unable to recruit physicians who do not have significant ties to the Greater Cincinnati community and who wish to return in spite of a significant penalty in initial and ultimate reimbursement. A group of oncologic surgeons with which I am familiar, has been trying for three years to recruit an additional surgeon. One individual who came and interviewed demanded a salary that was greater than any of the senior associates in the medical corporation. Of course, they were unable to adequately answer his salary demands.

Across the board, as Mr. Scully indicated, this creates a downward spiral in employment opportunities and institutional viability, as well as in the general level of medical care. I am hopeful, Rob, that you can address these inequities in this session of Congress, as in some instances, physicians are really on the economic bubble and may have to bail out on the Cincinnati community and move elsewhere. I am hopeful that our parents and ourselves as we age, will have an excellent medical environment in which to receive care. I am sincerely concerned that this reimbursement discrepancy will lead to a lower tier of care in the long run, as it seems to have in the short run in certain areas, for our future.

Finally, it appears to me that we are reaching a crisis in the Medicare program. I believe that the President's proposal for phased-in prescription coverage for the poorest seniors is an appropriate first step. I also believe Mr. Scully's comments that Medicare needs to be overhauled to be more of an insurance plan with co-payments, and follow the insurance model is an appropriate one. We find often that families insist on heroic measures for their elderly family members that appear to be related to their complete desensitivation from financial responsibility. This often leads to patients receiving extraordinary heroic care in the last waning moments of their lives, which often does not provide any benefit to the patient, but only prolongs suffering. A reasonable economic model, I believe, would help reign in these excesses.

Rob, as always, I appreciate your listening to my concerns as a friend and constituent, and as a practicing Radiologist in the Cincinnati community. In my new role as a member of the Board of Trustees of the Health Alliance, and as President-Elect of the Alliance Physicians and Surgeons, as 1200 member group of specialists and primary care physicians, I am in a position to speak for numerous physicians. In addition, in my position as President-Elect to the Ohio State Radiological Society, I represent the views of 950 radiation oncologists and diagnostic radiologists who practice in Ohio. I look forward to any way to serve you to provide time, expertise, or counsel regarding these complex issues in the healthcare arena.

As always, those of us in the Cincinnati community feel proud and privileged to have you representing us in the United States Congress.

With fondest regards,

Frank E. McWilliams, M.D.

Sun Health
Sun City, Arizona 85351
March 7, 2002

The Honorable Nancy Johnson
Chairwoman, Subcommittee on Health
Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Re: March 1, 2002 Ways and Means Health Subcommittee hearing

Dear Chairwoman Johnson:

I respectfully request that this letter be included in the official record for the Ways and Means Health Subcommittee hearing on March 1, 2002, regarding physician payment for Medicare services.

Sun Health is a nonprofit healthcare system with over 90% of its hospital admissions representing Medicare beneficiaries; for this reason, Sun Health is often the harbinger of various healthcare trends and Medicare reimbursement implications. In the case of current Medicare reimbursement for anesthesia services, the **quality of care offered to Medicare beneficiaries is suffering and will become substandard** in Medicare-dependent locations nationwide. The following appeal is in support of an increase in Medicare's anesthesia conversion factor, and strives to depict the early albeit devastating implications of the current anesthesia conversion factor insufficiencies.

Sun Health prides itself on a tradition of offering superior patient care to over 135,000 seniors in our service area. During 2001, Sun Health treated 28,228 inpatient cases and 124,033 outpatient cases, and is well on its way to surpassing those numbers in 2002. However, the quality of care offered to our Medicare beneficiaries is threatened by Medicare's minimal reimbursement for anesthesia services.

Currently, Arizona anesthesiologists serving Medicare patients receive $16.61 per unit. In contrast, commercial payers in Arizona reimburse up to $42 per unit. This translates into an Arizona Medicare rate that is 50–60% lower than current market value. Accordingly, Sun Health and other Arizona facilities that serve high proportions of Medicare patients are facing a crisis in recruiting and retaining qualified anesthesiologists because serving Medicare beneficiaries results in a financial detriment to the anesthesia professional.

There is an exodus of anesthesiologists from Medicare-dependent facilities. For instance, Walter O. Boswell Memorial Hospital, our Sun City facility, lost an unheard of 65% of its anesthesia professionals in the past year, while Del E. Webb Memorial Hospital, our Sun City West facility, lost its entire anesthesia group because of the Medicare reimbursement insufficiencies.

An inadequate supply of anesthesiologists translates into longer days for the few anesthesiologists who do stay, often upwards of 12 hours for five consecutive days of direct patient care, and often in critical care situations. When anesthesiologists who leave Sun Health or other Medicare-dependent facilities to seek at least the median income in their profession at other hospitals, a multitude of surgical procedures must be cancelled or postponed. This compromise to Medicare beneficiaries is inexcusable.

While Sun Health continues to search for methods to recruit and retain anesthesiologists, we are utilizing locum tenens, or temporary, anesthesiologists. Between this unforeseen expense and the added expense of guaranteeing after-hours coverage of staff anesthesiologists, the substandard Medicare reimbursement **cost Sun Health over $2,920,000 during 2001 for anesthesia services, and is projected to cost Sun Health $1,680,000 in 2002.** This expensive subsidization solution should not be borne by community hospitals, but will continue to be an extreme financial burden as this issue intensifies for Medicare-dependent facilities nationwide.

In order to solve the anesthesia payment crisis, anesthesiologists serving Medicare beneficiaries nationwide deserve at least a 25% adjustment to the conversion factor. Additional increases may still be required in the future. Sun Health urges the House Ways and Means Subcommittee on Health to reform the process for physician payment under Medicare in an effort to avoid the Medicare patient anesthesia catastrophe that otherwise awaits us.

This issue is so critical to the health of our patients and to the future of our hospital system that our system appeals to Congress to take steps necessary to ensure a fair rate adjustment. If I or any of my colleagues at Sun Health may be of assistance to you in this endeavor, including providing additional correspondence, contact with our anesthesiologists, or personally testifying in Washington, D.C., we would be pleased to do so.

Respectfully submitted,

Leland W. Peterson
President and Chief Executive Officer

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