AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

MEDICARE PAYMENT POLICY: ENSURING STABILITY AND ACCESS THROUGH PHYSICIAN PAYMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

FEBRUARY 14, 2002

Serial No. 107–91

Printed for the use of the Committee on Energy and Commerce

Available via the World Wide Web: http://www.access.gpo.gov/congress/house

U.S. GOVERNMENT PRINTING OFFICE

77–992CC WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

W.J. "BILLY" TAUZIN, Louisiana, *Chairman*

MICHAEL BILIRAKIS, Florida
JOE BARTON, Texas
FRED UPTON, Michigan
CLIFF STEARNS, Florida
PAUL E. GILLMOR, Ohio
JAMES C. GREENWOOD, Pennsylvania
CHRISTOPHER COX, California
NATHAN DEAL, Georgia
STEVE LARGENT, Oklahoma
RICHARD BURR, North Carolina
ED WHITFIELD, Kentucky
GREG GANSKE, Iowa
CHARLIE NORWOOD, Georgia
BARBARA CUBIN, Wyoming
JOHN SHIMKUS, Illinois
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES "CHIP" PICKERING, Mississippi
VITO FOSSELLA, New York
ROY BLUNT, Missouri
TOM DAVIS, Virginia
ED BRYANT, Tennessee
ROBERT L. EHRLICH, Jr., Maryland
STEVE BUYER, Indiana
GEORGE RADANOVICH, California
CHARLES F. BASS, New Hampshire
JOSEPH R. PITTS, Pennsylvania
MARY BONO, California
GREG WALDEN, Oregon
LEE TERRY, Nebraska

JOHN D. DINGELL, Michigan
HENRY A. WAXMAN, California
EDWARD J. MARKEY, Massachusetts
RALPH M. HALL, Texas
RICK BOUCHER, Virginia
EDOLPHUS TOWNS, New York
FRANK PALLONE, Jr., New Jersey
SHERROD BROWN, Ohio
BART GORDON, Tennessee
PETER DEUTSCH, Florida
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
TOM SAWYER, Ohio
ALBERT R. WYNN, Maryland
GENE GREEN, Texas
KAREN McCARTHY, Missouri
TED STRICKLAND, Ohio
DIANA DeGETTE, Colorado
THOMAS M. BARRETT, Wisconsin
BILL LUTHER, Minnesota
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
CHRISTOPHER JOHN, Louisiana
JANE HARMAN, California

DAVID V. MARVENTANO, *Staff Director*
JAMES D. BARNETTE, *General Counsel*
REID P.F. STUNTZ, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON HEALTH

MICHAEL BILIRAKIS, Florida, *Chairman*

JOE BARTON, Texas
FRED UPTON, Michigan
JAMES C. GREENWOOD, Pennsylvania
NATHAN DEAL, Georgia
RICHARD BURR, North Carolina
ED WHITFIELD, Kentucky
GREG GANSKE, Iowa
CHARLIE NORWOOD, Georgia
Vice Chairman
BARBARA CUBIN, Wyoming
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES "CHIP" PICKERING, Mississippi
ED BRYANT, Tennessee
ROBERT L. EHRLICH, Jr., Maryland
STEVE BUYER, Indiana
JOSEPH R. PITTS, Pennsylvania
W.J. "BILLY" TAUZIN, Louisiana
(Ex Officio)

SHERROD BROWN, Ohio
HENRY A. WAXMAN, California
TED STRICKLAND, Ohio
THOMAS M. BARRETT, Wisconsin
LOIS CAPPS, California
RALPH M. HALL, Texas
EDOLPHUS TOWNS, New York
FRANK PALLONE, Jr., New Jersey
PETER DEUTSCH, Florida
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
ALBERT R. WYNN, Maryland
GENE GREEN, Texas
JOHN D. DINGELL, Michigan,
(Ex Officio)

CONTENTS

Page

Testimony of:
- Lewers, Theodore, Trustee, American Medical Association 46
- McSteen, Martha, President, National Committee to Preserve Social Security and Medicare 65
- Russell, Thomas R., American College of Surgeons 58
- Scanlon, William J., U.S. General Accounting Office 44
- Scully, Hon. Thomas A., Centers for Medicare and Medicaid Services, Department of Health and Human Services 10
- Shuren, Allison Weber, American College of Nurse Practitioners 53
- Turney, Susan, Medical Group Management Association, Marshfield Clinic 67

Material submitted for the record by:
- American Academy of Family Physicians, prepared statement of 73
- American Academy of Ontolaryngology—Head and Neck Surgery, prepared statement of 74
- American College of Osteopathic Physicians, letter dated February 15, 2002, to Hon. Michael Bilirakis 75
- American College of Physicians—American Society of Internal Medicine:
  - Letter dated February 14, 2002 76
  - Prepared statement of 77
- American College of Radiology, prepared statement of 80
- American Osteopathic Association, letter dated February 15, 2002, to Hon. Michael Bilirakis 81
- American Physical Therapy Association, letter dated February 12, 2002, to Hon. Michael Bilirakis 82
- American Society for Gastrointestinal Endoscopy, letter dated February 13, 2002, to Hon. Michael Bilirakis 83
- Association of American Medical Colleges, prepared statement of 84
- Coalition for Fair Medicare Payment, letter dated February 14, 2002, to Hon. Michael Bilirakis 86
- Lewers, Theodore, Trustee, American Medical Association, responses for the record 92
- McSteen, Martha, President, National Committee to Preserve Social Security and Medicare, responses for the record 96
- Medical Group Management Association, letter dated March 6, 2002, enclosing response for the record 104
- National Association of Rehabilitation Providers and Agencies, letter dated February 22, 2002, to Hon. Michael Bilirakis 87
- Russell, Thomas R., American College of Surgeons, responses for the record 100
- Scanlon, William J., U.S. General Accounting Office, responses for the record 87
- Scully, Hon. Thomas A., Centers for Medicare and Medicaid Services, Department of Health and Human Services, responses for the record 107
- Shuren, Allison Weber, American College of Nurse Practitioners, responses for the record 97

MEDICARE PAYMENT POLICY: ENSURING STABILITY AND ACCESS THROUGH PHYSICIAN PAYMENTS

THURSDAY, FEBRUARY 14, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 8:30 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Greenwood, Burr, Ganske, Norwood, Wilson, Shadegg, Bryant, Buyer, Brown, Waxman, Barrett, Capps, Stupak, and Green.

Also present: Representative Bereuter.

Staff present: Anne Esposito, health policy coordinator; Erin Kuhls, majority counsel; Eugenia Edwards, legislative clerk; Amy Hall, minority counsel; Karen Folk, minority counsel; Bridgett Taylor, minority professional staff; and Nicole Kenner, minority research assistant.

Mr. BILIRAKIS. Good morning. I call to order the first hearing of the Health Subcommittee in the second session of the 107th Congress. Today, we will examine the Medicare payment policy for physicians and at the outset I would say I know we've already extended our apologies to Mr. Scully, but I wanted to also apologize to our witnesses and the audience for such an early start. I think members will be coming in and out, but we were in session until 2:45 this morning, so we're going to do the best that we can.

I did want to announce that on this Valentine's Day in addition to saying Happy Valentine's Day, I would like to take a moment on behalf of all of us to say goodbye to Anne Esposito who is sitting here to my right. Anne has been with me for some time. She has been, of course, a terrific staffer, conscientious, hardworking and she has an awful lot of energy. But because she has been so conscientious, so hardworking, she's been snapped up by downtown. That is the downside for having an effective staff. But anyhow, she has contributed so very much toward improving the health care system for all Americans and on behalf of Mr. Brown and the other members, I'd like to wish her the best of luck as she moves into the private sector and let her know, and I'm sure I speak for all of us on the committee, that she will be greatly missed. Thank you very much, Anne, for everything.

Well, it's vital that we ensure the stability of the Medicare program and guarantee access to provider services for beneficiaries. This hearing will focus on the formula used to update payment rates for individual physician services under Medicare's Physician Fee Schedule.

In 2002, health care professionals paid under this fee schedule will experience the largest, the largest across the board payment cut since the fee schedule was first put in place a decade ago. This subcommittee is concerned that the current update formula is flawed and may at times put at risk, as it is now doing beneficiaries' access to critical health care services.

I would like to thank all of our witnesses for coming before the subcommittee so early this morning and as I've already said, I'd like to wish you all a Happy Valentine's Day.

Our first panel consists of Tom Scully, the Administrator of the Centers for Medicare and Medicaid Services. He will discuss the history of physician payments under Medicare and explain the circumstances around the -5.4 percent reduction, in physician payments this year.

On our second panel we will hear from Bill Scanlon our good friend who we hear from so very often with the General Accounting Office. He will lay out the various policy choices the subcommittee will face as we consider making changes to the current update system. We will also hear from a number of stakeholders, including the American Medical Association, the American College of Nurse Practitioners, the American College of Surgeons, the National Committee to Preserve Social Security and Medicare, and the Medical Group Management Association. These witnesses will testify about the real world effects of the payment cuts while highlighting ways to improve the current update system.

As many of you know, late last year we realized the magnitude of this payment reduction and the trouble it would cause. In response, I introduced, along with Ranking Member Brown, Chairman Tauzin and Ranking Member Dingell, H.R. 3351, the Medicare Physician Payment Fairness Act of 2001. This legislation was intended to correct the conversion factor for payments in 2002 so the reduction would be a negative .9 percent rather than the current 5.4 percent negative figure. Unfortunately, due to budget constraints, we were unable to get this legislation signed into law last year, but we do remain committed to improving the formula used to calculate the annual update for Medicare payments to physicians and other health care professionals paid under the physician fee schedule. I think that 316 at latest count, 316 bipartisan co-sponsors in the House of Representatives, along with 69 co-sponsors of the companion legislation in the Senate agree with that statement.

I do want to keep my opening remarks brief. I will ask members to keep their remarks brief with the exception of Mr. Brown, to limit their remarks to no more than 3 minutes. And I also would like, on behalf of the committee to welcome Mr. Doug Bereuter from Nebraska here, from very cold Nebraska. Doug is not a member of this committee, but he has a concern regarding the physicians in his District and we wanted to give him the opportunity to sit here and to also query Mr. Scully.

With that, I now recognize Ranking Member Brown.

Mr. BROWN. Thank you, Mr. Chairman, I will also be brief. I want to echo what you said about Ann Esposito who's been terrific to work with and always straight forward, always honest and honorable in her dealings and thank you for that, Ann.

I want to thank Chairman Bilirakis for holding the hearing today. Administrator Scully, thank you for joining us. Mr. Scanlon, thank you for again joining us and all the witnesses that are here this morning.

There have been dramatic changes, as we know, in health care since Medicare was established in 1965. As the old saying goes, the more things change, the more they stay the same. Health care may be more sophisticated today than it was 27 years ago. Health care finance and delivery may have evolved from unfettered fee for service to coordinated care, to vertically and horizontally integrated care, HMOs, PPOs, PSOs, point of service plans and hybrid arrangements, I wouldn't even begin to explain. But it doesn't matter. Health care delivery still hinges on the doctor-patient relationship and when it comes to financing health insurance relies on the broad pooling of risk and health insurance still derives its value from the reliability of its coverage and the depth, the quality and the accessibility of its provider network.

Medicare fee-for-service program which, if you want to get technical, is actually not fee-for-service, but a hybrid, still delivers on all these fronts. That's why logic rests on the side of sustaining Medicare as a single insurance program, rather than parsing the risk pool into multiple private plans. That's why Medicare is enduringly popular with its beneficiaries and that's why it's critical to pay physicians and other professionals who contract with Medicare on a fair and consistent basis.

The current payment formula for Medicare physicians and allied health professionals is flawed. We need to fix it. These providers should not have received the 5.4 percent cut in their payments this year. I was pleased to join Chairman Bilirakis, Chairman Tauzin and Ranking Member Dingell in legislation to stop the cut from being implemented. That bill, H.R. 3351 enjoys strong bipartisan support. I thought it was 312 sponsors. The chairman says 316 which goes to show how productive he was on the House floor last night at 1 in the morning gathering more co-sponsors.

An identical measure in the other body has 69 co-sponsors. The problem last year, the problem this year is finding the money to pay for it. That's the perennial issue, but for reasons I'll leave aside, Mr. Chairman, in the spirit of bipartisanship, it's too early in the morning to do anything else, the funding problem is even more daunting this year. We're simply going to have to find a way to overcome that challenge. The current payment formula is tied to a general economic indicator, the GDP, an overall expenditure target that is simply out of sync with legitimate changes in the volume and cost of care, compounded by data errors, the GDP link produced the unjustifiable 5.4 percent cut this past year. And if we do not take action, physicians and other professionals will be subjected to another significant and unjustifiable cut next year. We have responsibility to the beneficiaries who depend on Medicare to the health care professionals who make the program work to stop

the 2002 cut in its tracks and establish a workable payment formula for the future. It's expensive, but it should be done.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. The Chair now recognizes for 3 minutes, the first member to appear here this morning and the vice chairman of the subcommittee, Mr. Norwood, Dr. Norwood.

Mr. NORWOOD. Thank you very much, Mr. Chairman, and I mean this sincerely, thank you for holding this hearing. If any of us really do care about the health care of senior citizens, there probably won't be a more important hearing. And as you and I have discussed many, many times and for a long time that the Medicare payment rates were ultimately going to affect access to care and quality of care and it appears to me that it is finally coming true.

I'd like to thank HCFA Administrator Tom Scully for joining us today. Tom, we don't have an opportunity to visit lots. You're busy, I'm busy. There are a number of little things I want to sort of talk about while we have you out there and frankly, I'm concerned about some of the things I've been reading in the press. Happily, the only reason I'm not mad, Tom, is that even I know by now you can't believe everything you read in the press and I'm sure before this hearing is over you're going to make me feel a lot better.

Mr. SCULLY. No question.

Mr. NORWOOD. I hear from the press that you don't like the provision in our Medicare Reform Bill that requires HCFA to tell someone whether a treatment is covered and I hear in the press you call that provision crazy and a Democratic provision and I'm upset because you're in a Republican Administration and I see no reason to give the Democrats all the credit solving that problem.

I happen to like that provision very well. I happen to know it's a bipartisan provision. Dr. Ganske took the lead on that and it hurt my feelings a great deal to be honest with you, if you think I'm crazy, along with my mother-in-law to know if HCFA is going to cover something that she needs in health care.

I also hear that you've been threatening to change the AWP for oncologists without changing the—you know how the press is, you can straighten me out in a minute. The AWP for oncologists without changing the reimbursement structure to pay oncologists for the services they perform. I read where you think that you have the authority to change AWP while leaving the oncologists high and dry. Now I don't think that would be a wise thing to threaten. In fact, somebody might call and idea that would blatantly drive up hospital treatment like that real crazy.

We have some very important issues before us today, Mr. Chairman, on Medicare and I'd like to be comfortable with Mr. Scully on these issues and I know we will be by the end of the day. Take today's issue and what we're actually here about which is a very important issue. I know it's going to be costly, but let's be honest, please. Providing almost free health care coverage for American seniors is simply not an inexpensive proposition. And I don't lay all that at your door. That's Congress' responsibility. I know we're giving you signals saying that you've got to cut costs, cut costs, cut costs and we keep sending you less money.

If your response, however, to the growing expense of Medicare is to constantly decrease payment to providers my view is that's just really not smart.

Mr. BILIRAKIS. Please summarize. We're very happy that you aren't angry this morning.

Mr. NORWOOD. Well, ultimately, as we all know, providers are simply going to walk away from Medicare. They can't continue to treat patients when it costs them money and I hope you realize that. I've got another 5 or 10 pages, Mr. Chairman. I will quit with this. I hope you will stay and hear the other witnesses. That's important that you hear what people who are in the trenches are going to tell this committee this morning. So I'll be observant whether you can stay or not.

Thank you very much.

Mr. BILIRAKIS. I thank the gentleman. For 3 minutes, Mr. Greenwood, a warm up for your later session today.

Mr. GREENWOOD. Oh, I'll pass. It's too early in the morning.

Mr. BILIRAKIS. Mr. Burr.

Mr. BURR. After that, I wouldn't try it.

Mr. BILIRAKIS. Let's see, I'm not sure who came in first. Dr. Ganske. Three minutes, Greg.

Mr. GANSKE. Thank you, Mr. Chairman. My State of Iowa ranks dead last in terms of provider reimbursement, 50th out of 50 States. We are about 25th in terms of overhead expenses. And we are eighth in terms of quality of care delivery. So, we're dead last in terms of our reimbursement. We're in the middle, average, for overhead, yet we're still delivering really good health care. But I have some concerns if that can continue. I am hearing from physicians that they won't be able to take any more Medicare patients into their practices because they're having to make up the difference. And in small towns and rural areas, Medicare patients make up a disproportionate percentage of their practice.

Hospitals are in the same situation. Today, we're dealing with the physician provider formula. We need to fix it. It is fundamentally flawed and if we don't, I predict that we are going to see a real decrease in terms of health care access of senior citizens to physicians. There's a lot of historical reasons for this, including some recent ones. For instance, when Medicare started, we weren't so heavily dependent on technology. In my State, there were lower utilization rates, meaning in a rural State people don't go to the doctor quite as often unless they really need to. So we started out with a lower average cost per patient than say New York. So, over the years then if you get an across-the-board increase, then the gap increases. For instance, lets say, before Medicare started, the average cost in New York was calculated at $300 a month and in Iowa it was $100 a month. And then the next year you get a 3 percent increase across the board. Now you're dealing with $309 as the base for New York and $103 for Iowa. Then the next year you get a 3 percent increase and the gap gets bigger and bigger and bigger. We need to deal with that.

We had, as has been pointed out, a very large bipartisan group of Congressmen and Senators that wanted to move on this issue before we left for Christmas and I really applaud the chairman for taking a lead on this. We need to get this thing moving. So I'll look

forward to the testimony from you, Mr. Scully, and the other members of the Panels, thank you.

Mr. BILIRAKIS. I thank the gentleman. Mr. Buyer, for an opening statement.

Mr. BUYER. I'd just say, I don't know if it's in response or in addition to Mr. Ganske's comment, I don't think it would be accurate to infer from his comment that if Iowa is last in reimbursement, but eighth in delivery of care that the other 49 States are inflationary in their reimbursement. Because I think it would be easy to infer that from that statement. I do remember very well in April 1995 serving on a health care task force and when we got the letter delivered to us about Medicare and its potential insolvency and how difficult it was to work through that and sometimes we got it right and sometimes we didn't. And I think what was most distressing about reimbursements, whether it was to hospitals and others, was how the formula was handled. It was fascinating to see when you took a map of the United States and trying to follow the money and where it was, we actually took an overlay on to the map of the United States and learned that after, there was a 40-year domination of one political party when you laid the political map and Districts on to the reimbursements you saw where there was seniority in political power, that's where the money was going and that was wrong. And so we sought to bring equity to the reimbursements across the country. And I want to thank Mr. Brown and the chairman both for this hearing so we can—I'm hopeful that we continue in our equity in this funding formula, not just giving it to—let it follow the power, but make sure that it is done correctly.

I yield back my time. Thank you.

Mr. BILIRAKIS. I thank the gentleman. Ms. Wilson for an opening statement.

Ms. WILSON. Thank you, Mr. Chairman. I'd like to echo the comments of my colleague from Iowa as well as my colleague from Indiana. Medicare, Dr. Norwood said in his opening statement that Medicare reimbursement rates affect access to care and quality of care. That shows up so astoundingly when we look at the discrimination within this program against States like New Mexico and like Iowa where we are at the low end of the reimbursement scale.

Dr. Ganske is right. Iowa is No. 50. New Mexico is No. 37. And what makes it particularly difficult is that a doctor who is practicing in Albuquerque can go over the line to Amarillo, Texas and get a $20,000 or $30,000 raise just because of Medicare discriminating against New Mexico. New Mexico paid—New Mexico citizens pay into Medicare at the same rate as everybody else and we shouldn't be denied access to care because Medicare has set up a system that discriminates against doctors in the State of New Mexico. The geographic disparity in this system is appalling. And I think it's about time that we put a little sunlight on that and what it does to access to care and quality of care in rural areas, in poor areas and in areas where people are under served by health care.

We're going to talk today about the physician reimbursement payment and adjusting that and I am a co-sponsor of that bill, but I wish it was only 5 percent that we were arguing about here because in New Mexico, the average reimbursement for a Medicare—

we can't get the reimbursement payments for physicians and compare completely apples to apples. I think somehow that's intentional. People don't really want everybody to know just how bad it is. But if you just look at the average per enrollee reimbursement for Medicare in the State of New Mexico, $3,726. In Texas, $6,539. We're talking about disparities of 40, 45 percent. You can't keep doctors in New Mexico for that. We have to address the geographic disparity and until we do that, we will continue to struggle with lack of access to care and lack of quality of care because the Federal Government discriminates against about 14 States in this country.

I yield the balance of my time.

Mr. BILIRAKIS. Thank you. Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman, and good morning. Nice to see you bright eyed and bushy tailed like the rest of us this early morning after a nice evening last night.

I am thrilled that you're holding this hearing, Mr. Chairman, because I believe it is critically important. Medicine across America, I believe, is in a crisis of its own, indeed, my staff would say medicine in America, we're in such a deeply troubling situation that it's as though the building is on fire, but nobody can smell the smoke.

I grew up with a number of young people in Arizona who are now physicians. I will tell you they come to me every day and they make a compelling case for what is wrong with medicine, or the hassle of their lives, or being ordered around by bureaucrats, or being ordered around by HMO bureaucrats and now on top of that, Mr. Chairman, we plan as a result of I believe a deeply-flawed formula, to reduce their reimbursement.

Make no mistake about it, Mr. Chairman, if we do not pay physicians well, if we do not provide them control of their own lives, if we do not enable them to exercise their professional judgment in a way which they feel is appropriate, and reward them for doing so, then we will not attract qualified people to the practice of medicine. This 5 percent reduction is an outrage.

Now there are serious problems with Medicare and the Medicare and the Medicare system, but I want to pay compliments to Tom Scully and the new administration for what they've done. This is a headline from the East Valley Tribune, the second biggest paper in the State of Arizona, I think, very significantly, it says "Valley's ERS Overwhelmed". This is a problem that has been emerging in my community and it is extremely severe. But I raised this problem with Tom Scully, the CMS Director who is here today and I want to tell you that he was incredibly responsive. He agreed after a brief series of meetings where I outlined what was going on in Arizona to come to Arizona to see the problem first hand and to work to address it. And he has done that.

Your bill, Mr. Chairman, has I believe, 312 co-sponsors——

Mr. BILIRAKIS. 316.

Mr. SHADEGG. 316. And I cannot remember a time when I knew of a bill with that many co-sponsors that did not see floor action.

There's a great deal to be done here with regard to Medicare. There's a great deal for us to do with regard to medicine, because if we do not act now, we will have—we will not have quality people going into medicine. I'll bet you there's not a person in this room

that's involved in this issue who hasn't had a doctor come up and tell them that they were encouraging their son or daughter not to go into medicine because of the condition of medicine today. We can't fix it overnight, but we must fix it. This bill is a good start. This hearing is a good start. I compliment you, Mr. Chairman.

Mr. BILIRAKIS. Well, thank you, sir. And I endorse your comments and I would say that there's one other bill. It's a Veterans' bill that has considerably more co-sponsors and still has not seen the light of day.

Mr. Barrett, for an opening statement, 3 minutes.

Mr. BARRETT. Thank you, Mr. Chairman. I won't need 3 minutes. I just want to thank you for holding this hearing so quickly after we finished our debate on campaign finance reform.

I'm pleased to be here because I think that this is an issue that needs our immediate attention. Obviously, as the previous speaker said, as we listen to health care providers in our Districts, we know that there's a problem here and I appreciate your convening this and hopefully, we can address this problem as quickly as possible.

Mr. BILIRAKIS. Thank you, thank you, Tom. The Chair is pleased to recognize the gentleman from Nebraska, Mr. Bereuter, for an opening statement.

Mr. BEREUTER. Mr. Chairman, thank you very much for your courtesy. I admire the work ethic of this subcommittee, especially in light of what's happened. I do want to associate myself with remarks of the gentlemen from Iowa, the gentle lady from New Mexico, the gentleman from Indiana. This is an extremely important issue. I think the gentle lady has pointed out how our beneficiaries, of course, the people paying into the Medicare system are, in fact, cross subsidizing areas of the country with less than conservative practice styles and beneficiary preferences.

Really, the result is that I introduced a bill which will attempt to deal, in part, with this problem by physician work adjustment changes, the formula thereof. And the current reimbursement rates are really having a negative effect on our ability to recruit adequately quality health care professionals in my State, particularly in the most sparsely settled parts of the State. The inequities really do need to be addressed and I'm very interested that you're holding this hearing, that you're trying to take some action and I appreciate the ability to sit in and listen to the witnesses and perhaps ask a question or two.

Mr. BILIRAKIS. I thank the gentleman. Thank you for your interest.

I believe that completes the opening statements. The Chair first would ask unanimous consent that all members of the subcommittee, their written statements might be made a part of the record. There's a written statement by Congressman Joe Knollenberg who he has asked might be made part of the record, so by unanimous consent I request it includes that, as well as a number of statements that have been furnished to the subcommittee by various stakeholders, unanimous consent of those, all be made a part of the record.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Chairman Bilirakis, thank you for holding this important hearing. I'd like to acknowledge your leadership in recognizing the urgency of the issue before us today. The Subcommittee has been actively engaged on the critical issue of physician payments, sponsoring Member and staff briefings, holding a press conference, and introducing legislation to provide immediate relief to those physicians and health care professionals experiencing a significant payment cut this year.

At this hearing, we will focus our attention on how we got to where we are today and why we are using such an unpredictable formula, which has resulted in widely oscillating payment updates over the years. In my home state of Louisiana, according to the AMA, total Medicare losses for physicians will exceed $28 million—or $3,549 per physician. I'm concerned that the 2002 payment cut and the expectation of similar significant reductions in the future will cause many Louisiana physicians who are near retirement to leave medicine, which could have a serious effect on patient access to care.

I'm sure many of us have heard from physicians and other health care professionals in our districts about the effect the 2002 negative payment update will have on their practices and the beneficiaries they serve. Just recently, I received a distressing letter from a surgeon in Louisiana. One comment Dr. Opelka made was particularly striking and I'd like to share it with you today.

He states in his letter that "reductions in Medicare physician payments are beginning to seriously impact Medicare patient access to the *full spectrum* of care in our community. Patients continue to receive treatment, but the availability of *all* aspects of care has decreased . . . If reimbursements continue to decrease, I have concerns that further changes will continue to erode the fabric of the finest care delivery system in the community." We must ensure that beneficiary access to critical health care services is not put at risk.

At the same time, I recognize that money doesn't grow on trees. We are once again in deficit spending. Moreover, the Administration instructs us that we need to find offsets for any increases in provider payments. We take that budget proposal very seriously, and yet, at the same time, this payment policy needs to be fixed. But to accomplish this, we are going to need the Administration's help as well as the affected groups' input to make sure this type of cut never happens again.

During today's hearing, we are honored to have before us Tom Scully, the Administrator of CMS. I look forward to hearing your testimony today and hope that it yields additional insight into ways we can improve our federal health care programs and remedy the instability plaguing the physician payment update system.

Bill Scanlon from the General Accounting Office is also with us today. He will lay out the different policy options we will face as we work to draft a legislative fix—a fix that will make sense, be good policy, and last the test of time. We are also fortunate to have representatives from beneficiary, physician, and practitioner groups who are particularly affected by the negative payment update this year. They bring a valuable perspective that is critical to developing the right legislative fix.

Chairman Bilirakis, thank you again for holding this important hearing. I yield back the balance of my time.

PREPARED STATEMENT OF HON. JOE KNOLLENBERG, A REPRESENTATIVE IN 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.

Mr. BILIRAKIS. Having done that, the Chair now would recognize, Mr. Scully. Tom, I'll set this for 10 minutes. Just present your story and don't worry too very much about the clock, even though I would say that we have to give us this room by 11 o'clock.

Mr. Greenwood will definitely boot us out of here, if we're not finished. Enron, these days, takes priority apparently over everything else. In any case, Tom, please proceed.

STATEMENT OF HON. THOMAS A. SCULLY, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. SCULLY. Thank you, Chairman Bilirakis, Congressman Brown and other distinguished members of the committee. I'll go as fast as I can. First, I'd like to quickly add my thanks to Ann. I didn't know she was leaving until this morning, so I'm sorry to hear that. She's been a terrific help to me and a lot of people in the administration.

I also brought with me Rick Foster, who is the Chief Actuary at CMS, in case there are any technical questions and I'm not smart enough to answer or in case Mr. Norwood gets too mad at me. He'll get all the questions.

But anyway, I'll go through this as quickly as I can. Let me just start off by saying I've worked on Medicare physician payment issues since 1989 when I was one of two people in the first Bush Administration who was, I guess, primarily responsible for working with Congress to develop the RBRVS system. Over the years, I think you can argue, that this has been the most stable system in Medicare and historically, the payments to physicians have been more predictable, more stable than most of the other Medicare payment systems. I think it's worked reasonably well, and in fact, of all the Medicare payment systems, this is probably the one that is mimicked most regularly by the private insurance sector.

However, I do think it's important that we fix Medicare's payment mechanism because I think it does have significant problems

for a variety of reasons, including the fact that I think we have to be careful that doctors don't lose confidence in the system and that the beneficiaries don't start to lose access to the vital services they provide.

This year, Medicare will make about $43 billion in physicians payments. Between 1997 and 2001, Medicare physician spending went from about 17.6 percent of the program to 20.5 percent of the Medicare fee-for-service program, so physician spending is not shrinking as a percentage of the program. It's actually growing and I'll get into that in much greater detail.

Each year, Medicare processes about 600 million physician claims and the fee schedule that we use—the relative value fee schedule—pays for about 7,000 different physician services. The annual update for these services is now calculated based on inflation in physicians' costs to provide care and it's adjusted up or down for what is called the sustainable growth rate. I'll try to go through this as sanely as I can and explain how this extremely complicated system works.

The system was designed to constrain the rate of Medicare physician spending and link the growth of physician spending to the overall economy as well as to take into account physician growth of volume and intensity of services. In large part, believe it or not—and there are obviously significant flaws and I'll try to explain them—the system has been working almost exactly as designed. There's just been a lot of factors that have come together in probably the worst possible way to throw the formula out of whack, but it is, in fact, working as designed.

The law, as it was designed in 1989 and then updated in 1993, 1997, and 1999, is extremely prescriptive, especially the last two updates. It gives CMS virtually no administrative flexibility to change anything. I think, as many of you know, I spent about a month working every day with many of the physician groups, including the AMA, to see if I had the administrative flexibility to change it this fall and it was abundantly clear that legally we do not. So the negative update was a surprise to us when the formula produced this mumber in September. We came up as quickly as we could to the Congress and explained it. Normally, we don't talk to anyone about this regulation until it comes out in November, but this year we started explaining it probably in mid-September.

Several factors led to this negative update. First and most prominent is the downturn of the economy, since the formula, the sustainable growth rate formula, is tied to the gross domestic product. Second, the annual cumulative physician spending for services in prior years is much higher than expected. And third, as we go back and calculate actual expenditures in the past, there were some significant miscalculations—a couple of billion dollars a year, which I'll explain, in past years—that were basically missed in the expenditure formula. So we actually identified those and calculated them correctly and it significantly increased expenditures, basically putting the target back down—I'll go into great detail explaining this.

The combination of the lower target for GDP and the much higher expenditures produced the negative update for physicians for 2002. We're required by law to make an estimate for 2003 on

March 1—and Rick actually does it—and it is in these charts, as you'll see. We have given you our projections for the next couple of years and as you will see, the update is again significantly negative for next year.

I think it's important to understand, from a historical perspective, how the system was set up and why it was designed, so let me just very quickly go through that, if I can.

During the 1970's and 1980's—this is a quick discussion of physician payment before 1997—the annual growth rate for physicians was an unsustainable average growth rate of about 14 percent. And because the system was based on historical charges, it produced even wider geographic variabilities and variabilities between medical specialties and services than the system we have now, which as you can see from the opening statements, is certainly not perfect.

To address these criticisms, Congress directed the Physician Payment Review Commission, which is the predecessor of MedPAC, to come up with a new formula and on a bipartisan basis in 1989, the first Bush Administration, which I was a part of, and bipartisan Members in Congress—in this committee and the Ways and Means Committee and the Finance Committee in the Senate—pushed through those recommendations to create what is now the RBRVS, resource-based relative value system. Under these recommendations, we created a lot of relative values for each physician's service and the system is based on work from the AMA. So essentially, every year, the Relative-Value Update Committee, which is basically put together by the AMA and all of the physician groups in the country, sits down and says, "Here's $43 billion. What's the relative value of rates between anesthesiologists, gastroenterologists, surgeons," and recommends relative values of what the physician community thinks the relative payment should be.

We take over 90 percent of the RUC's recommendations—that really is what drives the payment system.

Let me just quickly, I'm going to quickly, since it's a very complicated structure, what I'm going to try to do, rather than just spend a lot of time testifying is I brought some charts which I was going to use the easel, but due to the cameras and the microphones, I'll just go through them over here at the table and I hope each of you have these charts in front of you.

This is an unbelievably complicated process. I spent 15 years on it and a lot of time in the last couple of days trying to figure out exactly how it works, so I don't expect everyone here to understand this in the next 5 minutes.

Ms. WILSON. Mr. Chairman?

Mr. BILIRAKIS. Yes?

Ms. WILSON. Do we have these charts?

Mr. SCULLY. You should have the charts, I hope.

Mr. BILIRAKIS. No, they're not part of your statement.

Mr. SCULLY. They were handed out separately from my statement because they weren't done in time to come up with the statement. They should be there. And I apologize that they're not, but we have charts and brought many copies.

Mr. BILIRAKIS. Why don't you proceed, Tom.

Mr. SCULLY. Anyway, just to walk through this quickly, what you'll find on the top line in the orange, in the dark orange is the sustainable growth rate, which is largely based on the GDP and what you see there is for 1998—I did it from 1998 through 2003. The sustainable growth rate is 1.5 percent in 1998 and goes up to 7.3 percent in 2000. That is the first major piece of the puzzle of how this works.

The second piece is the actual annual spending target. This is what the current statute does. You look at 1998, the spending target for what we were supposed to spend in the year under the statute was $49.6 billion. This includes physician payments and additional things like lab services, other things that go into the pot.

In 1999, it was $49.4 billion and then the next year 2000, $39.6 due to the changeover from fiscal years to a 9-month calendar year in 2000. For calendar year 2000, it was 55.9, then 59.3 for this year. The point of that is those are the statutory targets and they were set in 1997. So pre-1997, this target floated and changed every year.

After 1997, it was locked in, locked in to GDP growth, locked in to expenditures. So what's happened to produce this? As I said, the formula worked virtually exactly as expected; this was the target and the target expenditures in orange and blue and then you have the target, the actual expenditures in the lighter shaded orange and, in the light blue, real spending. So what happens when you match up the years is, in 1998 for instance, we're supposed to spend $49.6 billion. We spent $49.2. So we came in under the target. In 1999, we were supposed to spend $49.4 billion. We spent $50.6 billion, so we're obviously $1.2 billion over the target. It's important to remember, because as you go over the target, the numbers buildup and you have to recapture in later years.

In 2000, the fiscal year was 9 months, there were two 2000s, strangely, we were supposed to spend $39.6 billion in fiscal year 2000. If you look at the blue line, the two blue lines as a comparison, $39.6 billion versus $39.5. So we're under the target. Then the problems begin.

In calendar year 2000, the target was $55.9 billion. We actually spent $58.2 billion. In calendar year 2001, we were supposed to spend $59.3 billion and we actually spent $65 billion. So what you find is in 2000, we were $2.3 billion over the target and in 2001, we were $5.7 billion over the target. And this target is cumulative and it adds up every year and over a number of years you have to recapture the excess spending. This is the way it was designed. It's obviously not a perfect formula, but it's working exactly as designed, a whole bunch of factors, unfortunately, kicked in this year's very negative update.

What you end up with is the cumulative growth target. If you look at the far right side in green, under the year 2001, over this year period, up through 2001, we were supposed to spend $302.7 billion. We, in fact, spent $311.6 billion and that's how the formula works. So roughly we have $9 billion in overspending over those years that, under the formula, has to be recaptured over the next couple of years.

So two things happened. One is that, under the formula, the spending has to be recaptured and two things happened that really

threw the formula off, resulting in the big change. One is GDP went down, so the target, which had been determined a year ago, had been estimated to be significantly higher but is now 5.6 percent. The target had been a lot higher when GDP was higher. In addition, spending was significantly higher than expected for two reasons. One, and I don't want to confuse you too much, but originally looking back at last March, we expected that spending was going to be significantly higher and it came down as GDP went up. Second, spending was much higher because we discovered a couple billion dollars a year in spending. What happens in these codes, and it's very confusing, I know, is that we have 7,000 codes. We used to have about 6,000. We keep adding codes. Over the years as we added codes, some of the spending of those codes never showed up in the system. So going back a couple of years, our actuaries and our people found out the spending was actually larger, and they have to put that into the formula. Spending was actually larger, the GDP came down, the two lines crossed and instead of having a positive update, you ended up with a significantly negative update.

So what you've got if you looked at last March when the Congressional Budget Office and CMS came out and said what is update going to be for this year, it was basically negative .1 percent. The GDP came down this summer. The actual spending that we found going on was significantly higher, so instead of having a negative .1, you had a negative 5.4.

The second chart, which is important, is that this is a per code calculation. This is not total spending. The negative 5.4 is the base amount, called the conversion factor, and the original idea when it was passed in 1989 was to represent a base office visit for a physician. So the next code—when I go through and you see it ranges from anywhere from $31 to $38 and back down—that's the base dollar conversion factor for every one of these 7,000 codes. The update for that, next year is negative 5.4. Spending does not go down. The update of the dollar conversion factor is what's going down by 5.4 percent and that's important to remember. There are a lot of factors beyond that, including the fact, as I'll go through, that as we add codes and we do this with the agreement of the AMA and the physician groups, when you go from the 6,200 codes we started out with to 7,000, as you add codes and we do this in support of the medical system and it's happened gradually over the years, it waters down the base conversion factor value. So it's not always a cut. If the physicians come in and say we need extra codes, it comes out of the stagnant, finite pot of $43 billion for physician spending this year, or roughly $60 billion for the whole pot.

So the point is it's not always a cut. Sometimes when you add codes, you actually water down the pot and payments go down.

Anyway, the point of this next chart, to go through as quickly as I can and I'm sure I'm going to create a lot of confusion, but if you're trying to redesign these, I think it's important to understand why the numbers are driving the change. It's not an easy decision to figure out what the right fix is because what you'll find under the current law baseline spending which is the top one, I'm going to jump down to the second one. We obviously made some mistakes. Had we hypothetically calculated everything totally right the

last couple of years and understood all the spending that was going on, what you'll find is that under the existing formula, if you look at line 2, you'll find that as a total amount of growth in the program, even though the updates are pretty flat and you see that they would be for 2002, the second line is if everything had worked fine and we understood all the spending, the physician payment update for 2001 would have been plus 3.6 percent and 2002 it would have been negative 2.1; 2003 would be negative 4.9 which sounds, obviously, unsustainable and outrageous. But if you look at what actual spending is, and you look at the next line below, you'll see in 2000, spending, if everything is going right, would have gone up by 5.9 percent; spending in 2001 would have gone up by 9.7 percent; spending in 2002 goes up by 5.2 percent and it's 1.2. But some of these numbers, obviously, 1.2 percent growth in physician spending is not a reasonable number, but I would argue 9.7 is and later on there's a 7.6 percent increase.

So even though the actual per code, per conversion factor, which is the base physician visit, may be going down, spending is going up because volume is increasing significantly.

The current law baseline, which is what we're really doing this year, given our errors, is a little harsher and produces a little tougher result, but as you can see, what's driven this, if you look under 2000 and 2001, the payment update for 2000 was 5.5 percent. It shouldn't have been 5.5 percent had we been doing it correctly. If you look down below it, it should have been 1.0 percent under the formula. The agency made some mistakes and did not understand the expenditures. It's a multi-year very static calculation.

If you look at 2001, physicians got a 5.0 percent update. They should have gotten a 3.6 percent update. The result of that is that real physician spending in this pot in 2000 went up by 10.7 percent and in 2001 it went up by 11.2 percent. Those numbers are obviously fairly high. Part of the problem here is we—it's not the physicians' fault—inadvertently did not understand how the numbers were growing. The formula was thrown off and we paid out significantly more in 2000 and 2001 than we should have. This is a recapturing formula by statute to take some of that back.

So you go from—this is the current law baseline, it's actual real law and how it works right now. In 2000, we had 10.7 percent increase; in 2001, we have 11.2; and the formula recaptures that spending. So under the current formula, you have a negative 4.8 percent update and there are other things that result in the 5.4 percent, but the 4.8 percent update results in a 2.4 percent spending increase. 2003, you get a negative 5.7 percent update, worse than this year. That results in a 1.1 percent spending increase. In 2004, and this is again current law, negative 5.7, results in a positive 1.5 percent spending increase.

Now I think there's probably a good argument to be had that 2.4 percent, 1.1, 1.5 is not a real significant spending increase. On the other hand, if you look at the other policy options, and I don't want to get into too much detail, but one of the major glitches in this formula, if you go down to the third option here, the way the statute was changed in 1998 and 1999, the numbers we used for 1998 and 1999 were projected numbers, not actual numbers. Some peo-

ple would argue that was a mistake as well and I think that's been some of the debate in the fall on the Hill.

If you plugged in actual numbers for spending in 1998 and 1999 rather than projections and, just to be clear about what that really means is the GDP under the formula we use early 1998 and 1999 estimates coming out of our actuaries and that's what the law says, use those estimates. The GDP in 1998 and 1999 was much, much, much higher than everybody projected. So if you actually plugged in real numbers instead of the projections, which the law does not allow us to do, you get totally different results. With that formula in place, if you look down there, you'd still have pretty significant negative updates the next 2 years. It would have been the same this year, but next year you have a positive update of 0.8, a positive update of 1.4, and in 2005, you go up to a positive update of 1.7. That would get you back on track, if you look at the growth in physician spending on the next line down under where it says fiscal year 1998 and 1999 adjusted for actual data, you'd have spending increases this year of 2.4 percent which is low, but next few years, 8.1, 9.1, 8.3, which some would argue is high. So that ought to give you the last torturous example because I think these are the sum of the policy suggestions.

MedPAC's suggestion I would argue, is probably overly generous as a fix and the reason is it sounds good. If you look down at the bottom under the MedPAC proposed formula—they're going to suggest formally in a couple of weeks, but they put it out a few weeks ago—would result in payment updates just to start in 2001 of 2.6 percent, 2.9 percent, 2.2 percent, 2.0 and 2.0, which sounds extremely reasonable and maybe modest. But the spending increases you get out of that are starting in 2001, 9.7 percent, 11.7 percent, 10.7 percent, 10.8 percent and 9.7 percent. And what that tells you is the problem is volume. There are a lot more services. A lot more high tech services. A lot more coming on line and the decision for Congress and it's obviously a very complicated one and we're happy to help redesign the formula any way you like, is what growth rate do you want? So the real issue is not necessarily the negative update, it's do you want physician spending in Part B to grow at 2 percent? Probably not. Do you want it to grow at 11 percent? Probably not. Do you want it at 5 percent, 6 percent, 7 percent? There are a million variables in between. I think there's a very strong argument this formula needs to be fixed and changed, but I don't believe anybody that I've seen has gotten it right yet and I think you can pick any of the numbers in between in their multi-billion calculations, and, obviously, even though this is incredibly complicated and very obscure stuff, it affects every physician in the country in a big way and as you know, I've spent a lot of time traveling around the districts and I've heard from 5 physicians in my family as well—I can't even identify my job any more. I get attacked too regularly.

There are a lot of very unhappy physicians for a lot of reasons, but I think when you look at the numbers, and I've been involved in this, as I said, since 1989, the goal here was to control physician spending at a reasonable rate. I don't think anybody expected it to be negative or even plus 1 or 2 percent, but I also don't think it needs to be plus 11 or plus 12 percent. A reasonable level is some-

where in between and it's not just the conversion factor. The uproar is about the negative 5.4 percent reduction in the conversion factor. But you can have a negative 5.4 percent update and if the volume is high, you can still get 6, 7, 8 percent of your increases in spending. So I believe that somewhere in between these four options is probably the right fix and the right course. I don't believe MedPac got it right. I'm not sure anybody has it right yet, but it's obviously complicated. It's a major, major task for this committee and for the Ways and Means Committee and the Finance Committee this year. We'd like to work with the Congress to get it right, fix it and hopefully not have to come back and do it in a couple of years, but it's also obviously a very major spending initiative because fixing this formula, which is very specific and very locked in in statute, is obviously going to cost a significant amount of money under the current law baseline.

So anyway, Mr. Chairman, I apologize if I went over and I again apologize if I confused everybody with my crazy charts, but I do think that if you look at them they'd really explain the problem pretty clearly, eventually.

[The prepared statement of Hon. Thomas A. Scully follows:]

PREPARED STATEMENT OF THOMAS A. SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Chairman Bilirakis, Congressman Brown, distinguished Subcommittee members, thank you for inviting me to discuss how Medicare pays for physicians' services. I have worked on Medicare physician payment issues since 1989 when I was one of the primary people in the previous Bush Administration negotiating the creation of the resource based relative value physician payment system, sometimes referred to as RBRVS. I personally think that, over the years, this has been the most stable payment system in Medicare, and historically there has been far less controversy in physician payments than we have witnessed with other providers. In fact, the resource-based relative value system has worked reasonably well and often is used by private payors. Last year we encountered a situation where a number of factors combined to cause the formula, as set in law, to produce a negative update. It is important that we fix the mechanism and explain it to doctors so they do not lose confidence in the system, and they continue to provide beneficiaries with the vital care they need.

This year, Medicare will pay about $43 billion for physician fee schedule services. Between 1997 and 2001, Medicare physician spending increased from 17.6 percent to 20.5 percent of total Medicare fee-for-service spending. Each year, Medicare processes about 600,000,000 physician claims. The fee schedule reflects the relative value of the resources involved in furnishing each of 7,000 different physicians' services. By law, we actually establish three components of relative values—physician work, practice expenses, and malpractice insurance—for each of these 7,000 services. The actual fee for a particular service is determined by multiplying the relative values by a dollar-based conversion factor. And the payment for each of the services is adjusted further for geographic cost differences among 89 different payment areas across the nation.

Payment rates for physicians' services are updated annually by a formula specified in law. The annual update is calculated based on inflation in physicians' costs to provide care, then adjusted up or down by how actual national Medicare spending totals for physicians' services compare to a target rate of growth called the Sustainable Growth Rate (SGR). If spending is less than the SGR, the physician payment update is increased, and if spending exceeds the SGR, the update is reduced. The system was designed to constrain the rate of growth in Medicare physician spending and link it to growth in the overall economy, as well as to take into account physician control over volume and intensity of services. In large part, the formula has been working as designed.

The law that sets this formula is extremely prescriptive. It does not give the Centers for Medicare and Medicaid Services (CMS) the administrative flexibility to adjust physicians' payments when the formula produces unexpected payment updates, as we witnessed last year. The size of the negative update for this year was a sur-

prise when it became apparent last September. As we looked at the actual numbers going into the formula, we explored every issue and every alternative that could have produced a different update, but we concluded that we did not have any flexibility. We made sure that every part of the update was accurate and fully in accord with the law. I know that you, Mr. Chairman, and this Subcommittee, are closely examining the issue and potential alternatives. The Administration is willing to work with you to find a budget-neutral way to ensure that physicians receive appropriate payment for Medicare services, this year and in the future.

Several factors led to the negative update. First, there has been a downturn in the economy, which affected the SGR because it is tied to the growth in the country's Gross Domestic Product. Second, actual cumulative Medicare spending for physicians' services in prior years was higher than expected. Third, our measure of actual expenditures had to be adjusted to capture spending information on services that were not previously captured in the measurement of actual expenditures. Counting these previously uncounted actual expenses, as required by law, also increased cumulative actual expenditures—driving down the update. I explain this in more detail later. The combination of a lower target and higher expenditures produced the negative update to physicians' payment for 2002. We are required by law to make a formal estimate of the update for 2003 by March 1 of this year. While we are still finalizing this estimate, our preliminary assessment is that the formula will produce a significant negative payment update again in 2003.

Physicians argue that these negative payment updates will hinder their ability to care for beneficiaries, and may result in some physicians not accepting new Medicare patients. We take these statements seriously, and are taking steps to monitor beneficiary access to care to ensure that our nation's most vulnerable citizens continue to receive the care they need. As we consider how to improve the Medicare physician payment formula, I think it's important to understand, from a historical perspective, how and why the formula operates the way it does today. It is, in fact, operating precisely as it was designed in 1997—but we recognize that this has produced some large short-term adjustments.

PHYSICIANS' PAYMENT BEFORE 1997

As the Medicare program has grown and the practice of medicine has changed, Congress and the Administration have worked together in an effort to ensure that Medicare's payments for physicians' services reflect these changes. As a result, the physician payment system has changed significantly in the past two decades. For many years, Medicare paid for physicians' services according to each doctor's actual or customary charge for a service, or the prevailing charge in the physician's area, whichever was less. From 1970 through the 1980's, spending for physicians' services grew at an unaffordable and unsustainable average annual rate of more than 14 percent. And, because the system was based on historical charges, it produced wide discrepancies in payments among different localities, medical specialties, and services. These payment differences did not necessarily reflect actual differences in the cost of providing services. As a result, the system was roundly criticized in the 1980's as overvaluing specialty services and undervaluing primary care services.

To address these criticisms, Congress directed the Physician Payment Review Commission, an advisory body established by Congress and one of the predecessor organizations of the Medicare Payment Advisory Commission (MedPAC), to examine different ways of paying physicians while protecting beneficiary access to care, as well as slowing the rate of growth in Medicare physician spending. On a bipartisan basis, and with the support of the first Bush administration, Congress accepted these recommendations and passed these and other reforms in the Omnibus Budget Reconciliation Act (OBRA) of 1989, and the new fee schedule was implemented beginning January 1, 1992. The resource-based work component of the fee schedule was phased in between 1992 and 1996.

Specifically, in its 1989 Annual Report, the Commission recommended a number of ways to change how Medicare pays physicians. The Commission first recommended instituting a fee schedule for physicians' payments based on the resources involved with furnishing each physician's service, rather than on historical charges. The Commission also recommended that the relative value of three separate components of each service—physician work, practice expense and malpractice insurance—be calculated, as discussed above.

Under the Commission's recommendations, once the relative values were established, they were adjusted for cost differences, such as in staff wages and supply costs, based on the area of the country where the service was performed. Then the actual fee for a particular service for a year was determined by multiplying the relative value units by a dollar-based conversion factor. The American Medical Associa-

tion (AMA) provides support for the Relative-Value Update Committee (RUC), a multi-specialty panel of physicians that plays an important role in making recommendations so that the relative values we assign reflect the resources involved with both new and existing services. We generally accept more than 90 percent of the RUC's recommendations, and our relationship is cooperative and extremely productive.

The Commission's second recommendation was to provide financial protection to beneficiaries by limiting the amount that a physician could charge beneficiaries for each service.

The Commission's third major recommendation was to establish a target rate of growth for Medicare physician expenditures, called the Medicare Volume Performance Standard (MVPS). The MVPS target growth rate was based on physicians' fees, beneficiary enrollment in Medicare, legal and regulatory changes, and historical measures of the volume and intensity of the services the physician performed. The MVPS was set by combining these factors and reducing that figure by 2 percentage points, in order to control to growth rate for physicians' services. OBRA '93 later changed this to minus 4 percentage points. Actual Medicare spending was compared to the MVPS target, which led to an adjustment, up or down, to the calculation to finally determine the update a future year. The law provided for a maximum reduction of 3 percentage points, which OBRA '93 lowered to 5 percentage points.

PHYSICIANS' PAYMENT SINCE 1997

The Balanced Budget Act of 1997 (BBA) changed the physician payment system in a number of ways based on Commission recommendations. In BBA, the SGR replaced the MVPS. Like the MVPS, the SGR is calculated based on factors including changes in physicians' fees, beneficiary enrollment, and legal and regulatory changes. However, the BBA did away with the historical target for volume and intensity of physicians' services. Instead, the real per capita Gross Domestic Product, which measures economic growth in the overall economy, was instituted as a replacement.

One other important difference between the old and the new growth targets is that the old method compared target and actual expenditures in a single year. If expenditures exceeded the target in the previous year, the update was adjusted for the amount of the excess in the current year, but there was no recoupment of excess expenditures from the previous year. Under the new SGR, the base period for the growth target was locked in at the 12 months ending March 31, 1997. This is the base period and remains static for all future years. Annual target expenditures for each following year equal the base period expenditures increased by a percentage amount that reflects the formula specified in the law, and they are added to base period expenditures to determine the cumulative target. This process continues year after year, adding a new year of expenditures to the cumulative target. If expenditures in a prior year exceed the target, the current year update is adjusted to make annual and target expenditures equal in the current year and to recoup excess expenditures from a prior year. While the BBRA made some further technical changes to allow these adjustments to occur over multiple years, that is the general way the formula was established in law. The SGR is working the way it was designed.

BBA also increased the amount that the update could be reduced in any year if expenditures exceeded the target. The maximum reduction was increased by 2 percentage points to 7 percentage points. Thus, for example, inflation updates in the range of 2 percent, reduced by the 7 percent maximum reduction, would yield a negative update in the range of 5 percent. BBA also established a limit of 3 percentage points on how much the annual inflation update could be increased if spending was less than the target.

Additionally, BBA created a single conversion factor (previously there were three separate ones for different types of services). BBA also required that the practice expense component of the relative value calculation, which reflects a physician's overhead costs, be based on the relative resources involved with performing the service, rather than the physicians' historical charges. This change made the practice expense component of the calculation similar to the physician work component, and reflected actual resources. The change was phased in over four years, and was fully implemented in 2002. BBA further required that the malpractice insurance expense component of the relative value calculation also be resource-based. The law required that the resource-based practice expense and malpractice relative value systems be implemented in a budget-neutral manner. The BBA provisions affecting physicians accounted for about 3 percent of total BBA 10-year Medicare savings. Because physician payment accounts for about 17.6 percent of program payments in

1997, the physician savings in the BBA represented by these changes were perceived to be relatively modest.

The Balanced Budget Refinement Act of 1999 (BBRA) made further revisions to the SGR in an attempt to help smooth out annual changes to physician payments such as blending cumulative and annual comparisons of target and actual spending. Beginning with the 2000 SGR, the law required us to revise previous SGR estimates based on actual data that became available after the previous estimates. BBRA also required us to make available to MedPAC and the public an annual estimate of the physician payment update for the succeeding year. This estimate is due on March 1 of each year, and is very difficult to make, because none of the claims used to determine actual spending are available by the time we are required to make the estimate. Last year, we estimated that this year's update would be around negative 0.1 percent. However, when we determined the actual update, which was published 7 months later on November 1, revised figures lowered the Gross Domestic Product figures for 2000 and predicted a slower growing economy for 2001 than was previously estimated. Further, 2001 physician spending was higher than our March estimate.

Additionally, in making updates to the list of codes for specific procedures that are included in the SGR, we discovered that a number of codes for new procedures were inadvertently not included in the measurement of actual expenditures beginning in 1998. Therefore, the previous measurements of actual expenditures for 1998, 1999, and 2000 were lower than they should have been. As a result, the physician fee schedule update was higher in 2000 and 2001 than it should have been, had those codes had been included. These updates, which were inadvertently higher in 2000 and 2001, created a partial downward adjustment on the physician fee schedule for 2002, and will require a further downward adjustment for the 2003 physician update. The combination of these factors led to the large negative update for 2002.

In its March 2001 report to Congress, MedPAC recommended a complete repeal of the SGR system. MedPAC recommended replacing the SGR with a different type of annual update system like the one used for hospitals. That recommendation was not enacted in 2001. At its January 2002 meeting, MedPAC voted to make a similar recommendation to Congress in its upcoming March 2002 Annual Report.

As you can see, the process for calculating payments for physicians' services is highly complex. It is the result of years of efforts by Congress, previous Administrations, the Physician Payment Review Commission, and MedPAC to ensure that Medicare pays physicians as appropriately as possible. Today, while the underlying fee schedule and relative value system have been successful, we recognize that the update calculation has produced large short-term adjustments and instability in year-to-year updates. I know that you, Mr. Chairman, and others on this Subcommittee and elsewhere in Congress are involved with legislative efforts to improve the formula. I want to work with you and the physician community to smooth out the yearly adjustments to the fee schedule in a way that is budget-neutral across all providers. Although we cannot adjust the payment formula administratively, we have been working hard to do what we can, independent of the update levels, to help physicians and other providers in a variety of other areas.

HELPING PHYSICIANS OUTSIDE OF PAYMENTS

I worked in the hospital industry for years, and I know how frustrating it can be for physicians and providers to work with Medicare. We know that in order to ensure beneficiaries continue to receive the highest quality care, we must streamline Medicare's requirements, bring openness and responsiveness into the regulatory process, and make certain that regulatory and paperwork changes are sensible and predictable. This effort is a priority for me personally, as well as for Secretary Thompson and President Bush. And we have *a lot* of activities underway to make Medicare a more physician- and provider-friendly program.

In June, Secretary Thompson announced that, as a first step in reforming the Medicare program, we were changing the Agency's name to the Centers for Medicare & Medicaid Services. The name-change was only the beginning of our broader effort to raise the service level of the Medicare program and bring a culture of responsiveness to the Agency. These are not hollow words: creating a "culture of responsiveness" means ensuring high-quality medical care for beneficiaries, improving communication with physicians and providers, and increasing our education efforts. To promote improved responsiveness, we have created eleven "Open Door Policy Forums" to interact directly with physicians, as well as beneficiary groups, plans, providers, and suppliers, to strengthen communication and information sharing between stakeholders and the Agency. I chair three groups: long-term care, rural health, and diversity. My Deputy Administrator and Chief Operating Officer, Ruben

King-Shaw, chairs the Open Door Policy Forum for physicians, and I participate in the meetings. Ruben listens to physicians' concerns, and tries to fix them where possible. All of these Open Door Policy Forums facilitate information sharing and enhance communication between the Agency and its partners and beneficiaries. My goal is to make CMS an open agency—one that explains its policies to the beneficiaries and providers who rely on us.

We also are working to alleviate the regulatory and related paperwork burdens that for too long have been associated with the Medicare program. The Secretary has formed a new Regulatory Reform Advisory Committee, comprised of providers, patients and other experts from around the country to identify regulations that prevent physicians, hospitals, and other health care providers from serving Medicare beneficiaries in the most effective way possible. This group will determine what rules need to be better explained, what rules need to be streamlined, and what rules need to be dropped altogether, without increasing costs or compromising quality. To support this group, we have developed a program, focusing on listening and learning, to get us on the right track.

Under this program, we will conduct public listening sessions across the country. We want to hear directly from physicians and health care providers away from Washington, DC, and Baltimore—out in the areas where real people live and work under the rules we produce and with people who do not have easy access to policymakers to voice their legitimate concerns. Our first regional hearing is on February 25 and 26 in Miami, Florida. Most of you in Congress have these kinds of regular listening sessions with your constituents, and I have already participated in 12 of these with a bipartisan group of Senators and Congressmen. We want to hear from local physicians, as well as seniors, large and small providers, allied health professionals, group practice managers, State workers, and the other people who deal with Medicare and Medicaid in the real world. We are determined to get their input so we can run these programs in ways that make sense for real Americans with real life health care problems. We hear from some of these people now, but we want to get input from many, many more.

Like the physicians, providers, and beneficiaries who live and work with Medicare every day, CMS staff have worked with managing the system for years, and they too have suggestions about how Medicare can operate more simply and effectively. So, another aspect of our plan is to form a group of in-house experts from the wide array of Medicare's program areas. I have asked one of my close friends and advisors, Dr, Bill Rogers, a local practicing emergency room physician, to chair this group and challenge our in-house experts to suggest meaningful changes. This group of in-house experts will look to develop ways that we can reduce burden, eliminate complexity, and make Medicare more "user-friendly" for everyone.

Furthermore, our Physicians' Regulatory Issues Team (PRIT) integrates practicing physicians into our decision making process, allowing us to develop policies that will better serve beneficiaries and physicians. Specifically, PRIT members work within the Agency to serve as catalysts and advisors to policy staff as changes and decisions are discussed. Team members have assisted us with:

- Streamlining Medicare forms, including the physician enrollment form;
- Improving operational policies;
- The PRIT also is working to improve current channels of input from practicing physicians;
- Clarifying oversight policies; and
- Identifying and changing excessively burdensome requirements.

The PRIT also has initiated a Physician Issues Project, where they sought and obtained from the physician community their input on those Medicare issues that seem particularly burdensome to them on a day-to-day basis. The PRIT identified 25 issues to address, and where change or elimination of a requirement is not possible, we are looking for creative solutions that, at the very least, provide more information and clarification. I was very pleased that when I was in Tupelo, MS, a few weeks ago with Representative Wicker, the incoming Chair of the AMA, Dr. J. Edward Hill, who is from Tupelo, gave me unsolicited congratulations for the fine job that Dr. Barbara Paul and the PRIT are doing. So it is working a bit already!

Furthermore, we are participating in and co-sponsoring "preceptorships" with local county medical societies, where our policy staff can get out in the field and "shadow" physicians, watching them provide care, listening to lectures, and even observing operating room procedures. This is a great way for us to observe first-hand their daily work life and the challenges they face in providing care to our beneficiaries.

These outreach efforts will allow us to hear from physicians and all other Americans who deal with our programs. We are going to listen and we are going to learn. But we also are going to change. I am committed to making lots of common-sense

changes and ensuring that the regulations governing our program not only make sense, but also are in plain and understandable language. This will go a long way in alleviating physicians' fears and reducing the amount of paperwork that, in the past, has all too often been an unnecessary burden on physicians.

IMPROVING PHYSICIAN EDUCATION

As part of our efforts to reinvigorate the Agency and bring a new sense of responsiveness to CMS, we are enhancing our education activities and improving our contractors' communications with physicians and providers. The Medicare program primarily relies on private sector contractors, who process and pay Medicare claims, to educate physicians and providers and to communicate policy changes and other helpful information to them. We have taken a number of steps to ensure the information our contractors share with physicians and providers is consistent, unambiguous, timely, and accurate.

We recognize that the decentralized nature of our educational efforts has, in the past, led to inconsistency in the contractors' communications with physicians and providers, and we have recently taken a number of steps to improve the process. We have centralized our educational efforts in our Division of Provider Education and Training, the primary purpose of which is to educate and train both the contractors and the physician and provider community regarding Medicare policies. We also are providing contractors with in-person instruction and a standardized training manual for them to use in educating physicians and other providers. These programs help ensure consistency so that our contractors speak with one voice on national issues. We are continuing to refine our training on an on-going basis by monitoring the training sessions conducted by our contractors, and we will continue to work collaboratively to find new ways of communicating with and getting feedback from physicians and providers.

We also are working to improve the quality of our contractors' customer service to physicians and providers. Last year, our Medicare contractors answered 24 million telephone calls from physicians and providers. We now have toll-free answer centers at all Medicare contractors. To insure that contractors provide correct and consistent answers, we have performance standards, quality call-monitoring procedures, and contractor guidelines in place to make our expectations clear and to ensure that contractors are reaching our expectations.

Additionally, we want to know about the issues and misunderstandings that most affect physician and provider satisfaction with our call centers so that we can provide our customer service representatives with the information and guidance to make a difference. To improve our responsiveness to the millions of phone calls our call centers handle each year, we are collecting detailed information on call center operations, including frequently asked physician questions, the call centers' use of technology, and the centers' training needs. We will analyze this information so we can make improvements to the call centers and share best practices among all our contractors. We also developed a new Customer Service Training Plan to bring uniformity to contractor training and improve the accuracy and consistency of the information that contractor service representatives deliver over the phone. In addition, we are holding regular meetings and monthly conference calls with contractor call center managers to ensure Medicare's customer service practices are uniform in their look, feel, and quality.

Just as we are working with our contractors to improve their physician and provider education efforts, we also are working directly with physicians and other health care providers to improve our own communications and ensure that we are responsive to their needs. We are providing free information, educational courses, and other services through a variety of advanced technologies. We are:

- *Making our Agency website more useful to physicians* through a new website architecture tailored to be intuitive for the physician user. We want the information to be helpful to physicians and their office and billing needs. Once this new website is successfully implemented, we will move to organize similar web navigation tools for other Medicare providers. Additionally, we have improved our Frequently Asked Questions section, making it more intuitive and easier to search.
- *Expanding our Medicare provider education website,* www.hcfa.gov/medlearn. The Medicare Learning Network homepage, MedLearn, provides timely, accurate, and relevant information about Medicare coverage and payment policies, and serves as an efficient, convenient physician education tool. In recent months, the MedLearn website has averaged over 250,000 hits per month, with the Reference Guides, Frequently Asked Questions, and Computer-Based Training pages having the greatest activity. I encourage you to take a look at the website

and share this resource with your physician and provider constituents. We want to hear feedback from you and from your constituents, especially physicians, on its usefulness so we can enhance its value. In fact, physicians and providers can email their feedback directly to the MedLearn mailbox on the site.

- *Providing free computer and web-based training courses* to physicians, providers, practice staff, and others. Interested individuals can access a growing number of web-based training courses designed to improve their understanding of Medicare. Some courses focus on important administrative and coding issues, such as how to check-in new Medicare patients or correctly complete Medicare claims forms, while others explain Medicare's coverage for home health care, women's health services, and other benefits.
- *Installing a Satellite Learning Channel* to provide Medicare contractors with the latest information on contemporary topics of interest. We recently completed the installation of a network of satellite dishes at all contractor call centers to improve our training efforts with contractor customer service representatives.

These reforms are just examples of the work we are doing. We also have a comparable number of efforts underway to reach out to beneficiaries and to make Medicare a friendlier, easier-to-use program for them. These changes have been my top priority in my nine months at CMS, and I will continue to pursue these types of improvements as long as I am Administrator.

CONCLUSION

I took this job because I know how important Medicare, Medicaid, and SCHIP are to Americans, and because I want to make a difference in improving our health care system. I am just as frustrated as you and all of the physicians that you hear from when it comes to how confusing and complex these programs are, and I am working hard to improve them. I also am working hard to monitor beneficiary access to care, while ensuring that America's elderly and disabled can receive the high quality care they need and deserve.

The Administration is willing to work with Congress to smooth out the physician payment system, but I know that it will not be easy. Any spending increases will have to be offset by corresponding adjustments in other provider payment systems so that it is budget neutral in both the short- and long-term. Therefore, improvements in physician payments, or any other Medicare payments, likely will lead to declines in Medicare payments for some other group of providers. There will be tough choices to make. The Administration will be helpful to you as you consider them. Thank you for the opportunity to discuss this important topic with you today. I hope that I have helped to explain the issues, and I look forward to answering your questions.

Mr. BILIRAKIS. Thank you, Mr. Administrator. When you met with Chairman Tauzin, Dr. Ganske and I you basically agreed, I think, that the cut was just too onerous, you agreed that the formula was flawed. You've said it time and time again. I guess I would have one bottom line question. We have people here, physicians and what not, who could probably go into some of the details better than I, but does CMS—Mr. Norwood kept referring to your agency HCFA. We should fine you a dollar every time you said that.

Mr. NORWOOD. Mr. Chairman, I only meant that it hadn't changed any, other than the name.

Mr. BILIRAKIS. That Georgia boy is quick, isn't he?

Mr. NORWOOD. With 4 hours of sleep, not bad.

Mr. BILIRAKIS. Do you have the flexibility, does CMS not have the flexibility? I guess nothing is going to be right, whatever we come up with. I would suggest and I'm not sure we have the expertise up here to determine what that formula should be. MedPAC has a lot more than we have. They apparently are coming forward with some recommendations. They have not issued them publicly and that's why they're not here, basically, to defend them, but we will have a subsequent hearing to go into that.

But CMS, do you not have the flexibility to basically work on this and to determine what you think might be as close to right as possible?

Mr. SCULLY. We certainly, Mr. Chairman, have given you a lot of technical advice and guidance and we'd be happy to do that. I've got a lot of people in the agency who have done this since it was written in 1989. Some of them I knew back then are still there. So we'd be happy to do that.

We don't have the flexibility to do anything administratively in the law. I have gone up to the highest level of the Justice Department last fall but the law is incredibly prescriptive and gives us no flexibility to change it. It has to be done legislatively.

Mr. BILIRAKIS. Should you have more flexibility?

Mr. SCULLY. I think we probably did have more flexibility, the statute was more flexible, pre-1997. To be honest with you, the 1997 bill, the physician cuts in that bill were very, very modest. They were about 5 percent of the 1997 bill's cuts and physician spending is probably over 20 percent of the program. But this is part of 1997 bill and one of the ways they saved a little money on physicians in 1997 was to ratchet down in the formula a little bit, but they made it much more prescriptive. They basically made it a multi-year recapture. If you find overspending, it all comes back and is recaptured. And it's just a much tougher formula. It's much tighter, with much less wiggle room.

But we'd be happy to work with you any way we can to come up with the right policy.

Mr. BILIRAKIS. I wonder, you indicated that the proposed MedPAC formula would be terribly expensive. You didn't use a dollar figure unless I missed it. As I understand it, your actuaries have reported it would cost $127.7 billion over 10 years to adopt the recommendation. Is that correct?

Mr. SCULLY. That number is pretty close.

Mr. BILIRAKIS. I don't know whether Mr. Foster wants to very briefly go into the basis for your coming to this cost estimate?

Mr. SCULLY. He'd be happy to do that because a lot of people have questions about it. I mean the one thing I'm proud of—and I think the agency is too—is that our actuaries have always been perceived to be totally independent, above board, trusted on a bipartisan basis and of all the scoring and I spent many years at OMB, as you know, I think the No. 1 place in the Federal Government where the people who do the scoring has never been doubted is CMS. And Rick, I think, has an unbelievably squeaky clean 30-year history at this. So with that, Rick is our chief actuary.

Mr. BILIRAKIS. Very, very briefly if you can, Mr. Foster. I know it's very difficult to describe it briefly.

Mr. FOSTER. Sure. Can you hear me? Let me emphasize first that MedPAC, of course, has not actually released its recommendations yet.

Mr. BILIRAKIS. Right.

Mr. FOSTER. So we were working off of what our understanding was of the likely recommendation. That would involve essentially a limit in the SGR process and then paying an update each year based on an inflation index, the Medicare economic index with an adjustment or productivity. What happens is, if you use that basis,

first, instead of getting these large negative updates that Mr. Scully referred to in his remarks, you would have something like a positive 2 to 2.5 percentage here. So, on an on-going basis, you've have 2 or 2.5 percent. Instead of for the next several years, minute 5.7, etcetera. That's where the bulk of the cost would come from and the $127.7 billion over 10 years, as we said was remarkably close to our estimate.

Mr. SCULLY. Mr. Chairman, I might add that if you look at the chart we handed out and if you basically add up current law baseline physician spending, which is the top line versus the MedPAC proposal and you add up the numbers year by year, it only goes out to 2005, but those are Rick's numbers and if you calculate them, you get the first few years of the calculation pretty much dollar for dollar.

Mr. FOSTER. The one other issue I would add is that the SGR process exists because Congress was worried about rapid growth in physician expenditures under Medicare. Without the SGR and with no other constraint on growth and volume or intensity of services, you would probably have more than you would have under the SGR and we estimated a modest additional growth in that regard which contributes further to the $127.7.

Mr. BILIRAKIS. Well, my time has expired. I guess I just wonder wouldn't it have been simple to just start out with a certain basic figure that everybody kind of feels is relatively realistic and then just jack it up on the basis of cost of living increases or inflation increases and just let it go at that, rather than GDP? Why GDP is a part of this formula? What the heck does GDP have to do with doctors' costs?

Mr. SCULLY. Mr. Chairman, I will say having been involved in this and I was not in the government, times have changed, obviously, but the argument at the time was that the formula used to grow with physician volume and intensity of services and that wasn't particularly well liked either. In 1997, this was expected to be in 1997 a more stable situation. I would argue it probably backfired to some degree, but it was with the best of intents when it was originally done.

Mr. BILIRAKIS. I honestly feel that you care about the problem, Tom, and hopefully you'll continue to care. I know the dollars are big here and I don't know if the MedPAC formula is the best way to go, but I think we all are very intent on changing that formula. I don't know how many lost dollars, if you will, we can recover, but certainly in the future we should come up with something a little smarter, it seems to me.

The Chair yields to Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Tom, thank you again for joining us. I think our primary mission here today is not to satisfy doctors who do enjoy by and large pretty good incomes. Our mission it to make sure, obviously, that patients have good, quality care. We sometimes lose sight of that in our deliberations here. We're talking about 2002 and beneficiary and reimbursement levels. The last, my understanding is the last survey of beneficiaries was from 1999 which is a poor measure, I think, of whether seniors will have access in 2002. Is there a way, would you comment on that? Because reimbursement rates were obviously different, as

your charts show in 1999. How do we get better measures of beneficiary access and participation? Ultimately, we want physicians to continue to provide that care. We want to make sure that the physicians are participating, beneficiary levels in 1999 were different from 2002. How can we measure that better and what are your plans to do that?

Mr. SCULLY. I believe we have a new measurement coming out shortly, but I personally think, and I watch it reasonably closely, and there are probably other private measures as well, more than 85 percent of physicians always take Medicare assignment, which is where they take full Medicare payment as full payment, and about another 10 percent take Medicare patients, but charge what they're allowed to charge, 15 percent above the fee schedule. So I personally don't believe that right now there's a significant access problem for seniors. I do think that it's very possible that if this formula is not changed and you have multi-year reductions, then you will find more and more physicians not taking new Medicare patients in the least and you will eventually see an access problem. I don't believe we have one now, but I do think it's a boiling pot.

Mr. BROWN. So even with this new, these new 2002 numbers, surveys coming out, that's not going to measure something that you think is not a problem yet, but could possibly be or two or three from now?

Mr. SCULLY. We haven't seen a significant erosion of access of physicians, taking Medicare patients yet. I would say anecdotally from just spending a lot of time talking to physicians I think more and more are trying to avoid taking new Medicare patients, but they generally do still take Medicare patients.

Mr. BROWN. The administration's 2003 released last week indicates that any so-called "give backs" to providers should be made in a budget neutral fashion, obviously payment increases to one provider should be paid by reductions in payments to others. We have sort of been in a sort of whipsaw situation the last four or 5 years with the cuts in 1997. And then we're restored some of the excessive cuts, the 15 percent cut in home health payment is imminent. DSH payment cuts. When we're talking estimates of fixing this problem seem to be as much as $80 billion over the next 10 years, how is the administration recommending we make this budget neutral, be able to do these "give backs" to providers that I think everybody up here wants to do? Where does it come from? What does it mean with DSH? What does it mean with the cut in home health payments, all of that?

Mr. SCULLY. Well, that's multiple questions. As I said, I think the MedPAC formula—with all respect to MedPAC—probably goes a little too far. I think there are a variety of ways to do it. I think $80 billion is probably on the high end of what needs to be done and we're happy to work on that. In our budget, we also did not extend any existing Medicare policies, called baseline extenders, so virtually every policy from 1997 that expires this year was not extended in our budget. And we did that intentionally because we did not have a specific way—because there are many ways to do this—to fix this policy, but there are a whole bunch of things. There are virtually no "cuts" in the traditional sense in our budget either. So for instance, the hospital payments—and we certainly have a de-

bate about that—go back to the full market basket for the first time. I think it's happened once since 1982. So there are a lot of different policy options out there to "save money" to pay for this in a budget-neutral way. I'm not suggesting that. That's certainly one that the Ways and Means Committee has brought up in a previous hearing last week with Secretary Thompson and pretty directly asked his opinion on it. We basically said we're happy to sit down and evaluate the merits of all these different pieces.

On home health for instance, and I know this probably won't be a popular comment, but it's our position, we very specifically did not propose fixing the 15 percent cut. Home health spending went up 42 percent last year and even if the "cut" goes in place, spending goes up 12 percent next year, 8.3 percent the year after that, 7.8 percent the year after that. And the fact is it's really not a cut, it's a 15 percent reduction in a 6-year-old calculation. The actual per home health spending rate from last year will go down by 7 percent from the old interim payment system. I'm not saying that we shouldn't look at home health as well, but just purely getting rid of the 15 percent cut will result in many, many double digit spending increases for years to come. So I think there's some mid-range approach to home health too.

There are many pieces that are put together. I think there are certainly the grounds for putting together a budget-neutral reasonable package that can deal with some of the more acute provider problems that we have. I'm not suggesting specifically one way or the other. Obviously, the President's budget came up. I'm not the only one that has input in that. The President's budget very specifically did not fix this. It also very specifically did not extend a lot of the baseline extenders that traditionally had been in past budgets, so we could come out and work out some of these extremely complicated policies.

Mr. BROWN. Thank you.

Mr. NORWOOD [presiding]. I recognize myself now for 5 minutes. Tom, I think you do a great job. It's much like it was when you started. I thought you were crazy to take the job because there's no way you can win. I don't actually, in my heart, that it's you or your agency nearly as much as the problems that are in Congress, but you're much funner to shoot at than Congress.

And what we want from you is to try to help Congress get it right because Congress has not gotten it right. Since 1992, Medicare payments to physicians averaged only 1.1 percent annual increases or 13 percent less than the annual increase in practice costs as measured by the Medicare Economic Index.

Do you agree with that?

Mr. SCULLY. I would certainly agree, I'm not sure the numbers are right, now that the per visit, what a physician gets paid per office visit, I'm sure that's right. But the fact, that because volume has been increasing and because we've added——

Mr. NORWOOD. Well, this is accounting an annual increase, this is how much more money, in general, they receive.

Mr. SCULLY. Per visit, that's probably true.

Mr. NORWOOD. And the reason I'm saying that, we're going to have a witness testify to that. My question to you, you keep talking about increased spending, but clearly the problem isn't necessarily

increased spending at the provider level at 1.1 percent increase isn't exactly what I'd call increased spending.

Are we directing our attentions to the fact that there are other factors that are causing this program to grow, rather than continually dealing with the problem of always costing more money, let's cut the providers back. Are you even talking about the other areas that are causing this increased spending?

Mr. SCULLY. There are a lot of factors across the board. To be honest with you, one of the reasons I think RBRVS was put in place in 1989 and because, for instance, when you look at hospital spending, volume of services has not always been as big a variable. So there's never been a design situation for volume of services. Hospital spending has been flatter and more predictable.

There's no question that per visits for physicians, the spending has been relatively flat and probably at or slightly below inflation. But the problem and the reason the system was designed in 1999 was that volume, new technologies, new services, the volume of service has grown and frequently have 2 percent or less annual increases in the actual per visit fee, while spending was going up 15, 17 percent a year. So the idea has always been to find the right balance to disincentivize greater volume, but also to be fair to the individual physician.

Mr. NORWOOD. If you want to do that, does that imply you mean they're treating people who don't need to be treated, that's how they increase their volume?

Mr. SCULLY. No, part of it is also the physician community comes in every year and argues for new codes and new services and we've added hundreds in recent——

Mr. NORWOOD. Well, why do you suppose they do that?

Mr. SCULLY. To be more accurate, but the fact is, there's basically an agreement between the government and the physician community that as you add a new code, you take that percentage out of the pot, so every other one goes down a little bit.

Mr. NORWOOD. I understand you take that percentage out of the pot, but I presume the new codes are for treatments that patients need and they're trying to make it clear with you guys so they can be paid.

Mr. SCULLY. Sure. Mr. Norwood, obviously, the formula we use, the physicians come in and argue and we try to be conscious that we're not going to add a new gastroenterology code unless it's needed because by law, we're required to—let's say we add 2 percent new codes, every other code goes down by 2 percent to pay for it. So if you add new codes——

Mr. NORWOOD. That's part of the problem with the system is why the system is sort of broken.

Let me get on to the next part because I'm running out time.

Mr. SCULLY. Yes sir.

Mr. NORWOOD. You implied earlier that CMS estimates were very wrong in 1998 and 1999. In fact, you were wrong with the GDP growth and enrollment changes and the fact is that ended up costing about $20 billion and I would suspect you would think it saved $20 billion, but it took away $20 billion from people who should have been paid and we have been told that you don't have the legal authority to fix that even though you know it was wrong

3 years ago. We still can't fix it because you don't have the legal authority. It is of interest to me that you're now spending in 2002 in the final rule that you do have the legal authority to change the 1998, 1999 SGR projections related to expenditures for certain CPT codes that had been overlooked by the agency.

One gets the impression that you have the legal authority to do what you need to do, if it cuts payments or decreases your costs. You just never have the legal authority to do what you need to do if it increases the cost and I don't guess I have especially a question about that, other than that is an observation that I'd like to see somebody look at.

Mr. SCULLY. I'd be happy to address that. I think this has been totally completely by the book and the fact is the AMA sued the Clinton Administration over the issue about whether they could use real numbers in 1998 and 1999. It was litigated extensively and the Clinton Administration prevailed and won in court. So it was litigated at length for 2 years because the previous administration said we are required by law, by statute to use projections and I can tell you that's very clear, I used to be a lawyer, thank God, I'm not anymore, and it says, by law, we have to use the projections. It was litigated in length. The Justice Department prevailed in that, so we're stuck.

On the other side of spending, the law also clearly says you put in expenditures and what happened was inadvertent, the Department did not know about some of these expenditures related to new codes that we added. When they found them out, by law they're required to say those billions of dollars came out of the trust funds and were spent and they have to be calculated and I honestly, I'd be happy to spend as many hours as it would take, but I really believe we've done this totally by the book.

Mr. NORWOOD. I'll finish with this. I know Congress requires you to use projections. Does Congress require you to continue to use projections that are known to be wrong?

Mr. SCULLY. Unfortunately, it's only for those 2 years. The law, when it was changed in 1999, said continue to use projections for 1998 and 1999. For the years after that we can actually update it with real numbers. So since 1999 the numbers are correct. I mean they're real numbers, but what happened, as you know, it wasn't just CMS's numbers. It was the OMB numbers for GDP and if you look back in 1999 and 1998, no one projected 4 or 5 percent annual growth rates, they projected 1 and 2 percent. And at the end of the year it turned out to be 5 and 6. So if those numbers were plugged in, the targets would have been higher. But it's very clear in the statute that we do not have the flexibility.

Mr. NORWOOD. That sort of reminds me of the projections Lyndon Johnson's staff made in 1965. Not to worry, Medicare will only cost $9 billion 25 years from now. We don't do very well in this government with projections and when we do them wrong, we hurt a lot of people.

My time is expired.

Mr. SCULLY. Can I say just two quick things? You asked in your opening statement, you asked about our appeals policy and if I thought it was crazy and I said it was a Democratic provision. I

don't believe I ever said it was a Democratic provision, by the way——

Mr. NORWOOD. Great.

Mr. SCULLY. But—and I'm happy to say it's crazy on a bipartisan basis. It's crazy, not because the policy is not good. My frustration, Mr. Norwood, is that basically what we allow, as I said, we get 600 million physician claims a year. What it would allow is for every patient that walks into an office to call up Medicare first and say is this claim going to be paid, and to be honest with you, my biggest concern about that——

Mr. NORWOOD. It actually doesn't allow that. What it allows is what used to be done with predeterminations where when a patient comes in, the physician says you need such and such a treatment. The patient needs to know is this covered or not and the physician applies for that information. I think the crazy part is—what it basically does it a way of rationing care, it's a way of keeping people from getting treated because if you come in and need an MRI and the doc says hey, I don't know who's going to pay for this and if HCFA doesn't, you're going to and the patient's headache isn't real bad. They put it off. It's a way of rationing care.

Mr. SCULLY. My concern, just to be clear, is not with the policy. My concern is that—and I'm a cheap OMB guy, so I'm not asking for more money. I run a $525 billion agency with a $2.3 billion administrative budget. If we had seniors—you can debate the policy whether they should be able to call up and get preauthorization—if they did, I'd probably need at least $1 billion to hire more staff to answer those phone calls. We just don't—and the authorizing committees, as much as I love them, if the appropriators will give me the money to hire all those people, wonderful—but I just don't have the staff to do it. And so my concern about it being crazy is that it may be a wonderful idea, but frequently, with all due respect, Congress passes things and then CMS gets stuck with hundreds of thousands to millions of phone calls and nobody to answer them and it causes a lot of problems.

Mr. NORWOOD. I stated that up front. It's Congress' fault, but if we're going to run an insurance agency, in my mind, that's what you really are, you're a third party, do it right for pity's sake. I'm way overboard.

Mr. SCULLY. Well, can I have one more thing because I normally do stay around for these hearings and I would like to, but because the chairing was changed, I was supposed to speak at the AARP's Board at breakfast and I'm going to speak to them afterwards, so I'll stay as long as I can, but I have to go talk to the AARP right after this, so it's not out of lack of respect or interest of the other witnesses, but at some point I have to go over there and speak to their Board.

Mr. NORWOOD. Thank you. Mr. Barrett, I apologize. You're recognized for 5 minutes.

Mr. BARRETT. Thank you very much, Mr. Chairman. It's a pleasure to have you here this morning, Mr. Scully. As I listen to your testimony and showing the charts and going through the charts, the thing that became most clear to me is that none of this is very clear to me.

Mr. SCULLY. Sorry about that.

Mr. BARRETT. And I realize that we've discovered the enemy and the enemy is us in large part because of the actions taken by this Congress. But if you can just sort of help me. And hindsight is 20-20, but I'm still baffled as to why GDP is the factor here as opposed to a combination of factors, medical, technology, aging population. What would you give as the best rationale for using the GDP?

Mr. SCULLY. From 1989 to 1997, volume and intensity of physician services, new technology was, in fact, the factor. And to be honest, I think, for a variety of reasons, some physicians didn't like it, to some degree, in those years because in many cases volume and intensity went up higher and they said what does this have to do with—maybe health care should be 1 or 2 percent higher spending. If the physician volume intensity was higher than GDP, they got cut more. So some people perceived the GDP to be a better number because it wasn't going to cut physicians as much and that might have been the case, but two factors happened. One is that GDP was added and it's argued that because it's bounced around much more than expected the last couple of years, it had a much more erratic effect. The second thing is that until 1997, the formula wasn't a multi-year calculation. So if you had found out that you paid too much out in 1999 and 2000, and they discovered in 2001, you only recaptured a little bit for past errors. This new formula is very strict, so if you make multi-year errors or over payments, as we have, to the tune of $209 billion, it's all recaptured over a certain period of time. It's just a much harsher formula.

In addition, before 1997, the most the update could be, the true inflation update this year is about 2.9 percent, but then we go back and recapture previous spending. The current formula allows you to go as negative as negative 7 percent—we actually did it this year, negative 7 percent. We took 7 percent out to make up for what we were spending in past years because that's what the formula says. Prior to 1997, I believe the cap was originally 3 percent and then 5 percent. So this formula, I wouldn't say necessarily GDP is the problem. It's just that GDP has been much more erratic than it had been in the past and wasn't as predictable, plus the formula is much harsher at recapturing past errors or overpayments and I think all three of those combined come up with a particularly harsh result.

Mr. BARRETT. We're going to hear in the next panel from some people who are going to talk about the impact on rural areas and they will make the case, I think, that rural areas are hit disproportionately higher. Can you address that? What's your analysis as to which areas are hit the hardest and where beneficiaries potentially will be hit the hardest?

Mr. SCULLY. I'm not sure that I can really give a fair analysis of who gets hit the hardest. I'm sure physicians any place that are getting lower payments per visit probably all feel like they're hit the hardest. I think the argument on the rural areas applies more to the Hospital Wage Index Update, that Congresswoman Wilson and others mentioned. When you get into rural areas, there's obviously a significant differential in payment, both in hospitals and physicians and across the board based on geographic area costs. Some have argued that maybe this is not fair. You could certainly spend a couple days debating that, but for a hip replacement, for

instance, you may have the base rate, maybe $10,000, and in New York City make it $17,000 and in a rural area make it $6,000. Very similar things happen in physician payments. A gastroenterologist may get paid, if the base rate, I'm just picking out of thin air—I don't know what the rate is, $600 for a colonoscopy as the national rate. In some areas you may get $850 and some areas might get $450. It's all based on the area wage costs that are measured again through a statutory formula, for what it costs in Phoenix as opposed to rural Arizona or Los Angeles versus Santa Barbara or some place with the various wages in those areas. There's a very strict formula, both on the physician side and the hospital side, but the payments vary pretty significantly. In some places, like Mr. Ganske mentioned in Iowa for instance, that have traditional low costs of health care, health providers would argue that for being efficient and low cost they pay for that and there's probably some truth to that.

Mr. BARRETT. Has CMS run any data or do you have any data on specifically how different segments of the community——

Mr. SCULLY. How different the payments are?

Mr. BARRETT. The impact.

Mr. SCULLY. We have unbelievable amounts of data. I'd be happy to share whatever you'd like. The impact is probably a little tougher to measure, what the real impact is as far as the impact on provision of care. I think probably the impact probably—talking about rural versus urban and provision of care and access—is probably clear when you talk about what the base fee for service rates provide and as a result of Medicare+Choice payments is probably the clearest place it shows up, rather than as far as physicians versus hospitals.

We have unbelievable amounts of data, if you'd like to get some for your District, I'd be happy to provide it for you.

Mr. BARRETT. I would like that. In terms of a remedy, and you've talked about cost neutrality——

Mr. BILIRAKIS. Please finish up, Tom. I tell you, we've got to give us this room at 11 o'clock. So it's critical that we stay within——

Mr. BARRETT. Do you realistically think we can do this in a cost neutral basis?

Mr. SCULLY. Yes, I do. I would think this formula is significantly flawed and it's up to Congress as to how you'd like to fix it. I personally believe that the MedPAC formula, it's just my personal opinion, it's not a good idea to return to double digit, Part B spending or any place in Medicare. So I don't think you have to spend $127 billion. I think there are some fixes that are significantly less expensive. I also think there are some other places in the Medicare spending and budget where you can extend some existing policies that expire and save enough money to come up with a budget neutral fix.

Mr. BARRETT. For example?

Mr. SCULLY. The President, to be honest with you, sent up his budget last week and I don't think it's appropriate for me to make suggestions outside of that, but I think if you look at existing policies, there are many——

Mr. BILIRAKIS. I'm sorry, we're going to have to move on here.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. Tom, I don't know if you've testified on this this morning or not, I'm a little groggy, but what has been the experience, the relative experience in the fee alterations in the Medicare managed care system versus the fee-for-service schedule?

Mr. SCULLY. I'm sorry, as far as the year by year, the changes or? Well, I personally didn't testify to this. I personally think that it could be a toss-up as to which is more screwed up, the physician schedule or the managed care, Medicare+Choice schedule. Again, this is my opinion, I'm not sure it's administration policy, but I'm not sure we have one.

In 1997, with the best of intentions at the time, Medicare+Choice was booming and it was about 18 percent of Medicare and CBO and everyone else projected we'd be at 30 percent Medicare private plans by 2002. I believe a lot of rural areas, I'm sure Mr. Ganske could agree with this, said managed care is booming in New York and Philadelphia and Chicago, why can't it come to Iowa and Minnesota? And so effectively what Congress did in 1997 is they capped most of the urban areas for 5 years at 2 percent increases by statute while the rural area payments have gone up pretty significantly. What's effectively happened is there have probably been $2 billion a year that was expected to be spent and actually allocated under the budget that's not being spent because, basically, managed care rates really went up significantly and no one showed up. They built it, nobody came. And so the money has been allocated out there, but actual managed care spending in Medicare dropped from $42 billion last year to about $34 billion this year. That was never in the projections, but the idea was that managed care was on cruise control in the urban areas and was going to continue to do well and we need to push the money in the rural areas. Well, there is no managed care in many rural areas——

Mr. GREENWOOD. My question is—sorry to interrupt you, my question is you're looking at the negative update for physicians and the fee-for-service fee schedule. What are the physicians looking at in average, if we know, in the managed care system?

Mr. SCULLY. Well, obviously they don't get paid directly by us, but it's calculated in the formula, so overall, within the managed care formula, is an averaging of the fee-for-service payments. So fee-for-service payments are going down for physicians, that's built into the base Medicare+Choice managed care payment rate. That also, pro rata, goes down because it's basically——

Mr. GREENWOOD. Are they, in fact, experiencing or projected to experience actual decreases in their fees?

Mr. SCULLY. That's hard to say. We have, I guess, we're down to, how many, less than 250 Medicare+Choice contractors and I'm not exactly sure where the balances come down, but essentially what's happened is you know, especially in your District, premiums have gone up, deductibles have gone, drug coverage has dropped and physician payments have been squeezed, so it's hard to measure in M+C, but I would be very surprised if physician fees haven't been flat or reduced.

Mr. GREENWOOD. On your charts, when we look at growth in physician benefit, do you have statistics to break that down so that we can take a look at how that affects the average physician? Is

the average physician increasing volume to get that growth or is that—how do you separate that out from growth in the number of participating physicians, for instance?

Mr. SCULLY. We have lots of data on that and I'd be happy to share it with you. It depends on physician practice areas. Some physician practices and the AMA puts out a lot of this data, but we have quite a bit too, some physician area incomes have been going up, volumes have been going up, payment for the services has been going up. The services that have been covered have been going up. For example, the last few years, Congress has covered a lot more services of gastroenterologists. And I think you can see that gastroenterologist Medicare services, that's probably a good thing. It's mainly colonoscopies that have been going up and some of the incomes have been going up. In other areas, like primary care and others, it's been going down, but we have a lot of data on that and I'd be happy to give you information by specific practice groups, if you'd like.

Mr. GREENWOOD. You've talked about the increase in codes. Are codes regularly deleted? Is there any fall off? Is it only an additive process?

Mr. SCULLY. I'm sure we do delete codes. It's my experience, I think we've gone from about over a little over 6,000, close to 7,000 codes in the last 15 years, so they've generally been more additive, but occasionally we do delete them. But it's almost always done with the cooperation of the RUC, which is an AMA-guided physician group.

Mr. GREENWOOD. Mr. Chairman, in the interest of time, I'll yield back the balance.

Mr. BILIRAKIS. The Chair appreciates that. Ms. Capps?

Ms. CAPPS. Thank you, Mr. Scully, for being here with us today. If you want more data about rural areas of our country, I can tell you that there are increasing number of physicians in my rural District who are applying for work at the prison hospital facility, citing that they will get better payment, payment on time and better hours. Because the number of Medicare+Choice programs is almost gone, our reimbursement rate in our District in California is so disproportionate to the costs of living in our area and they are also facing a very skewed geographic practice cost index, the GPCI, which means for them this current physician payment update is just kind of like the last blow. So it's reached dire proportions in many parts of the country, I'm sure, but I can tell you from first hand experience with the providers in my District that it is really a problem and it needs to be addressed. That's not in the form of a question. I would like for you to speak about two parts of technology. One piece of the physician payment formula need to account for scientific and technological advancements and changes in the complexity of services provided, the ability to account for that in a better way more quickly. And also, almost like the flip side of that, what kind of technology is going to really make a difference within your Department as you've come on to the scene now and taken over the helm, so that you can be better and that we can better monitor? In other words, accounting for the technology that is in medical practice, but also the use of technology to do a better job of monitoring the practice of medicine in the country as you do

with the reimbursement rates and all of the reporting that needs to be done, the paperwork aspect of this for the providers?

Mr. SCULLY. Well, there are a lot of things. One, to be honest with you, just with my own agency because we pay probably, certainly 50 percent of hospital bills and the bulk—we're by far the biggest payor in the country—we're dealing with 35-year-old computers and our own systems are a disaster. The Clinton Administration tried to fix that and put several hundred million dollars and flipped the switch and it blew up. So we clearly, to their credit, they tried.

We clearly have a technology problem at CMS. We have a very old, antiquated insurance system. As far as technology goes, the biggest help as far as monitoring the doctors and others is the paperwork burden, which is as controversial as HIPAA, which was put off for a year by Congress. I think that was probably wise, but we've been talking about streamlining paperwork for 15 years. At some point we need to quit delaying it and just flip the switch and close our eyes and do it. Hopefully, we're going to do it in about a year and a half with HIPAA, but eventually, every physician will have common codes, common paperwork, common forms, every Blue Cross plan, every Cygna, Medicare will all be on one common coding system and it will be very difficult to pull off, but in four or 5 years when we actually do it, I think most physicians will find much less burdensome paperwork as will hospitals and providers all across the board, because they'll have basically one set of common insurance codes. That will be a big change.

As far as technology, obviously medical technology is wonderful and there are a lot of terrific things about it. But part of our exploding health care problem is technology. I spent an enormous amount of time, for instance, spent a lot of time, 12 years ago when MRIs were coming in, trying to figure out how quickly we should pay for them, when we should pay for them, under what circumstances. There's a new generation of that. I spent a lot of time PET scans right now and I'm sure, as you know, it's wonderful technology for some things. I also know a lot of radiologists would like three in every hospital, so finding the balance where patients get access to the right things like PET scans, but that you don't have too many, generate too much volume and have an explosion of inappropriate volume for services is a very tough balance. It's something that I struggle with with the help of my large staff of physicians every day. There are a lot of complicated issues around technology and volume. And a lot of it is wonderful and terrific for the patient, but it also generates costs, that's one of the reasons why you have flat per visit fees and exploding health care costs. It's a tough balance to keep.

Ms. CAPPS. I've had some manufacturers of devices and other people tell me that they know that even though this is developed in this country that there are other countries where patients are getting access to that kind of care at a much faster rate and that's a hard thing to swallow.

Mr. SCULLY. It's tough. On the other hand, there are a lot of times when I get calls from the device manufacturers asking me to call people in Japan who are about six times as slow as we are, so it's a balance. There are some countries that are quicker. There

are some that are a lot slower. And we're spending a lot of time working on this to try to improve new technology as quickly as we can. On the other hand, it is a constant debate, I spent most of last night on it. FDA approves things, drugs and devices, for being safe and efficacious. We're an insurance company. We have to pay for it with the taxpayer dollars and we try to find the balance to pay for the right things. We don't always pay for everything if it's not efficient for the patients and not a significant enhancement in health care.

Mr. BILIRAKIS. The gentle lady's time has expired. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman, I remember back in 1995 when we had committee hearings and we were looking down the road at increased costs for Medicare. We were trying to preserve and protect and strengthen Medicare. I gathered a group of 30 Republicans the night before our vote on the House floor and we marched over to the Speaker's Office and I basically led that discussion and told Newt he didn't have the votes unless we began to address this issue of inequitable geographic payments.

We got some improvement then, but I also warned everyone at the time that a tourniquet can stop a hemorrhage, but applied too tightly can cause gangrene. We are looking at a situation here where we can have gangrene happening.

In the interest of disclosure, I think most people here know that I am a physician. I am a member of the American Medical Association and the American College of Surgeons and I'm proud of the professional ethics enforcement and standards of both of those organizations. Representatives will be testifying here.

Now, my daughter is a senior is college. She's major in architecture, but she's interested in going into medicine. She asked me recently what I thought of her interest. With all of this data from Mr. Scully in mind, I said well, Ingrid, I don't know what your reimbursement will be. I then showed her a bill I received from the auto shop where I took my car. I pointed to the labor expense line and I pointed out to her what the mechanic was getting paid on an hourly basis compared to family physicians in my District. But I said to her, Ingrid, taking care of patients is the greatest privilege in the world and that's how you should make your decision because it's a wonderful profession. And helping people is really important.

Nevertheless, we are dealing with a situation here today that, Mr. Scully, when I look at your own chart, for instance, on the third main line where it has data measured correctly all along physician update, if you look from 1995 through 2005, you're talking about on average of 1.1 percent annual increase and that is probably about half of what the medical inflation rate is.

We have to do something about this. And so Medicare, MedPAC in January, voted to recommend adjustments to the Medicare update system to better account for actual physician practice costs, including a 2.5 percent payment increase in 2003. Now CMS actuaries, I am told, have reported that it would cost $127 billion over 10 years to adopt those recommendations.

I think we have to recognize that when we have an aging population, when they're getting treatments that help them be healthier, freer of pain and when we're dealing with the high cost

of prescription drugs, we are going to have to spend more on health care.

My question to you is this, the President identified the need to fix the update formula in his fiscal year 2003 budget. You also have expressed a willingness to work with Congress to develop a fix, albeit a budget neutral fix. Can you outline for this committee any solutions the administration has developed to deal with this problem?

Mr. SCULLY. We don't have a specific policy proposal and what I tried to do with these charts is to outline the variations. I would say that probably we're somewhere between current law which is probably not sustainable and the MedPAC proposal and I think to be honest with you, I can't calculate it real quickly. I'm not that smart with the—1.1 percent is roughly the average conversion factor increase, but the average actual, part of the spending increase during those years is probably more along the lines of 7 or 8 percent. And I think that's the balance we have to find which is——

Mr. GANSKE. Mr. Scully, but we're recognizing that we have a lot more Medicare patients. They're getting total hip replacements. They're getting coronary artery bypasses. They're getting a lot of procedures that are helping them to be healthier, but also live longer and therefore have more expenses.

Mr. SCULLY. I understand that. We're happy to find a fix, but we're also very committed, and incredibly serious about doing prescription drugs and Medicare reform this year and I'd also personally like to very much push through some combination of access expansions to knock down 42 million uninsured. There are a lot of claims on health care dollars and we're trying to do a lot of things with—I think there's no question we're going to spend more money on health care, but some of that has to go to the 42 million uninsured and some it has to go to prime prescription drugs, particularly for low-income seniors and hopefully for all seniors. And we obviously have to fix the physician update as well, but there's a lot of claim on what is going to be a growing health care budget, there's no doubt, but how much it's going to grow I think is the challenge.

Mr. BILIRAKIS. The gentleman's time——

Mr. GANSKE. One question——

Mr. BILIRAKIS. We've got to give up this room at 11 o'clock and we have another panel coming up. I can't. Mr. Green?

Mr. GREEN. Thank you, Mr. Chairman. I know we have a vote and I'll be as quick as I can. I know our next Panel, Mr. Scully is going to—he said many of the witnesses suggest that we adopt a MedPAC, suggest we adopt the Medical Economic Index and you said earlier that you thought that an $80 billion fix might be excessive for the physician formula. Can you give us a number that you think would be available and also, since you also mentioned that the MedPac recommendation might be too much, can you tell us how we're going to deal with some of the problems my colleagues have asked questions about earlier, and I know you recognized and it is particularly sad that my colleague from Iowa who has a daughter who may go into medicine suggesting she not do that and maybe become an auto mechanic. I have lots of auto mechanics in my District, but not many doctors.

Mr. GANSKE. No, I actually suggested that she strongly think about going into it, but that the reason should be because she'd love to take care of patients.

Mr. GREEN. Yes, and I understand that. It's just that we can't continue to see physicians who serve our Medicare population continually not matching what inflation is because they can't continue that. Maybe on a short term basis because of our budget needs, but not over the long term.

Mr. SCULLY. Mr. Green, there are a million ways to do this. As a technical matter, a couple days ago I gave some of the staff a variety of different options done by our actuaries who were available to both sides of the aisle, any time they want, to run these numbers. And it went anywhere from $16 billion to $127 billion. So there are a variety of ways to do it. One observation I make is, and I hate to create policy that looks closely like what we arguably did in home health, but these numbers could get much smaller tomorrow if the economy comes back. A lot of this is related to the SGR which is related to GDP. So my own opinion, this hole is about as deep as it's going to get and you could argue they should make a two or 3 year fix and if the economy comes back, Congress' ability to fix it much less expensively might be easier in a year or two. So you could certainly argue that a shorter-term fix to spend less money and see if this formula also has the capability of self-correcting the other way, so if the economy came back up and spending went back down, you could come back in 2 years and make a fix that was a lot easier. So fixing it for 10 years may not always be the right way to do it. Sometimes, for purely technical scoring purposes, and that sounds confusing, but from the point of view of spending money under the Federal budget guidelines on a pay-as-you-go basis, there certainly might be an argument for not fixing this. This is probably as backfired as this formula is going to get.

Mr. GREEN. I can understand on a short term basis you can force Congress to revisit it on a timely basis instead of waiting like we have a tendency to do until maybe if we had dealt with it last year it might not have been as big a crisis as it is now for our medical community. That's why we want to do it in the long term because it takes Congress so long to come back and revisit some of these issues.

Mr. SCULLY. This formula has gotten a lot of people angry. I personally, I shouldn't bring up old news, but I was very involved in writing it. I think it's still a good structure. It works and can be saved and I'm certainly committed to doing that.

Mr. GREEN. At least a short-term fix on an immediate basis we have to do something. Should have done it last year with our Chairman's bill. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Burr to inquire.

Mr. BURR. Thank you, Mr. Chairman. Tom, you know I wouldn't have your job. Of course, I'm pretty safe in saying that. I don't think it would ever be offered to me.

Mr. SCULLY. You never know, standards have gotten pretty low, obviously.

Mr. BURR. I've got a lot of confidence in your ability to understand both sides, the policy side and the fiscal side. That doesn't necessarily help you to increase the number of pools that you've got

to solve the problem. And I'm confident that we will or have come to an agreement between Congress and the administration and the Agency on how to tweak the formula to where it may make more sense long term and the process that we've got to go through.

I remember some time ago when there were targeted cuts, specifically for thoracic surgeons that were huge and I think Bruce Vladeck was the Administrator. I went home that next week and called one of my physicians and I said I want to come to the OR. I want to go in with you. And my purpose was to go in and see who was in that room, to see what could be eliminated in that bypass surgery or in that lung removal and that day I went through three surgeries. I was there all day. And I came back and I called Bruce and I said I don't know how we can propose a 55 percent cut because if I was on that table, there was nothing I didn't want in there.

My point to him was at some point you have to look at what it takes to accomplish what you're trying to do. And I know you made the statement earlier, I don't want to see double digit increases in any part of Medicare. My response would be are we going to ration care or are we just going to ration reimbursement?

Mr. SCULLY. Do you want me to answer that?

Mr. BURR. Loved for you to.

Mr. SCULLY. If I could just leave.

I've been through—in the first Bush Administration, as you know, I was there from the first day to the last and we went through 18, 19 percent medical inflation in Medicaid, probably 16 percent in Medicare. Everybody said this is the way it has to be. And we got back to where we had negative Medicare inflation in 1989 and certainly much for sustainable growth rates in the 1990's of 4, 5, 6 percent and I think the health care system did fine. Now I think we've got a significant problem with the Medicare update, but I don't think it's healthy for the economy or healthy for health care to have medical inflation running double or triple the rate of inflation of the rest of the economy. It may be a few percent higher, but I think there's no reason we should have 15 percent.

I also think the reality is there are many demands. As I mentioned, we have 40 million, pick your number, uninsured, and I think we need to do something about that. I know President Bush and Secretary Thompson and I are incredibly committed to that and we also have seniors who want prescription drugs. So if we're going to fit all these demands in a pot, I think we have to be somewhat restrained when we do the base programs. We certainly want to provide great health care and I think we do. I was in Grady Memorial Hospital, probably the biggest public hospital in the country, with Congressman Lewis Tuesday. I was thrilled to see the good quality care there. I think we need to make sure the quality care stays up. But there's also the great potential, because I've seen it, for overspending in health care and I think that's a tough balance we have to keep.

Mr. BURR. I notice that as you presented the charts, it hit the percentage of increase, but it also talked about the total outlay, the total amount of money spent. And one of the things that you pointed to is that there are new procedures that are coming on line every day. They're requesting codes and physicians want to do this

and companies are out trying to create a better way to accomplish a certain procedure.

There's no mechanism for this process where we talk about physician reimbursements that if these procedures that we reimburse physicians under that are new and technologically advanced, enable us to keep somebody out of an in-patient 10-day stay in the hospital, there's nothing that correlates the savings with the increase that's happening over there, is there?

Mr. SCULLY. I think there are. I think in a lot of cases you've seen outpatient spending has clearly grown over the last few years, the trend——

Mr. BURR. Not just when you're looking at the raw numbers of physician reimbursement.

Mr. SCULLY. You can see where preventive services, and clearly I mean the drug companies make the argument that there's no question, some prescription drugs have reduced hospitalizations. They've reduced coronary bypasses. There's a lot of positive spending that saves money in other areas. But there's also places where there are services that aren't appropriate and I don't think we should always assume everything is appropriate. One example, we talked about home health earlier and I think home health is wonderful, but when I was booted out of the government in 1992, home health spending was $3 billion a year. By 1997, it went to $18 billion a year and then it went back to $9. It was a harsh cut, but the fact is it's probably should have gone from 3 to 9 without the 18 in between. There was a lot of churning home health services in the mid-1990's that shouldn't happen. Home health services are wonderful, but there is clearly the potential, if you don't watch it, for health spending to get out of control. And I think that's a very tough balance for us to keep an eye on. There's no doubt that new technologies, new spending and new services in many cases have positive benefits for patients, but not all of them.

Mr. BURR. Thank you very much. We have home health to take care of before the calendar year is over too. Thank you, Mr. Chairman.

Mr. NORWOOD [presiding]. Heather, it's a general vote and we've asked them to hold it until you get there. You're recognized for 5 minutes.

Ms. WILSON. Thank you, Mr. Chairman, I appreciate that very much.

Tom, I also appreciate you for being in this job, although like my colleagues, I'm not sure why the heck you took it, but it's certainly one of the tougher jobs in the country at this point.

You were talking about various things the administration is considering for changing these formulas and as I mentioned in my opening statement my primary concern is the geographic disparity in these formulas which make this physician reimbursement issue just a side bar as far as my State of New Mexico is concerned.

Would the administration support or consider changing this geographic adjustment for the physician work component or eliminating it entirely?

Mr. SCULLY. Sure, I mean obviously, we'd be happy to discuss anything with Congress. I think that the statutory fix, it's very similar, as I said on the hospital side, there was a minor adjust-

ment in the hospital geographic adjustment made a few years ago and we're happy to talk to anybody in Congress about doing that. Obviously, it's the tension between rural New Mexico and New York City and Philadelphia and Pittsburgh and that's the tension. We're happy to sit down and try to come up with the right substantive result.

Ms. WILSON. The more I read about this and look at the Medicare system, the more I see the kind of Rube Goldberg patterns on the wall as to the way the whole system is set up. We've talked about—last year we dealt with Medicare+Choice and New Mexico, I think, is an anomaly in that 40 percent of New Mexicans have HMO health care coverage. It's a very high rate which is one of the reasons I think why we have very efficient health care and we're discriminated against in some of these reimbursements. But how many different fee schedules are there? I mean you talk about the fee-for-service Medicare physician payments. We know we've got Medicare+Choice. How many different fee schedules are there that have geographic components in them in the system that you operate?

Mr. SCULLY. Virtually, all of them. There's only one that I'm aware of that does not have a geographic difference which isn't even out yet. It's coming out in 2 weeks is the long-term, acute care hospital and that the hospital inpatient/outpatient hospitals are geographically adjusted, physicians are. I think virtually everything is. Clinical labs may not be. But all the major payment systems. It's a $256 billion year program and I would say that the vast bulk of that is geographically adjusted.

Ms. WILSON. How many payment systems, how many different schedules are there in this?

Mr. SCULLY. The biggest are hospital in patient which is $100 billion. Hospital out patient is about $20 billion a year. Physicians are about $43 billion. That's the bulk. There's probably another, I guess, 25 different payment systems or so at much smaller levels. It's a great country, isn't it?

Ms. WILSON. It's amazing this works at all.

Have you ever considered or is it taking into account quality or efficiency factors into the formula, either as to control inflation and also to eliminate some of the disparity and the punishment of places that are efficient?

Mr. SCULLY. That's very hard to do because, obviously, quality measurements are very subjective. The first major quality initiative we have, which actually starts April 1, is with the National Quality Forum. We've taken on six States—and New Mexico is not one of them, unfortunately—where we're basically going to measure every nursing home on an objective set of criteria on 11 outcomes. And as of April 1 in those six States, every nursing home, every local newspaper will publish the outcomes and relative quality. And we're trying to put together broad-based widely supported quality measures that we can start using to identify relative quality health care. But right now every hospital in Arizona or New Mexico or Georgia or anywhere gets paid the exact same amount in the same region for hip replacement or heart bypass regardless of quality and some day I think that's a very legitimate point, but I think we're a long way away from getting there.

Ms. WILSON. Thank you, Mr. Chairman. It is hard to underestimate the impact this has on a community like Albuquerque, New Mexico and these disparities. We are hemorrhaging doctors to surrounding States where the payment rates are just much higher. In Albuquerque, New Mexico, we are so short of anesthesiologists and neurosurgeon, we are almost at the point where you cannot get neurosurgery in the State of New Mexico, the entire State of New Mexico. We have limited enclosed newborn ICU beds as we don't have the staff.

I was talking to an OB/GYN recently and he just sent to hospitals in Phoenix and Denver critically ill newborn babies, 15 of them within the prior 3 months because we don't have the staff in New Mexico to take care of them, so we had to close the beds and the reason we don't have the staff is because we can't compete with Denver and Phoenix and Amarillo and Dade County, Florida, because they pay so much more. And the reason they pay so much more is because the Federal Government pays so much less. If you just look at Medicare+Choice, even with the fixes we got last year with putting in a floor for Medicare+Choice. Per person per month in Albuquerque, New Mexico is $553 per person per month. In Dade County, Florida that same person, the Federal Government pays $834 per person per month for their health care. Until we got that floor last year, in Torrance County which is just outside of the Albuquerque, New Mexico, that amount was $370 per person per month. How can you attract doctor practice in Estancia, New Mexico with that kind of disparity? We have to fix that system or we will never have access and quality of care in my State.

Thank you, Mr. Chairman.

Mr. NORWOOD. Thank you. Mr. Scully, I don't know how you feel about it, no offense to my friend, Mr. Burr, who is my friend, but it makes me real nervous when a Member of Congress goes into an OR looking for efficiency.

Mr. Waxman? No questions. We thank you very much for coming and in conclusion, let me just point out to you that in 1973 when Congress, in its wisdom, decided to take taxpayer dollars and fund managed care, the idea, of course, was to save money. Now we're at the process where we're saying oh, we have to reimburse managed care, Medicare+Choice at 100 percent level for fee-for-service where at the same time continuing to cut fee-for-service. My President's budget has $4 billion for managed care, Medicare+Choice and we don't have any money out there for fee-for-service.

Do you believe that there's an effort anywhere in this government that is trying to totally wipe out fee-for-service and move all Medicare patients into managed care?

Mr. SCULLY. Absolutely not. We feel strongly about Medicare+Choice for one reason—I feel extremely strongly is that it's a great option for low-income people and the people in that program are disproportionately low income. And if you look around the country and you find people who are getting Medicare+Choice, it's usually because they can't afford Medigap and they, generally in the past, have gotten drug coverage, relatively low deductibles and co-payments and they're losing those options. And that money in the President's budget which is 6.5 percent increase, mainly for urban areas to be honest, is what our actuaries have told us was

treading water, so we don't lose more people, but low-income people are seeing higher premiums, higher co-payments, less drug coverage. The money in the President's budget is a maintenance-of-effort level that would just keep us treading water where we are. It's not going to improve anything. We think that—I personally feel very strongly that it's a terrific option for low-income people, and it's one that's evaporating quickly and I think it's very dangerous to let it go. I have personally zero bias one way or the other toward—we like the private sector health plans, but we are committed to the Medicare fee-for-service program every bit as much.

Mr. NORWOOD. What you're doing whether you like it or not is you're driving everybody in to managed care by simply running people out of fee-for-service because they can't afford it and I would just simply say let's use a little bit of that $4 billion to put back into the fee-for-service program particularly the 1.25 because of this cut.

Mr. Shadegg, do you wish to question?

Mr. SHADEGG. I do.

Mr. NORWOOD. You're recognized for 5.

Mr. SHADEGG. Thank you. I may be briefer than that. I recognize there's a Panel to follow you, Mr. Scully and I appreciate your being here. And we're going to have a limited time for them because as the chairman has pointed out, we're getting kicked out of the room.

I simply want to kind of step back one notch. We're looking at the individual trees and we need to look at the forest. I've got to say if you look at the forest, it's a very bizarre picture. Indeed, I'm not certain that the Soviet Union could have created a more bizarre structure. I will compliment you on the charts. I actually never understood this one, but I tried diligently.

I did understand this one. And it made sense to me and it compared what we planned to spend and the mistakes we made, what we actually spent and then you carefully explained it, this entire structure was created and I wrote your words down because I know you were accurately representing the system which you articulately make the case for that it was well intentioned, that it was signed with good intention. But what you said is we are—it is designed to control physician spending at a reasonable rate. In all candor, and without directing this at you in any personal way at all, I want to point out that that sounds precisely like the planned economy of the Soviet Union.

We, the government, created the Medicare program. Good or bad, we made this decision and we said to America's seniors, these services will be there for you. And then we discover oh my gosh, they cost more than we thought. Why do they cost more than we thought? Well, we didn't take into consideration the aging of the population. We didn't take into consideration their increased demand for services. We didn't take into consideration it appears to me technology and the fact that much of the medicine today would be vastly more expensive then the medicine of 20 years ago, but by God, look how much better it is than the medicine of 20 years ago. I think you and I have had this discussion. We're saving the lives of people that 15, 20 years ago we would have said goodbye on. We're performing operations on people we wouldn't have thought of

operating on 15, 20 years ago. We're extending their lives and their life spans and doing it in a great way. And I think that's appropriate, but we didn't account for those factors. But here along comes the government and says well, we better control physician spending. And what that sounds to me like is we promised these benefits. Then we've discovered what they cost and so what we're going to do is we're not going to pay for the benefits. We're going to squeeze the people in between the government and the patient. And the people in between the government and the patient are the physicians. And it may have been a laudable goal in 1997 to say well this is the way we'll do it, we'll squeeze down costs by projecting only these certain growth rates, and we leave out some facts in what now I think everybody agrees is a flawed formula and at the end of the day what we'll get to is a restraint from the growth of spending which harms physicians or which kind of takes the cost of the system, the differential between what it really costs to provide the services and what we're willing to pay for it out of the hides of physicians. It doesn't work. I think a complete abandonment of this formula is called for and I think we need to create a formula which takes into account what is necessary to pay for the services we've promised and to do so in a fashion which keeps professionals in the field. I think that you've been very candid about telling us that you're open to whatever we do. I hope we'll do something more responsible in the 1997 formula. I hope we do something that gives America's seniors the benefits we've promised them. And I really don't have a question, Mr. Chairman.

Mr. NORWOOD. Thank you very much for that speech, Mr. Shadegg. We appreciate, Mr. Scully, thank you, sir.

Mr. SCULLY. Thanks. Can I add one thing because I really would like to work on a physician formula? We really are extremely serious about Medicare reform, prescription drugs, and access for the uninsured and so I hope we can have an extremely active year in health care. We've got a lot of things like Enron, other things going on, but thank you very much.

Mr. NORWOOD. Thank you, sir. If we can ask the other panelists to quickly come to the table. I apologize for the rush here.

The committee will come to order. Ladies and gentlemen, thank you so much for being here. It is something we badly need to do is hear from you and we're all under time constraints that I'm very sorry about, but if we could, Mr. Scanlon, who is Director of Health Care Issues, U.S. General Accounting Office, if you begin your testimony, sir.

STATEMENTS OF WILLIAM J. SCANLON, U.S. GENERAL ACCOUNTING OFFICE; THEODORE LEWERS, TRUSTEE, AMERICAN MEDICAL ASSOCIATION; ALLISON WEBER SHUREN, AMERICAN COLLEGE OF NURSE PRACTITIONERS; THOMAS R. RUSSELL, AMERICAN COLLEGE OF SURGEONS; MARTHA McSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE; AND SUSAN TURNEY, MEDICAL GROUP MANAGEMENT ASSOCIATION, MARSHFIELD CLINIC

Mr. SCANLON. Thank you very much, Mr. Chairman. I'm pleased to be here and I'll try to be brief, given the time constraints. As

you review how Medicare pays physicians and deal with the incongruous result that we have had this year with the 5.4 percent reduction in fees while CMS has estimated that the cost of inputs required to produce physician services have increased 2.6 percent. It is not surprising, given that result, we have heard calls for the elimination of the spending targets that are in the sustainable growth system and——

Mr. NORWOOD. Mr. Scanlon, if you will suspend just a minute. If we can have quiet in the back of the room, and close that door as quickly as possible. Please, proceed.

Mr. SCANLON. As I've said, we have had calls to eliminate the sustainable growth system or at least to provide for changes in it. What I'd like to do today is provide you with some information about the potential for changes in this system. I think it's important first to take a historical perspective that looks at why we have the SGR and its predecessor the Volume Performance Standards and why they were created and what has transpired since their introduction.

In the 1980's, the Congress began a series of steps to address the continuing rapid increases in Medicare spending by revising provider payment methods. The first step involved the hospital prospective payment system, the second, the physician fee schedule. When the fee schedule was adopted, it was widely recognized that controlling fees alone would not moderate physician growth.

It was something that was recognized by analysts at CBO, at HCFA at the time, and in the private sector. We had some controls on physician fees during the 1970's, but the spending growth continued due to increases in volume and intensity beyond the increases that would be attributable to increases in the numbers of Medicare beneficiaries.

If you look at Figure 2 in my written statement which is on page 6, you see that, prior to 1992 when the volume performance standards were introduced, annual increases in volume and intensity per beneficiary were quite significant—averaging nearly 8 percent per year between 1985 and 1991. After the introduction of the spending targets under the volume performance standard first, and then under the sustainable growth rate, increased spending due to volume and intensity declined dramatically, averaging roughly 2 percent per year between 1992 and 2000.

While we've benefited from these moderations in spending, today we have this incongruous result that the fees are being reduced 5.4 percent. Administrator Scully, I think, gave you very clearly the reasons why this occurred, the confluence of events in terms of correcting for errors in past targets and mis-estimates of the spending in prior years.

As we think about how to deal with this, one option is, of course, to deal with how errors are incorporated into payment adjustments. They can be phased in over time. Some steps in this direction were taken within the BBRA. It's clear though that those steps to moderate the annual changes do not result in enough moderation. Therefore, payment adjustments could be made over longer periods of time.

A second thing to think about, and it's come up today, is the issue of the target itself. As we've talked, it's partially based on

GDP and I'd underscore that "partially." Other factors that are taken into account are increases in the number of beneficiaries in Medicare fee-for-service as well as increases in the costs of delivery of physician services, and changes in law that result in additional services—such as the addition of preventive services to Medicare over the last few years.

GDP though is potentially a measure of the affordability of Medicare to our economy. The Comptroller General has testified many times before the Congress about the problem that we face over the longer term as the baby boom generation joins the ranks of Medicare beneficiaries. The cost of this program is going to be greater, if current trends continue, than what we currently spend on all Federal activities. We need to find a way to generate control over that spending.

Using GDP though, is potentially problematic because of the fact that GDP is a cyclical variable. It moves up and down with the economy, whereas the health care needs of Medicare beneficiaries do not. We need to think about how we can take into account affordability without having this cyclical variation. One very simple way would be instead of using GDP for a single year as the basis for a target, is to take the average of GDP over much longer period of time. It reflects our economic wealth, but does not fluctuate with the business cycle on an annual basis.

Let me end by saying that while we need to be very concerned about maintaining fiscal discipline, we also need to keep in mind the primary purpose of this program which is to generate appropriate access to services for Medicare beneficiaries. The one thing I think that is incredibly lamentable at this time is the fact that we have such inadequate data on access that we are not able on a timely basis to measure whether access is appropriate, whether a problem exists and whether an intervention is called for.

Part of what needs to be done as we move forward is to be able to position ourselves to generate that kind of information so that appropriate interventions can be taken.

Thank you very much, Mr. Chairman. I'd be happy to answer any questions the committee may have.

[The prepared statement of William J. Scanlon appears at the end of the hearing.]

Mr. BILIRAKIS. Thank you very much, Dr. Scanlon. Again, we appreciate your taking time to be here with us.

Dr. Lewers is a trustee with the American Medical Association. Please proceed.

STATEMENT OF THEODORE LEWERS

Mr. LEWERS. Thank you, Mr. Chairman, and thank you, members of the committee, we do appreciate your holding this hearing in such a timely fashion. I am Dr. Ted Lewers and I am a Trustee of the American Medical Association and a nephrologist from Easton, Maryland. I have to also reveal that I am a former member of the Medicare Payment Advisory Commission and its predecessor, the Physical Payment Review Commission, so this is something I have lived with for a number of years.

Mr. Chairman, I want to thank you personally and Ranking Member Brown for the leadership in advancing H.R. 3351 and we'd

also like to thank Committee Chairman Tauzin and Ranking Member Dingell for their support as well.

The bipartisan majorities that you have spoken about are super majorities and they're both in the House and in the Senate and they recognize the need for Congress to correct a Medicare policy that threatens access to care for Medicare patients.

We strongly urge this committee to promptly report out legislation that immediately halts the 5.4 percent cut that took effect on January 1, 2002. The SGR system must be repealed.

CMS uses estimates that everyone agrees with, and you've heard today, are seriously off the mark. On Chart 2 on the panel down on the end, you will see these SGR projection, errors have short-changed physicians and other health professionals by over $20 billion since fiscal year 1998. That was brought out earlier in the testimony. The errors that were made in predicting the enrollment mean that every year, physicians care for nearly 1 million Medicare patients whose costs are not counted in the update. Under this flawed formula, these errors are compounded annually and if you just look at the numbers on each year, the compounding comes to $20 billion.

The current Medicare policy links physician updates to changes in the GDP, as Dr. Scanlon has just mentioned. There is no relationship between GDP and disease. The medical needs of the Medicare patient do not wane when the American economy falls into a recession. Chart 1 indicates information that has been discussed and clearly indicates the growing gap between the Medicare economic index or the practice cost inflation and the annual physician updates. Since 1991, physicians have received an average annual increase of 1.1 percent as shown by the red line versus the 2.4 percent increase in practice costs as shown in the blue line. That's called negative reimbursement and you cannot survive in a small business with negative reimbursement. This trend has serious implications for Medicare patients.

Medicare payments are continually falling behind the actual cost of running a practice. In addition, physicians are experiencing a sharp increase in professional liability premiums, something we have not had the opportunity to discuss today. It is particularly acute in Pennsylvania, West Virginia, Florida and several other States.

In addition to that, we have a host of regulatory burdens. The 5.4 percent Medicare cut will force physicians to make difficult choices such as whether to stop accepting new Medicare patients. This is occurring. Last night late, I got the word from Baylor that the orthopedic spine surgeons of Baylor University are no longer going to accept Medicare patients. This is a disaster and it is occurring and anyone who says it's not occurring needs to tour this country with me on a few visits.

Other things that physicians are having to do, include discontinuing the provision of some medical services, stopping or reducing charitable care, limiting or discontinuing investments in new technology, laying off staff or retiring from practice entirely. These are not choices that physicians want to make because in each case their patients lose.

Medicaid history teaches us that a payment structure that does not support the economics of maintaining a medical practice ultimately decreases physician participation in the program. Congress must promptly intervene. According to our estimates, physicians may see an additional 5 percent cut next year on top of the 5.4 percent that we've been discussing today.

Last June, MedPAC warned that if the update of 2002 was "significantly lower" then the negative .1 percent update that CMS was predicting at that time, this could raise concerns about the adequacy of payments and beneficiary access to care.

Ladies and gentlemen, clearly, the 5.4 percent cut is significantly lower than .1 percent. The Commission recently recommended a new framework for Medicare physician updates and a repeal of SGR. We wholeheartedly agree. We support the MedPAC general framework and look forward to working with the committee on the specific details of a new update system.

We ask the full committee to ensure that its views and estimates submitted to the Budget Committee include necessary funds to implement the MedPAC recommendation.

In conclusion, we strongly urge Congress to enact an immediate halt to the 5.4 percent cut and repeal the flawed SGR system that threatens access to care for Medicare patients.

Thank you, Mr. Chairman.

[The prepared statement of Theodore Lewers follows:]

PREPARED STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association (AMA) is grateful to the Subcommittee for the opportunity to provide our testimony concerning the fatally flawed Medicare physician payment update formula as well as the 2002 Medicare payment cut of 5.4 percent. This sudden and unexpected steep payment cut is alarming, and 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 first would like to express our sincere appreciation to Subcommittee Chairman Bilirakis and Ranking Member Brown for your lead co-sponsorship of H.R. 3351, the "Medicare Physician Payment Fairness Act of 2001," as well as for your strong efforts to move this critical legislation. We further extend our appreciation to full Committee Chairman Tauzin and Ranking Member Dingell for your additional support of H.R. 3351. Finally, we thank the more than 300 House co-sponsors of this bill, many of whom are on the Committee, and believe that the strong and broad bipartisan support of this legislation underscores the need to remedy the flawed Medicare physician payment update formula.

CONGRESSIONAL ACTION NEEDED TO REMEDY ACCESS PROBLEMS

Because no action was taken last year on H.R. 3351, as of January 1 of this year, the 5.4 percent Medicare cut impacts all Medicare services provided by physicians and other health professionals, including, but not limited to, physical therapists, audiologists, optometrists, advanced practice nurses and podiatrists, as well as medical doctors and osteopaths.

This is the largest payment cut since the Medicare fee schedule was developed a decade ago, and is the fourth cut over the last eleven years. Since 1992, 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.)

Further, this 5.4 percent cut is forcing doctors to make difficult choices concerning their ability to continue accepting new Medicare patients. It also raises questions about whether they can continue accepting assignment for their Medicare patients, and, ultimately, whether to retire from medicine and change careers. If the pay cut is not quickly reversed, it could become extremely difficult to prevent serious access problems for elderly and disabled patients.

We appreciate the Subcommittee's continued support of legislation to remedy the ongoing problems resulting from the flawed Medicare physician payment update, and 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 fatally flawed Medicare payment update formula with a new system that appropriately reflects increases in practice costs, including changes in medical practice, changes in technology, patient need for medical services 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 until consideration of a broader package that might face significant delay. Continuation of the SGR system beyond 2002 would likely produce another steep payment cut in 2003, and there are no guarantees that a positive update would occur in 2004.

Further, we ask the full Committee to ensure that its "views and estimates" on budgetary and legislative matters, to be submitted to the House Budget Committee, include an appropriate and specific amount of funds that should be set aside in the budget resolution to replace the Medicare physician payment update formula beginning in 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 Centers for Medicare and Medicaid Services' (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 urge the Subcommittee to act on MedPAC's recommendations.

MEDICARE PATIENT ACCESS IS SERIOUSLY THREATENED BY THE FLAWED MEDICARE PAYMENT UPDATE FORMULA AND 5.4 PERCENT MEDICARE PAYMENT CUT

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 impacted by the cut. In addition, many private health insurance plans base their rates on Medicare payment rates.

Most significantly, the payment cut jeopardizes access for elderly and disabled patients. Two-thirds of physician offices meet the definition of a small business. If a business, especially a small business, continues to lose revenue and operate on a negative income statement, the business cannot be sustained. Thus, when physicians and non-physician practitioners experience a Medicare cut of the magnitude being incurred in 2002, as small businesses, they will lose significant amounts of revenue and operate in the red. This means that physicians and impacted non-physician practitioners 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;
- Lay off administrative staff;
- Relocate to an area with a smaller Medicare patient population;
- Discontinue certain low-payment/high-cost Medicare services;
- Limit or discontinue charity care;
- Retire early;
- Partial or complete career change; 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, surveys and reports

have found that Medicare patients increasingly are experiencing access problems. For example, an American Academy of Family Physicians (AAFP) survey found that nearly 30 percent of family physicians are not accepting new Medicare patients. 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 *(Doctors criticize federal pay cut; AMA says state physicians will lose $4,889 each).*

We urge the Congress to enact legislation to ensure that the 85 percent of Medicare patients enrolled in the fee-for-service program will maintain access to physicians and the health care services to which they are entitled.

FACTORS COMPOUNDING MEDICARE PAYMENT CUTS

Several factors 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.

Further, 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, in-

terpreters for non-English-speaking patients and a host of other well-intentioned requirements also are pushing medical practice costs ever upward.

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.

FLAWED MEDICARE PHYSICIAN PAYMENT UPDATE FORMULA

Medicare payments to physicians are annually adjusted through use of a "payment update formula" that is based on the SGR and the MEI. As discussed above, this formula has a number of critical flaws that create inaccurate and inappropriate payment updates that do not reflect the actual costs of providing medical services to Medicare patients.

Flaws In The Sustainable Growth Rate System

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

Allowed expenditures under the SGR system are intended to be 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 business cycle that bears no relationship to the health needs of Medicare beneficiaries. Indeed, incidence of disease does not track the business cycle.

Specifically, GDP does not take into account health status, the aging of the Medicare population, the costs of technological innovations or the escalating costs of medical practice. Thus, the link between medical care utilization and GDP growth under the SGR system creates a terribly flawed system as well as seriously deficient public policy. For example, 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, and, as discussed above, if the economy remains slow, an additional cut is likely in 2003. Yet, despite the economy, the health needs of patients continue and the use of new medical services increases.

SGR Requires Unreliable Economic Forecasts: The SGR is based on factors, such as GDP or enrollment changes, that require CMS to make economic forecasts that almost always turn out to be erroneous. Thus, it is impossible to make accurate projections about future payment updates. When the resource cost-based physician payment system was first enacted in 1989, its major advantage was intended to be its stability and predictability over time. It is apparent, however, that the update formula has exactly the opposite effect; it creates payment updates that are unpredictable and subject to sharp swings as economic circumstances, beyond physicians' control, change. Perhaps most disturbing is that because of the lack of predictability, 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. Tens days later, CMS reversed this prediction 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.

As MedPAC has recognized, it has become clear that the current physician payment update system simply is bad public policy and should be replaced.

Erroneous SGR Projections: In annually calculating the SGR, as discussed above, CMS has repeatedly underestimated or even ignored certain critical data. Erroneous CMS estimates of GDP growth and enrollment changes in 1998 and 1999 have shortchanged physicians by $20 billion to date. (See attached Chart 2, *CMS Errors in SGR: Impact on Funding for Physician Services.*) CMS projected, for example, that Medicare+Choice enrollment would rise 29 percent in 1999, despite the many HMOs abandoning Medicare in 1999. This error led, in turn, to a projected drop in fee-for-service enrollment and a negative 1999 SGR. Accurate data later showed that managed care enrollment increased only 11 percent in 1999, a fraction of CMS' projection and a difference of about 1 million beneficiaries.

Nevertheless, based on this erroneous estimate, each year since 1999, when CMS has calculated the total amount of expenditures that it is allowed to spend on physicians' services, the agency has not taken into account the cost of treating these 1 million patients. Since the SGR is a cumulative system, every year physicians are continuing to treat 1 million patients for whom the costs of their care are disallowed under the SGR system.

CMS acknowledged its erroneous 1998 and 1999 SGR estimates at that time, but concluded it did not have the authority under the law to correct its erroneous projections. We disagreed, and were further perplexed by CMS' announcement in the 2002 final rule that it does have the legal authority to change 1998 and 1999 SGR projections relating to expenditures for certain CPT codes overlooked by the agency. CMS' interpretation of the law is highly unusual; it 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.

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 with respect to physicians 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 three times higher than MedPAC's. It is highly improbable that physician practices, which generally operate as small businesses, 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 overstates productivity gains in the physician services industry for two reasons. 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 massive regulatory burden imposed on physicians. As discussed above, physician compliance with such matters as evaluation and management guidelines and other documentation requirements, workplace and patient safety requirements, quality improvement initiatives, language interpreter requirements, and certification (medical necessity) requirements, places demands on physician and staff time and reduces physician productivity. The cost of these regulatory 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 any 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 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, state-of-the art quality medical care.

All of the foregoing factors contribute to a payment update system that does not adequately reflect increases in the costs of practicing medicine 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 of legislation to remedy the ongoing problems resulting from the flawed Medicare physician payment update.

We urge the full Committee and Congress to (i) immediately halt the 5.4 percent Medicare payment cut, and not defer action on this matter for consideration as part of a broader package that might face significant delay; and (ii) replace the flawed Medicare payment update formula with a new system that appropriately reflects increases in practice costs, in contrast to the current system, the flaws of which are significantly illustrated in attached Chart 1.

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

Mr. BILIRAKIS. Thank you, Doctor.

Dr. Shuren, Allison Shuren represents the American College of Nurse Practitioners.

STATEMENT OF ALLISON WEBER SHUREN

Ms. SHUREN. Good morning, Mr. Chairman, members of the committee. My name is Allison Shuren and as a Nurse Practitioner, I'm honored to be here today to testify on behalf of the American College of Nurse Practitioners. ACNP thanks the committee for giving us this opportunity to share how the reimbursement cut and the difficulties with the MEI and SGR impact providers other than physicians.

We also wish to thank the chairman, the members of the committee, as well as Chairman Tauzin, Ranking Member Dingell for your support of H.R. 3351.

The Balanced Budget Act of 1997 authorized Nurse Practitioners to bill the Medicare program directly and set the reimbursement rate at 85 percent of that received by other providers. As a result, an additional 5.4 percent reimbursement cut impacts NPs particularly hard. From the Nurse Practitioner perspective, we start at 15 percent below what is already a low payment rate, given that our costs of providing care are similar to those of other health care providers who receive 100 percent of the fee schedule. Now, we're being asked to function with 5.4 less reimbursement.

Furthermore, physicians and Nurse Practitioners who provide technical component services for Medicare beneficiaries such as diagnostic ultrasounds or EKGs experience an additional 4 to 6 percent cut in their practice expense reimbursement this year. This cut was implemented by CMS without any notice in last year's proposed rule.

If the update factor suffers another 3 percent decrease next year, that would leave NPs just 10 months from now receiving as much

as 23 percent below the level of reimbursement other providers received just 2 months ago.

If we consider the change in the payment for the technical component services, that number would rise to 29 percent. What profession would not be crippled by such a devastating series of losses in such a short period of time.

Our members do not talk about profits or profitability. They talk only of surviving, to fulfill their commitments to patient care.

We have already heard from NPs in at least 23 States, stating that the cut is affecting access. NPs are reporting that practices are limiting or refusing to accept new Medicare beneficiaries. They're laying off staff. They're reducing the length of patient visits and they're eliminating ancillary services such as vaccinations, EKGs and blood draws.

Perhaps the best window into what our members are experiencing is the following comment from an NP in New York. She says, "Currently, our practice is approximately 65 percent Medicare. A 5.4 percent cut will require us to stop accepting new Medicare clients. The physician in our practice will be cutting his hours and my hours will also be cut as a result. Urgent visits usually seen on the same day by the practice will become emergency room visits. We're planning on cutting certain conveniences already." She says she has one couple that she brings to mind. The husband is 91. The wife is 82. And just 1 month ago the wife's hypertension became unstable. This couple until now was relatively self-sufficient, now she can't even get to her office for follow-up care. How is she possibly going to get to a laboratory for blood drawing and to a cardiologist to have an EKG. She says these people who lived through the Depression, a World War and know how to ration to help on the home front, what will we tell them now? Do we just tell them to go away?

This situation has led our members and many others to ask us and you why—when 316 co-sponsors support H.R. 3351—this bill has not passed. We recognize and sincerely appreciate this committee's leadership, but our members are searching for definitive action.

We urge you to please change the MEI to be a forecast that reflects cost changes for the coming year and that takes into account, among other things, the tremendous increase in malpractice premiums being experienced in State after State and increased practice operational costs that include new technology and expenses associated with compliance of the plethora of well-intentioned, although costly, mandates such as compliance plans and the HIPAA privacy standards. Furthermore, the MEI must take into consideration nonlabor productivity and use professional and technical employment cost indicies rather than the nonfarmworker index.

Finally, the SGR mechanism needs to be replaced with a mechanism that in some rational manner determines to increase or decrease costs associated with providing services. As currently structured, the spending target really operates as an automatic tax on the physician fee schedule providers that can jeopardize the availability of health care to our elderly without any benefit of congressional debate nor an opportunity for providers, patients and pa-

tients' advocates to discuss whether this cut or another alternative is more appropriate from a policy perspective.

On behalf of ACNP I thank you again for inviting us to be here and we look forward to working with you in the coming weeks to fix this issue.

[The prepared statement of Allison Weber Shuren follows:]

PREPARED STATEMENT OF ALLISON WEBER SHUREN ON BEHALF OF THE AMERICAN COLLEGE OF NURSE PRACTITIONERS

Good morning. Chairman Bilirakis, Ranking Member Brown, and Members of the Committee, I am Allison Weber Shuren and I am honored to appear before you today to present testimony on behalf of the American College of Nurse Practitioners or ACNP regarding Medicare payment policy for nurse practitioners ("NPs"), physicians and other health care professionals. As both a nurse practitioner and a health care regulatory attorney, I understand that, as a country, we must find a balance between covering the costs of efficient providers of care to our elderly and addressing budget limitations. I also appreciate the enormity of this task.

ACNP is a national nonprofit professional society dedicated to ensuring consumer access to health care and high quality nurse practitioner services through professional education, promotion of research, and leadership in health care policy development. One of ACNP's highest priorities is to increase access to outcome-driven, cost-effective health care by educating policymakers of the benefits of an interdisciplinary team approach to the delivery of health care services. ACNP considers direct Medicare reimbursement for nurse practitioners a key component of this mission, and, as a result, is extremely concerned by the 5.4% cut for provider reimbursement under the Medicare Part B fee schedule and by the formula used to calculate the annual conversion factor update, as we fear that both constitute a fundamental threat to access.

ACNP thanks the Committee for including nurse practitioners in this important hearing and for giving us an opportunity to share how the reimbursement cut and the difficulties with the Medicare Economic Index ("MEI") and the Sustainable Growth Rate ("SGR") impact providers other than physicians. In addition, ACNP wishes to extend its appreciation to the Chairman and the many other members of this Committee for the introduction and sponsorship of The Medicare Physician Payment Fairness Act, H.R. 3351. This bill, along with the passage of the Medicare Regulatory and Contracting Reform Act last year, illustrate your commitment to addressing the pressing issues regarding health care for Medicare beneficiaries and the health care professionals who provide their care.

Nurse practitioners are registered nurses who are prepared through advanced education and clinical training to provide a wide range of preventive and acute health care services to individuals of all ages. The first nurse practitioners were trained on-the-job in the early 1960s. Today most nurse practitioners complete graduate level education and earn a master's degree. In addition, nurse practitioners who wish to obtain a Medicare provider number must be certified by a nationally recognized certifying body.

Nurse practitioners take health histories and provide complete physical examinations; diagnose and treat many common acute and chronic problems; interpret laboratory results and X-rays, prescribe and manage medications and other therapies; provide health teaching and supportive counseling with an emphasis on prevention of illness and health maintenance; and refer patients to other health care professionals as needed. Like our physician colleagues, nurse practitioners may choose to specialize in a particular clinical area. For example, there are nurse practitioners who specialize in geriatrics, family health, pediatrics, cardiology, women's health and critical care.

Nurse practitioners work in every site of service in which health care is delivered, solo practices, small and large group practices, medical centers, ambulatory surgery centers, skilled nursing facilities, homeless shelters, school-based clinics, and in the military, and in every possible geographic location, from the most inner city-urban areas, to upper class neighborhoods, to the most rural parts of this nation. Our patients range from the poorest, least educated individuals in this country to those who might be considered the most well-off, most educated members of our communities. According to 2001 data from the Health Resources and Services Administration, there are more than 88,000 nurse practitioners across the country. Nurse Practitioners have often been considered one of the backbones of care in underserved areas, willing to provide cost-effective, high quality services in rural and urban settings where providers are scarce.

The National Bipartisan Commission on the Future of Medicare reports that "Medicare must be strengthened and improved to handle the increased demand of 77 million 'Baby Boomers' who will begin entering Medicare in the year 2011." As the geriatric population grows, we must work carefully to protect patient care, the availability of services and the quality of those services. This is the prism through which both this Committee and provider organizations must view the difficult issue of payment policy—to do otherwise is to compromise our respective duties to the Medicare beneficiaries. Unfortunately, we fear that we are on the brink of failing at this very task.

The Balanced Budget Act of 1997 authorized nurse practitioners to bill the Medicare program directly and set the reimbursement value at 85% of the physician rate for identical services. As a result, an additional 5.4% cut in reimbursement impacts nurse practitioners particularly hard. From the nurse practitioner perspective, we started 15% below what is already a low payment rate given that our costs for providing care are similar to those of other health care providers who receive 100% of the fee schedule rate, now we are being asked to function with an additional 5.4% less in reimbursement. Furthermore, physicians and nurse practitioners who provide, or who are part of groups that provide, technical component services such as ultrasound and other basic diagnostic testing for their Medicare beneficiaries, experienced an additional 4 to 6 percent cut in practice expense reimbursement associated with these services this year. This cut was implemented by CMS without any notice in last year's proposed rule, and became apparent only after health care providers around the country began to calculate payment rates based on the Final Fee Schedule published November 1, 2001. Given the instability of the update factor and the practice expense formula, nurse practitioners cannot help but fear additional cuts next year unless these problems are addressed. If the update factor suffers another 3% decrease next year that would leave us, just 10 months from now, receiving as much as 23% below the level of reimbursement that other providers received just two months ago. If we consider the change in payment for technical component services that number could rise to 29%. What profession, trade, or industry would not be crippled by such a devastating series of losses in such a short period of time?

The unstable nature of reimbursement has left our members scared—scared for their patients, scared for their families, scared for the future of health care. Our members don't talk about net profits and profitability, instead they talk of surviving to fulfill their personal and professional commitments to patient care. Though the 5.4% cut is obviously a very recent change, our members report that it is already affecting access, and the willingness or ability to invest in additional personnel, equipment, and other inputs. We have heard repeatedly of practices that will stop offering vaccines, other injections, and blood drawing services as they simply can no longer afford to do so.

We have received ACNP member input on the 5.4% cut and the comments show a disturbing and consistent trend of threats to access. Here are some examples: "[w]e turn away Medicare patients every day," "[w]e will consider restricting our Medicare influx to handle costs," and "[w]e reached our quota [of Medicare beneficiaries]." A nurse practitioner from Texas stated that "NPs and physicians in our area already do not see Medicare patients due to poor reimbursement and tons of reg[ulations] and paperwork. This will not encourage taking those patients who need care." Similarly, an NP from Minnesota told us that "[t]here will be practices closing or limiting services due to these cuts." An NP from California advised us that the clinic where she works is experiencing an influx of Medicare beneficiaries who are being turned away by other practitioners. We have also been informed that many practices are being forced to reduce the time they spend with patients in order to increase the volume of patients treated each day. Finally, there appears to be considerable concern that the commercial insurance/HMO community will follow Medicare's lead regarding reimbursement, possibly creating comparable challenges for all patients.

Perhaps the best window into what our members are thinking and feeling is the comment on this issue shared by an NP in New York who told us the following—I note that some of what this practitioner who is struggling on the front lines articulates is a reflection of the frustration that so many feel. It is hard to hear, but it is important that we all listen:

> "A 5.4% cut in reimbursement will devastate the care received by the neediest segments of our society. Currently, our practice is approximately 65% Medicare. A [sic] 5.4% cut will require us to stop accepting new Medicare clients . . . the physician in our practice will be cutting office hours, [and] . . . [m]y hours will also be cut as a result . . . Urgent visits, usually seen on the same day will become Emergency Room visits as patients will be advised to seek care in an ER. We are planning on cutting certain conveniences already. For example, we at-

tempt to provide one stop shopping by doing our own labs and EKGs. We will now require patients to go to a laboratory, and for EKGs we will send the patients to a Cardiologist . . . I have one couple in particular. The husband is 91, the wife is 82 . . . Just one month ago, her hypertension was complicated with new onset atrial fibrillation. This wonderful couple who up until now was relatively self sufficient cannot even get here—how will she get to the lab for her blood draws? How will she get to a Cardiologist? . . . I am beginning to feel as though the government would really prefer that these people just curl up and die. It is certainly less costly than actually taking care of them. If I sound frustrated, I am. These are the people who lived through a depression, a World War (sometimes more than one), know the meaning of rationing to help on the home front, and what do we do when they are no longer "productive members of society"? We tell them to go away."

The situation has led our members to ask us, and you, their representatives in Congress some tough questions. If we as a society and as a government really value access to and the quality of the services that our elderly and disabled receive, is that commitment borne out by our actions? Why, when there are 312 cosponsors in support of H.R. 3351, has Congress not passed this bill? We know that this Committee has supplied tremendous leadership on this issue. We thank the Committee for that leadership, but our members are searching for definitive action. None of us want our commitment to the health of Medicare beneficiaries not adequately realized in policy and in fact.

Our members have also asked why, when this Committee and its exceptional staff were able to articulate steps that CMS could have taken to offset some of the devastating effect of the current formulae, such as using a professional/technical employment cost index rather than the all non-farm worker index, did CMS fail to adopt that simple solution to this problem. We appreciate the reference in the Senate Finance Report to the use of a "general earnings index," but the report did not say to use "the most" general index. This kind of rigidity strikes our members as failing to appreciate the need for a solution to a very real problem. It also seems to invite Congressional intervention.

There appears to be some broad support for a number of steps Congress can take to address the existing situation prospectively.

- The MEI must be refined to include non-labor productivity as a factor.
- The MEI must also be adjusted to be a forecast that reflects cost changes for the coming year and take into account, among other things, the tremendous increases in malpractice premiums being experienced in state after state, increased practice operational costs, and the expenses associated with developing, implementing and maintaining compliance programs and the new HIPAA Privacy Standards. When the government imposes additional burdens on providers, the MEI must reflect the real cost of complying with those burdens.
- Incorrect estimates from previous years need to be corrected—the current situation permits such arbitrary and capricious results as to taint the system and undermine basic confidence in the Medicare program.
- Finally, the automatic spending target mechanism needs to be removed and replaced with a mechanism whose focus is to, in some rationale manner, determine the increased or decreased costs associated with providing services. As currently structured, the spending target operates as an automatic tax on physician fee schedule providers that can jeopardize the availability of health care to our elderly without any benefit of Congressional debate, nor an opportunity for providers, patients, and patient advocates to discuss whether such a cut or other alternatives are appropriate from a policy perspective. Why are health care professionals automatically singled out to bear a disproportionate burden of a diminished Gross Domestic Product? We have no problem with health care providers sharing in the burden to balance federal expenditures in tough budget times, but we should have the opportunity at those moments to engage with Congress and the public regarding alternatives to such cuts, and the pertinent policy issues driving the perceived need to decrease Medicare payment rates—particularly, where the cut is so devastating as to risk the ability of the program to protect the very individuals it was designed to assist.

Given the support that has emerged for enacting at least these three modifications to the conversion factor update methodology, ACNP members are looking to this Committee to use its commendable leadership around this issue to implement such changes as soon as possible. Our members are counting on you as their representatives to fix a system that clearly seems broken at this point.

On behalf of ACNP, I thank you again for the opportunity to be here this morning. ACNP looks forward to working with you in the coming weeks to help resolve

the update issue as well as the many other significant health care issues we all face this session.

Mr. BILIRAKIS. Thank you very much.

Dr. Thomas R. Russell is Executive Director of the American College of Surgeons. Welcome, Dr. Russell, please proceed, sir.

STATEMENT OF THOMAS R. RUSSELL

Mr. RUSSELL. Thank you, Mr. Chairman, and members of the committee. My name is Tom Russell and I'm the Executive Director of the American College of Surgeons. To put it very briefly, I would simply like to say that the College urges prompt action on H.R. 3351, the Medicare Physician Payment Fairness Act, and an adoption of the framework MedPAC is recommending to address serious problems in the fee schedule update mechanism.

We agree with the Commission's conclusion that the current update system is seriously flawed and must be reformed. The 5.4 percent Medicare payment reduction in 2002 is the fourth across-the-board decrease in the last 10 years. Since 1991, Medicare payments to physicians have increased an average of 1.1 percent per year while physician practice costs over the same period rose more than twice that amount.

In addition, premiums for medical liability insurance are skyrocketing, up to 200 percent in certain States such as Pennsylvania and West Virginia. In my written statement, Mr. Chairman, I have some charts showing the history of Medicare payments over time for certain key surgical procedures, coronary artery bypass, cataract surgery, etcetera. These charts show the magnitude of the cuts that have occurred since 1989 and what payments would have been if they had been allowed to keep pace with inflation. Payment for surgical services would, in fact, be considerably higher today if Congress had decided back then to simply freeze them for the next 12 years.

One of the greatest achievements of the Medicare program is the access to high quality care it has brought to our nation's seniors and that's what this is all about, not so much payment reimbursement for physicians, but for our beneficiaries. We cannot expect this to continue uninterrupted, however, in the face of repeated steep pay reductions.

The gap between physician payment and physician costs is leading to reported access problems throughout this country. Two years ago I stopped doing surgery and I have in my new position traveled extensively around the United States visiting surgeons in academic medical centers, in large urban centers and in rural areas. I can tell you that the morale of the providers of health care is abysmally low at this point. Many of them are limiting their range of services to the elderly, limiting the number of Medicare patients they will see and opting out of the program on occasion completely.

Particularly, there are stressed areas of the country, such as Pennsylvania, which is driving physicians out of the area because of the cost of liability insurance. One of the most disturbing things that we've seen and Dr. Ganske alluded to this earlier, is the lack of people interested in a career in surgery, what I always call the joy of a surgical career, because nothing is any better. But young physicians today realize when they hear from the practicing physi-

cians how really difficult it is, the hassle of practice, the cost of liability, the increased cost of running an office and of course, the reimbursement issues.

I cannot overemphasize the seriousness of the situation from a provider aspect. This cut in the 2000 fee, the pattern of reductions of the last several years, escalating practice costs and the projected future decreases combine to create a truly urgent problem.

Despite assurances from other sources, we believe that there is a real cause to be concerned about access to care. The data may not be there, but I can tell you I'm in the trenches going around this country and I may not have the data, but there's a problem. I cannot stress enough the importance of this issue. For any problems that are created cannot be solved simply by passing a new omnibus spending bill. It takes a long time to train a surgeon. They're often in debt over $100,000 and they're about 35 years of age when they finish a training program in surgery and the new practice patterns that the system is forcing them to adopt are really going to be difficult.

Thank you again, Mr. Chairman, and members of this committee for the opportunity to give our comments on this very pressing issue.

[The prepared statement of Thomas R. Russell follows:]

PREPARED STATEMENT OF THOMAS R. RUSSELL ON BEHALF OF THE AMERICAN COLLEGE OF SURGEONS

Mr. Chairman and Members of the Committee, I am Tom Russell, Executive Director of the American College of Surgeons. I am pleased to appear here today on behalf of the College's 62,000 Fellows to present our comments and recommendations about problems in the annual update mechanism of the Medicare physician fee schedule. I also will be commenting on the recommendations of the Medicare Payment Advisory Commission (MedPAC).

First of all, I want to mention that the issue before you today affects all medical and surgical specialties and all Medicare patients. In an effort to develop a effective solution, the College is working closely with members of Congress and with other physician organizations, including the American Medical Association and the Coalition for Fair Medicare Payment—a group of medical and surgical societies that includes those who have been hit hardest by Medicare payment reductions over the course of many years.

I come before you today urging prompt action on HR 3351, the Medicare Physician Payment Fairness Act, and adoption of the framework MedPAC is expected to recommend in its upcoming report to address serious problems in the Medicare physician fee schedule update mechanism. I strongly concur with the Commission's conclusion that statutory provisions specifying the physician fee schedule update are seriously flawed and must be reformed immediately.

For 2002, the law produced a large negative adjustment in physician reimbursement—minus 5.4 percent—and government projections for the next few years indicate further significant cuts in Medicare physician payments. The reduction in 2002 is the fourth across-the-board decrease in Medicare payment rates for physician services over the last 10 years. Since 1991, Medicare payments to physicians have increased an average of 1.1 percent per year, while over the same period physicians' practice costs rose more than twice that amount. In addition, premiums for medical liability insurance are skyrocketing. Physicians in some specialties report liability premium rate increases of more than 200 percent.

One of the greatest achievements of the Medicare program is the access to high quality care it has brought to our nation's seniors. This level of access, however, cannot be expected to continue uninterrupted in the face of continued reductions in payments to physicians and other health professionals whose reimbursement is based on the Medicare fee schedule. The gap between physician payment and physician costs has already led to press reports of access problems for Medicare beneficiaries throughout the country.

The impact of the flawed update methodology and the negative update for 2002 must be viewed in the context of the significant Medicare payment reductions for

surgical services that have occurred since implementation of the Medicare fee schedule. The Omnibus Budget Reconciliation Act of 1989 changed the payment methodology for physicians' services from a charge-based system to a resource-based system with three service components: work, practice expenses, and malpractice. The fee schedule was implemented in 1992 with a three-year transition, and in 1999 the four-year transition to resource-based practice expenses began. Resource-based malpractice relative values were incorporated into the fee schedule in 2000. This year marks the end of the transition to a fully resource-based system.

Payments for surgical services have fallen substantially since inception of the fee schedule and they have suffered especially large decreases since passage of the Balanced Budget Act of 1997. The Medicare conversion factor applicable to surgical services decreased from $40.96 in 1997 to $36.20 in 2002, a reduction of almost 12 percent.[1] In addition to the conversion factor reduction, which dropped more for surgical services than for other physician services, the adoption of new relative values for the practice expense portion of the fee schedule cut payment rates for surgical services significantly. I would like to share some examples of how severe these decreases have been.

I am submitting for the record a table that illustrates the dramatic reductions in payments for surgical services by comparing 1989 average payments for commonly performed procedures to the 2002 fee schedule amounts. For all these procedures, the fee schedule rate decreased by 7 percent or more; for 10 of these procedures, payments decreased by 10 percent or more; and for 9 of the 12—three-quarters of them—payments were reduced by more than 20 percent. There are four procedures on this chart with 2002 payments that are half what they were in 1989.

Medicare Payment History for Representative Surgical Services

National Averages

DESCRIPTION	1989	2002	% Change 89-02
Removal of breast	$1,051	$961	-8%
Total hip replacement	$2,427	$1,452	-40%
Total knee replacement	$2,301	$1,514	-34%
CABG, vein, three	$3,957	$1,888	-52%
Rechannel carotid artery	$1,677	$1,061	-37%
Partial removal of colon	$1,256	$1,171	-7%
Diagnostic colonoscopy	$425	$205	-52%
Repair inguinal hernia	$560	$448	-20%
Prostatectomy (TURP)	$1,139	$770	-32%
Total hysterectomy	$991	$893	-10%
Removal of spinal lamina	$2,078	$1,036	-50%
Remove cataract, insert lens	$1,573	$669	-57%

Obviously, physician payment rates for surgical services would be higher today if they had been *frozen* in 1989 for the next 12 years—a policy Congress certainly would not have enacted.

As dramatic as the reductions are, they are much worse after considering the effect of price inflation. There are two principal measures of inflation that could be used to gauge whether physician payments are keeping pace with price changes: the consumer price index for U.S. cities (CPI-U) and the Medicare economic index (MEI). Comparing actual reimbursements to those that would be in place if updates were based on the MEI show that payments would have been 36 percent higher in 2002 than they were in 1989; using CPI-U they would have been 46 percent higher.

I am submitting for the record another table that compares actual 2002 payments to projected payments based on updates of the 1989 amounts using either the MEI or the CPI-U as the measure of inflation. The size of the payment reductions are so large that it can not be surprising that many skilled surgeons are considering early retirement while others are discouraging talented young men and women from pursuing surgical careers.

[1] In 1997, a separate conversion factor applied to surgical services. The Balanced Budget Act moved all services to a single conversion factor beginning in 1998.

Comparison of Actual 2002 payments to Projected Medicare Payments Based on Annual MEI or CPI-U Updates of the 1989 Average Payments

DESCRIPTION	2002 Actual Payment	MEI Update Payment	CPI-U Update Payment	% Decrease from MEI	% Decrease from CPI-U
Removal of breast	$961	$1,430	$1,528	-49%	-59%
Total hip replacement	$1,452	$3,303	$3,497	-121%	-141%
Total knee replacement	$1,514	$3,132	$3,316	-107%	-119%
CABG, vein, three	$1,888	$5,386	$5,702	-185%	-202%
Rechannel carotid artery	$1,061	$2,283	$2,417	-115%	-128%
Partial removal of colon	$1,171	$1,710	$1,810	-46%	-55%
Diagnostic colonoscopy	$205	$579	$613	-182%	-198%
Repair inguinal hernia	$448	$762	$807	-70%	-80%
Prostatectomy (TURP)	$770	$1,550	$1,641	-101%	-113%
Total hysterectomy	$893	$1,349	$1,428	-51%	-60%
Removal of spinal lamina	$1,037	$2,828	$2,994	-173%	-189%
Remove cataract, insert lens	$669	$2,141	$2,267	-220%	-239%

I cannot over-emphasize the seriousness of this situation. The 5.4 percent fee cut in 2002, the pattern of reductions over the last several years, escalating practice costs, and the projection of future decreases combine to create an urgent problem.

Many factors contribute to the flawed update mechanism, but none is as important as the Sustainable Growth Rate (SGR). Legislated in 1997 as part of the Balanced Budget Act, the SGR is used to set a target for aggregate Medicare expenditures under the fee schedule.[2] If actual spending for physician services exceeds the applicable target, physicians are penalized by having the MEI update reduced; if spending remains below the target, they are rewarded with a full inflation update plus a "bonus" percentage. The SGR provision was amended by the Balanced Budget Refinement Act of 1999 (BBRA) to correct some technical deficiencies, but the SGR remains a seriously flawed and misguided policy, with negative consequences for the adequacy of physician payment rates. The dominant factor driving the 5.4 percent reduction in physician reimbursement this year is the SGR update adjustment factor, which caused a 7.0 percentage point reduction. If physician payments had been updated by the MEI alone, rates would have increased 2.6 percent.[3]

The College is concerned that the current SGR growth limits are so stringent that they could affect Medicare beneficiaries' access to care both today and in the future as young men and women choose careers other than surgery. They also could have a chilling effect on the adoption of technological and clinical innovations in medical practice. Many organizations, including the Association of American Medical Colleges, the American Medical Association, and the national medical specialty societies comprising the Coalition for Fair Medicare Payment share this view. In addition, the Medicare Payment Advisory Commission (MedPAC) has identified serious problems in the SGR system and recommends replacing it with a totally different system. Improving the SGR is important to ensure that the 85 percent of Medicare beneficiaries enrolled in fee-for-service Medicare continue to receive the benefits to which they are entitled.

PROBLEMS WITH THE SGR

Before I discuss our recommendations, I would like to note a few of the most salient problems with the SGR.

The SGR sets an arbitrary target ceiling on physician spending unrelated to beneficiaries' need for physician services. Consequently, it does not ensure beneficiary access to high quality physician services.

To preserve access, Medicare payments should reflect the costs that efficient providers incur in providing services. Medicare's other payment systems are adjusted annually using an update framework that accounts for changes in the cost of pro-

[2] The SGR formula is based on the government's estimate of the change in each of four factors: the estimated change in payments for physicians' services; the estimated change in the average number of Medicare fee-for-service beneficiaries; the estimated projected growth in real GDP per capita; and the estimated change in expenditures due to changes in law or regulations.

[3] The fee schedule conversion factor fell 5.4% for CY 2002. Of the total reduction, 4.8% is due to the update adjustment percentage and the remaining 0.6% derives from the budget neutrality adjustments for the 5-year review and the final transition to resource-based practice expense. The -4.8% update is the combined effect of the MEI (2.6%, or 1.026), the SGR performance adjustment (-7.0%, or 0.93), and an additional 0.2% reduction (or, 0.998) required by the technical amendments to the SGR made by the BBRA.

viding services, including changes in practice patterns, the intensity of services, and service mix. No other component of Medicare is subject to an overall limit on spending. Even worse, the annual increase in the physician spending target is strictly limited by the rate of GDP growth. If the economy falters, as it has, the physician spending target drops. This approach completely fails to assure that payments keep pace with the needs of Medicare beneficiaries and the cost of providing care. Beneficiaries do not need fewer services when the economy slumps

The SGR is highly volatile and unpredictable.

In a letter to MedPAC and in data made public on its website in March 2001, the Centers for Medicare & Medicaid Services (CMS) estimated that the SGR adjustment factor for the CY 2002 update would be -1.5 percent. That is, the update percentage would be the MEI minus 1.5. The actual adjustment factor for 2002, published just eight months later in the November 2001 final rule, was -7.0 percent. The most volatile component of the SGR is projected GDP growth. The cumulative SGR fell 4.0 percentage points from November 2000 to November 2001 due to the slumping economy and lower forecasts of GDP.

The SGR ignores many factors that affect physician services.

Many factors influence the level of physician services provided to Medicare beneficiaries. The price of practice inputs like staff, building costs, equipment, and supplies; malpractice insurance premiums; productivity; new technology; aging of the Medicare population; site-of-service shifts; intensity of services provided in physician offices; preferences and needs of beneficiaries; and physician practice patterns all affect the cost of delivering physician services. Because the SGR only attempts to account for the first two factors—prices and productivity—it is an inadequate predictor of the appropriate level of physician spending.

The SGR is a crude attempt to control spending arbitrarily. Better strategies are available that would not threaten beneficiary access to services.

Adjusting the physician update for a current period based on total physician spending in a past period compared to an arbitrary and inappropriate spending target is a crude and ineffective policy instrument. It can lead to fee schedule updates that may appear inappropriately high, as occurred in a couple of years, or updates that bear very substantial reductions, as for 2002. If growth in the volume and intensity of physician services were to re-emerge as a Medicare policy issue, MedPAC's March 2001 Report to Congress identifies several strategies that could be used. For example:

- working to achieve appropriate use of services through outcomes and effectiveness research;
- disseminating tools for applying this research, such as practice guidelines; and
- developing evidence-based measures to assess the extent to which knowledge is being applied.

RECOMMENDATIONS

To address the many problems caused by the SGR and the fee schedule update mechanism, the College urges the Committee to approve legislative changes in several areas. We believe HR 3351 is an important first step and its enactment is our first recommendation.

Recommendation 1—Enact HR 3351 to limit the CY 2002 reduction in the fee schedule conversion factor to 0.9 percent.

HR 3351, introduced by Congressman Bilirakis, would limit the 2002 fee schedule cut to 0.9 percent. We are extremely pleased that the legislation now has 321 cosponsors and we hope this Committee can act quickly to move it now rather than waiting for a larger Medicare bill later in the legislative session. The need for action is urgent. Although the CY 2002 conversion factor took effect January 1, 2002, the legislation could be enacted with a prospective effective date as early as April 1, 2002.

HR 3351 also would require MedPAC to "conduct a study on replacing or modifying the sustainable growth rate . . . as a factor in determining the update for payments under the Medicare physician fee schedule . . . such that the factor used more fully accounts for changes in the unit costs of providing physicians' services." MedPAC would be required to submit a report to Congress on the study together with any recommendations for legislation and administrative action. The College is pleased that MedPAC's March 2002 report to Congress will include recommendations to fix the SGR problem. We believe that the Commission's imminent report

satisfies the study requirement in HR 3351 and that Congress can proceed immediately to make the necessary legislative changes.

Finally, we strongly support the technical clarification in HR 3351 that the additional expenditures made in CY 2002 due to the higher update would not be considered in any year in calculating subsequent physician fees; that is, they would not be built into the base for any purpose. This is a significant protection to include while the Congress considers and legislates a lasting solution.

Recommendation 2—Eliminate the SGR update methodology and replace it with an annual update based on factors influencing physicians' costs of efficiently providing patient services. The update formula would not include any performance adjustment factor based on an expenditure target.

This recommendation closely follows those made by MedPAC in its March 2001 Report to Congress, as well as those that are anticipated in its March 2002 report. Like MedPAC, the College believes the physician update should be based exclusively on Medicare beneficiaries' need for services and the cost of providing those services. Access to physician services under Medicare and payment for those services should not be limited, or even threatened to be limited, in any manner that could impede beneficiary access to the high quality care that the program has made possible for 36 years. Physician services provide the core of all patient care. They are essential for achieving quality care and, in addition, we believe they are the most cost-effective of all services included in the Medicare program.

Under this College recommendation, MedPAC and the Secretary would establish an update framework similar to those used for other Medicare services. In addition to changes in input prices (as measured by the MEI), the framework would include components to reflect changes in all other factors affecting the cost of delivering physician services. These other factors include changes in the volume and intensity of physician services due to new technology, site of service shifts, and practice patterns, among others. Physician updates would be based solely on beneficiary needs and the cost of providing physician services.

Under this recommendation, the SGR is repealed and it is not replaced with any expenditure target or similar adjustment mechanism. The expenditure target concept is a badly flawed policy. It is time to scrap it entirely.

The College is very concerned about reports about the cost of repealing the SGR. We acknowledge that the cost may be substantial, but we do not believe it is nearly as much as some have suggested, unless the budget baseline assumptions are out of touch with reality. While we do not have an estimate of the proposal's cost, we note that if physician fees were increased by 2.0 percentage points each year over the next five years, Medicare physician spending would be about $12.7 billion higher over the five years. If this continued for another 5 years, total spending over the 10-year period would increase about $55 billion. We also observe that if physician fees were frozen at their current level and given no MEI increase over the next 10 years, the savings would be about $53 billion. (The MEI is projected to average about 1.8 percent over the 10-year period.) In comparison to a savings estimate for a rate freeze, the projected price tags we have heard for eliminating the SGR suggests that the current payment system is expected to reduce physician spending by considerably more than a freeze—an outcome that is extremely troubling given the pressures facing the program today. Of course, estimates of the proposal's cost are driven by the baseline assumptions and projections made by the Congressional Budget Office (CBO) and CMS's Office of the Actuary. We think members of Congress should question a physician spending baseline that assumes physicians' payments will be reduced by an amount that is so much larger than the reductions that would occur under a rate freeze.

The College is committed to working with this Committee and others to eliminate the SGR and replace it with an update framework like those used for other Medicare updates. We do not believe that unrealistic cost estimates should block action on this urgent problem.

CHANGES NEEDED IN THE MEDICARE ECONOMIC INDEX (MEI)

The College also urges Congress to direct the Secretary of Health and Human Services to make needed changes in the MEI. This index is important because it is the basis for the annual inflation updates to the physician fee schedule. Over the last several years, we have shared our MEI concerns with the agency in commenting on proposed regulations and in other communications, but the problems persist. We do not believe that the MEI as currently structured provides an appropriate measure on which to base annual adjustments to the physician fee schedule.

The MEI continues to have essentially the same structure that it has had since its inception in 1972. Today, however, the Medicare program pays for physician

services in a completely different way than it did in 1972. At that time, physicians were paid their reasonable charges, and the MEI was employed to limit the portion of the annual increases in charges that Medicare would recognize in its reimbursement. The portion of charges not recognized by Medicare was owed by the beneficiary. In contrast, physicians are now paid based on a government-set fee schedule, and—importantly—physicians face strict limits on the amount that can be balance-billed to the beneficiary. The College strongly believes that CMS should re-examine the structure of the MEI and not continue to make only minor changes in an index that was developed 30 years ago under a very different set of payment rules. At a minimum, we urge two changes.

Recommendation 3—The price proxy for the physician earnings component of the MEI should be the employment cost index (ECI) for professional workers, not the average hourly earnings (AHE) for total non-farm workers.

The component of the MEI designed to track changes in the cost of the physician work component of the fee schedule uses the average hourly earnings of all non-farm workers rather than the more appropriate category of all professional workers. To support its position in its proposed regulations, CMS cites Committee report language from 1972. The report language states that "*it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality*." And, "*. . . Initially, the Secretary would be expected to base the proposed economic indexes on presently available information on changes in expenses of practice and general earnings levels*." CMS also states its own conclusion that "*there is an obvious concern about circularity if increases in prevailing charges are linked to increases in physician charges, which are then tied to increases in physician income.*"

The College strongly disagrees with the CMS position and emphasizes two points: (1) the Committee's concern about charge-based reimbursement is not relevant since implementation of the resource-based fee schedule; and (2) an index based on the earnings of *all* professional workers would have been sufficient to address the Committee's concern because physicians comprise a small portion of all professional workers. Physicians represent less than 3 percent of all professional workers in the economy, so the circularity point appears extremely weak. The College also notes that, in contrast, a significant portion of the hospital market basket, which is used as the basis for the annual update in the inpatient prospective payment system (PPS) rates, derives from the actual wages and salaries of civilian hospital workers. If there is any case to be made regarding circularity, this would seem to be the prime candidate.

The College believes it would be much more appropriate for Medicare to use the rate of growth in incomes of all professional workers as the basis for adjusting payments to physicians, rather than using an index based on all non-farm workers in the economy. According to CMS, basing the physician earnings portion of the MEI on increases in the incomes of all professional and technical workers would have produced an average annual MEI of 2.4 percent for the period 1992-1997, compared to an average 2.2 percent under the all-worker proxy used by HCFA. The College strongly urges the Committee to direct CMS to make this long overdue change effective January 1, 2003.

Recommendation 4—The non-physician employee compensation component of the MEI should be adjusted using a price proxy that reflects the increase in skill mix in physicians' offices.

Although CMS acknowledges that there has been a substantial shift in the skill mix in physicians' offices over the last few years, it continues to measure price changes using an economic statistic that holds the skill mix constant. The agency's rationale for this decision is that the use of higher skilled labor reflects the fact that work formerly performed in the hospital is now done in ambulatory settings. CMS continues its reasoning as follows: "*Skill mix shifts that reflect rising intensity of outputs in physician offices are automatically paid for by higher charge structures for the more complex mix of service inputs. Physicians performing more complex services may hire more skilled employees, and, thus, may tend to charge more for their services*."

We do not understand what points CMS is trying to make in its argument, or the relevance of those points to physician reimbursement under the fee schedule. Medicare pays for physician services based on rates set by the government, not based on charges. In addition, much of the increased care provided by physicians in their offices is for post-surgical care. These office visits cannot be separately billed under Medicare policy because they are included in the global service period. It is clear,

however, that responsibility for much of this portion of patient care has shifted to the physician office as patients are discharged from the hospital significantly earlier in their recovery than in the past. These patients' greater care requirements necessitate both a higher skill mix in physicians' offices and the use of more costly supplies and equipment.

The College would stress that payments under the Medicare fee schedule already fail to cover physicians' actual practice costs, a gap that has widened for surgeons under the recently implemented resource-based formula for practice expenses. And, the problem is compounded by the agency's continuing failure to recognize shifts in skill mix in its design of the MEI. We urge the Committee to direct CMS to remedy this problem by adopting an index—such as one based on the average hourly earnings of health care workers—that recognizes skill mix shifts. This change should be effective January 1, 2003.

In summary, the College strongly believes that the MEI as proposed by CMS does not provide an adequate basis for updating the physician fee schedule. The agency is continuing to rely on decisions made in the early 1970s about the appropriate structure of the index. We emphasize the points made earlier concerning the very different context for use of the MEI today compared to its use prior to implementation of the Medicare fee schedule and charge limits.

CONCLUSION

Finally, I would like to close with some additional comments about access to care. The College had an opportunity to review a draft of the section of MedPAC's 2002 report pertaining to physician payment updates, and we were concerned by conclusions reached about access to care. Survey findings from 1999 can not measure practice changes that are likely to have occurred with the phase-in to lower practice expense payments. Other limited studies we have seen tend to focus on allowed frequencies for the top three or four most often performed surgical services, or on the number of physicians signing Medicare participation agreements. These proxy measures are woefully inadequate to the task—and are likely to be misleading. Much more timely and sophisticated analysis is needed before the cumulative impact of payment reductions occurring over the course of more than a decade can be assessed in any meaningful way. I can not stress enough the importance of the issue, for any problems that are created can not be solved simply by swift passage of a new omnibus spending bill. It takes a long time to train a surgeon, or to change the new practice patterns that the system is forcing them to adopt.

Thank you once again, Mr. Chairman, for the opportunity to offer the College's comments and views. I would be pleased to answer any questions.

Mr. BILIRAKIS. Thank you very much, Dr. Russell.

Martha McSteen is the President of the National Committee to Preserve Social Security and Medicare.

Ms. McSteen, nice to see you again, welcome. Please proceed.

STATEMENT OF MARTHA McSTEEN

Ms. MCSTEEN. Thank you. Good morning, Mr. Chairman and Ranking Member Brown and members of the committee. Thank you for holding this important hearing on the issue of Medicare payment policy and I'm pleased to speak as President of the National Committee to Preserve Social Security and Medicare and also as one of the first regional administrators of Medicare back in the mid-1960's.

Certainly we find that many of our members across the country have been telling us that they are having a difficult time finding a physician who accepts Medicare. Now, with the 5.4 percent cut in physician reimbursement, we are particularly concerned about any issue that will serve as a barrier to care for Medicare beneficiaries.

Decreased payments to physicians can potentially be such a barrier, limiting beneficiaries access to primary and specialty care physicians. With decreased reimbursement, physicians may not be able to provide the same level of quality care. They may have to

limit the time they spend with a patient or cut back on support staff.

Some physicians may have to refuse to accept additional Medicare beneficiaries. Our members across the country tell us of physicians who are unable to accept Medicare reimbursement because they cannot afford to keep their offices open. The physician in many situations has to withstand some of the expenses of treating each Medicare patient. Frequently, that forces the physician to make an unwilling decision to eliminate Medicare patients from his or her practice.

We also wonder if the Medicare reimbursements force the physicians to make up the difference by cost shifting to non-Medicare patients.

Physicians should not be overpaid in certain years and underpaid in other years. Uniformity and predictability are needed so that Medicare beneficiaries will know that their physician will not suddenly drop out of the program.

One of our members who lives in Florissant, Colorado has advanced Parkinson's disease. He's had a terrible time finding a doctor who will accept Medicare. He says some doctors tell him he can pay them directly and he can try to get money from Medicare, if he would like. A person on Medicare shouldn't have to do this. Medicare shouldn't become two programs, one for the rich and one for the poor.

It should treat everyone equally.

Actually, our member says he probably can afford to do this more than some. He worries about his neighbors who may be living on a small Social Security check and have Medicare coverage, but no supplemental insurance. He says they can't afford to pay. Unfortunately, the parts of the country that are designated health profession shortage areas or medically under served areas are also the areas as we have heard this morning with the lowest physician reimbursement.

In these areas, beneficiaries already have a hard time locating a physician, particularly a specialist. We fear that the 5.4 percent cut in physician payments may cause more providers to stop accepting Medicare. This will further limit seniors' access to care.

The National Committee to Preserve Social Security and Medicare recommends that MedPAC study the issue again and again and suggest a payment formula to Congress.

Mr. Chairman and members of the committee, thank you for this opportunity on behalf of seniors who depend on highly skilled physicians in this great country of ours for their well-being.

[The prepared statement of Martha McSteen follows:]

PREPARED STATEMENT OF MARTHA MCSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Good Morning Chairman Bilirakis, Ranking member Brown and members of the committee. Thank you for holding this important hearing on the issue of Medicare payment policy and for inviting me to speak as president of the National Committee to Preserve Social Security and Medicare, a senior's grass root's education and advocacy organization with millions of members and supports.

Unfortunately, many of our members across the country, have been telling us that they are having difficulty finding a physician who accepts Medicare. Now, with the 5.4% cut in physician reimbursement, we are particularly concerned about any issue that will serve as a barrier to care for Medicare beneficiaries. Decreased payments

to physicians can potentially be such a barrier; limiting beneficiaries' access to primary and specialty care physicians.

With decreased reimbursement physicians may not be able to provide the same level of quality care, they may have to limit the time they spend with a patient or cut back on support staff. Some physicians may have to refuse to accept additional Medicare beneficiaries.

Our members tell us of physicians who are unable to accept Medicare reimbursement because they cannot afford to keep their offices open. The physician in many situations has to withstand some of the expenses of treating each Medicare patient. Frequently, that forces the physician to make an unwilling decision to eliminate Medicare patients from his or her practice.

We also wonder if the Medicare reimbursements force the physicians to make up the difference by cost shifting to non-Medicare patients.

Physicians should not be overpaid in certain years and underpaid in other years. Uniformity and predictability are needed so that Medicare beneficiaries will know that their physician will not suddenly drop out of the program.

One of our members, who lives in Florissant, Colorado has advanced Parkinson disease. He has had a terrible time finding a doctor who will accept Medicare. He says some doctors tell him he can pay them directly and try to get money from Medicare if he would like. A person on Medicare shouldn't have to do this; Medicare shouldn't become two programs; one for the rich and one for the poor. It should treat everyone equally. Actually our member says he probably can afford to do this more than some. He worries about his neighbors who may be living on a small Social Security check and Medicare with no supplemental insurance. He says they cannot afford to pay.

Unfortunately, the parts of the country that are designated Health Professions Shortage Areas (HPSA) or Medically Underserved Areas (MUA) are also the areas with the lowest physician reimbursement. In these areas beneficiaries already have a hard time locating a physician, especially a specialist. We fear the 5.4% cut in physician payments may cause more providers to stop accepting Medicare. This will further limit senior's access to care.

We recommend that MedPac study the issue and suggest a payment formula to Congress.

Mr. Chairman and members of the committee, thank you for the opportunity to testify on behalf of seniors who depend on the highly skilled physicians in this great country of ours for their well-being.

Mr. BILIRAKIS. Thank you very much, Ms. McSteen.

Dr. Susan Turney is a Member of the Board of Directors of the Medical Group Management Association. She has traveled all the way from Wisconsin to be here with us today. Thank you—and to get a little warmer.

Ms. TURNEY. Yes.

Mr. BILIRAKIS. Please proceed.

STATEMENT OF SUSAN TURNEY

Ms. TURNEY. Good morning. I am a Member of the Board of Directors of the Medical Group Management Association and on behalf of MGMA I would like to thank you for convening today's hearing.

I would also like to express our gratitude to the full committee for its leadership in pursuing the important issue of physician payments under Medicare. MGMA is the nation's oldest and largest organization representing medical group practices. There are 19,000 members who lead and manage more than 10,000 organizations and represent more than 200,000 practicing physicians.

Our individual members include practice managers, clinic administrators, and physician executives who work on a daily basis to ensure that the financial and administrative mechanisms within group practices run efficiently so that physician time and resources can be focused on patient care.

As such, MGMA members are uniquely qualified to assess the direct impact of Medicare payment inadequacies on the delivery of quality care to Medicare beneficiaries.

I am also a practicing internist and the Medical Director of Reimbursement at Marshfield Clinic. Marshfield is the largest private medical group practice in Wisconsin and one of the largest group practices in the United States. We have 678 physicians, over 5,000 staff and we had over 1.6 million annual patient encounters. We are a tax-exempt corporation and we include a major diagnostic treatment center, research facility, reference lab and we provide care to 39 sites in rural Wisconsin.

Mr. Chairman, the current Medicare physician payment system is stuck in reverse and threatens to severely impact beneficiary access and the stability of physicians practicing across the country. MGMA urges Congress to take three immediate steps to get Medicare moving forward in the right direction.

First, halt the 5.4 percent reduction to the Medicare fee schedule.

Second, eliminate the current unsustainable growth rate system.

Third, implement a methodology that bases Medicare reimbursement on a formula that measures actual practice costs.

Currently, Medicare patient access is unsustainable if we keep moving along this track. Again, at Marshfield, our experience serving a large rural region in northern Wisconsin is that the Medicare payment system falls far short of meeting the cost of delivering medical services to the Medicare beneficiaries.

Recently, we conducted an internal analysis to determine to what extent the Medicare program covers the cost of providing services to the beneficiaries. Our analysis demonstrated that the clinic presently recovers only about 70 percent of the cost that we have in providing Medicare Part B services. And we project that for 2002 that amount will actually decrease as a percent of cost to approximately 68.5 percent.

Like other practices, at Marshfield, we are directly impacted by the volatility of the current SGR system as well as the shortfall. The magnitude of the discrepancy between the 0.2 percent reduction which had been predicted in March of 2001 and the actual reduction which took place in November, placed our clinic in an untenable position.

In 2000, our clinic had net earnings as a percent of revenue of 2.87 percent and in 2001, this dropped to 1.58 percent. These tight margins highlight how even minor fluctuations in the revenue stream have a material impact on our operations.

Under the current Medicare payment system, SGR volatility plays havoc with our planning and our budgeting initiatives. We calculate that the revenue impact of the Medicare payment cut will be a negative $2.8 million for calendar year 2002. Such losses compromise acquisition of new technology as well as our ability to expand into additional rural areas.

Marshfield Clinic is currently in the final stage of an internal analysis to determine the feasibility of entering the Medicare+Choice market. Our objectives as a system are to improve choices and to expand services to under served areas throughout north, central and western Wisconsin. The startup costs of implementing a Medicare+Choice Plan are significant. But from

a Medicare beneficiary perspective, the plan potentially holds great value because beneficiaries with medigap insurance could receive a nearly identical plan and save between $35 and $95 per month to join.

Unfortunately, the greatest challenge to this effort comes as a result of the Medicare fee-for-service payment cuts that have reduced the revenue the clinic needs to take the risk of bringing on any new product.

At this time we are uncertain whether it is feasible in the present environment of pay cuts and with the SGR volatility to become an M+C plan.

The true test of a system is how well it takes care of those in need. Presently, the Medicare payment system places those most in need in jeopardy. The leadership of the chairman and ranking member and other members of the subcommittee has been demonstrated by sponsorship of H.R. 3351. This truly indicates your support for physicians' ability to take care of those who are most in need.

We do thank you for your efforts and we look forward to working with the committee to correct this problem.

[The prepared statement of Susan Turney follows:]

PREPARED STATEMENT OF SUSAN TURNEY, MEMBER, BOARD OF DIRECTORS, MEDICAL GROUP MANAGEMENT ASSOCIATION

Good morning. My name is Dr. Susan Turney. I am a member of the Board of Directors of the Medical Group Management Association (MGMA). On behalf of MGMA, I would like to thank the Chairman, the ranking member, and the entire Subcommittee for convening today's hearing. I also would like to express our gratitude to the full Committee for its leadership in pursuing the important issue of physician payments under Medicare so stability and access to this vitally important program are assured.

MGMA, founded in 1926, is the nation's oldest and largest organization representing medical group practices. MGMA's 19,000 members manage and lead more than 10,000 organizations in which more than 200,000 physicians practice medicine. Our individual members, who include practice managers, clinic administrators, and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices run efficiently so that physician time and resources can be focused on patient care. As such, MGMA members are uniquely qualified to assess the direct impact of Medicare payment inadequacies on the delivery of quality care to Medicare beneficiaries.

In addition to my leadership role with MGMA, I am a practicing internist and the Medical Director of Reimbursement at the Marshfield Clinic. Marshfield is the largest private medical group practice in Wisconsin and one of the largest in the United States, with 678 physicians, 5158 staff, and over 1.6 million annual patient encounters. A tax-exempt corporation, the Marshfield Clinic system includes a major diagnostic treatment center, a research facility, a reference laboratory, and 39 regional centers. The Clinic also provides services in partnership with a federally funded Community Health Center at 13 locations in Wisconsin, providing comprehensive integrated care to un- and under-insured residents of the community with incomes at or below 200% of the federal poverty level.

Mr. Chairman, the current Medicare physician payment system is stuck in reverse and threatens to severely impact beneficiary access and the stability of physician practices around the country. MGMA urges Congress to take three immediate steps to get Medicare moving forward in the right direction: (1) halt the recent 5.4% reduction to the Medicare fee schedule, (2) eliminate the current Sustainable Growth Rate system, and (3) implement a new methodology that bases Medicare reimbursement on a formula that measures actual practice costs. No other payment system under Medicare fluctuates with the Gross Domestic Product (GDP). Only physician fees are tied to this type of formula. Unless immediately addressed through congressional action, the cut in Medicare reimbursement rates will dramatically affect physician group practices that serve Medicare beneficiaries throughout the nation, especially in rural and underserved areas. MGMA is deeply concerned

this will lead to new barriers to access to care for many Medicare and privately insured patients.

IMPACT OF THE 2002 REDUCTION

According to MGMA data, the recent 5.4% cut steepens the slide created by inadequate Medicare payment updates over the last decade. From 1992-2000 MGMA's national practice cost survey indicates that total operating costs per physician in an average multi-specialty group practice rose 31.7%. During that same period, physician Medicare payments only increased 13%. Simply stated, Medicare payment increases covered roughly 40% of the actual cost increases that average group practices faced during this period. The recent cut exacerbates this critical situation.

Over the past few months, MGMA received hundreds of reports regarding the impact of the 2002 cut. I would like to share two specific examples from around the country, as well as some personal details from my work at the Marshfield Clinic.

In Colorado, a cardiology group practice reports that it expects an annual loss of over $1 million. To deal with the shortfall, it will dramatically reduce operating expenses and lay off employees. It has reached the point where the group is considering no longer accepting assignment for Medicare beneficiaries. These patients currently comprise 40% of its practice. In other words, it may no longer participate in the Medicare program.

An academic medical practice in New York estimates a $1.7 million loss from the 2002 cut directly attributed to its 15% Medicare patient population. It faces an even more critical cut from its private sector patients, impacting approximately 60% of its business. This is due to the reduction in managed care fee schedules, which are negotiated based on the Medicare fee schedule. Including both public and private payers it estimates the total loss this year could be close to $7 million. In addition, this academic group practice is comprised of full time faculty employed by a university. The patient care revenue supports the education and research mission of the university's medical college. To the extent that patient care revenue drops, it will not only reduce the amount of faculty physician time available to Medicare patients, but also the amount of faculty time available for clinical education and clinical research.

MEDICARE PATIENT ACCESS IS UNSUSTAINABLE

Patient access to care is a critical issue where I work at the Marshfield Clinic. Currently we have 102 physician openings that remain unfilled. These are most often in satellite clinics in rural areas we serve, where services are needed most but funding is limited. Physician recruiters advise the Clinic it will need to pay a premium to attract the physicians it needs. Under current funding conditions, let alone those reduced by recent cuts, this is extremely difficult. In 1999, Marshfield Clinic budgeted its physician salaries for the 50th percentile of relevant market surveys for the year, at the 45th percentile for the year 2000; and at the 55th percentile for the year 2001. Both specialists and primary care physicians are needed by the Clinic to fill vacancies throughout the rural area the Clinic serves.

In addition to physician openings, the Clinic presently has 237 staff vacancies. These include open positions for nurses, medical assistants, MRI/ laboratory/ECG/ Nuclear medicine technicians, phlebotomists, housekeepers, clerks, programmers, medical illustrators, social workers, and many others that are essential components of a large integrated system of care.

In our experience serving a large rural region in northern Wisconsin, the Medicare payment system falls far short of meeting the cost of delivering medical services to Medicare beneficiaries. To continue to exist as an organization, such revenue shortfalls are subsidized by private sector insurers, such as employer sponsored health coverage.

At Marshfield Clinic, we conducted an internal analysis to determine to what extent the Medicare program covers the cost of providing services to Medicare beneficiaries. Our analysis demonstrated that the Clinic presently recovers only about 70% of its costs in providing Medicare Part B services. Specifically, for FY 2000 Medicare revenue was 71.52% of costs for fee-for-service Medicare. For FY 2001 Medicare revenue (un-audited) as a percent of costs goes down to 70.59%. For FY 2002 we project that Medicare revenue will decrease as a percent of costs to approximately 68.5%.

To calculate the percent of its Medicare allowed costs for which Medicare reimbursement is received, Marshfield accountants eliminated all expenses and revenues received that might potentially be questioned by the Medicare program. Our methodology for FY 2000 follows principles applied in our annual federally qualified health center (FQHC) cost report that was audited by external auditors and sub-

mitted to the state. (Marshfield Clinic in conjunction with Family Health Center Inc. functions as a FQHC under the Medicaid Program.) For the purposes of this analysis, all expenses and revenues from activities such as the outreach lab, veterinary lab, research and education, rental property and optical and cosmetic surgery departments were removed. Our accountants also removed all non-Medicare "allowed" costs related to our bad debt, interest expenses, marketing programs, government affairs activities, National Advisory Council, goodwill amortization and other miscellaneous costs.

EFFECT OF SGR VOLATILITY

Like other practices, at Marshfield, we are directly impacted by the volatility of the current SGR system as well as the 5.4% shortfall. The magnitude of the discrepancy between the 0.2% reduction, which CMS predicted in March 2001, and the November 1 5.4% announced cut placed the Clinic in an untenable position. Using the best available data from CMS, Marshfield Clinic budgeted a 0.1% reduction in Medicare Part B reimbursement for 2002.

In 2001, the Clinic had net earnings as a percent of revenue of 1.58%, 2.87% in FY 2000, and 0.86% in FY 1999. These tight operating margins highlight how even minor fluctuations in the revenue stream have a material impact on operations. Under the current Medicare Payment system, SGR volatility plays havoc with our planning and budgeting initiatives.

We presently calculate that the revenue impact of the Medicare payment cut will be negative $2.8 million for CY2002. Such losses compromise planned capital equipment purchases, acquisition of new technology, and the Clinic's determination to expand the infrastructure of services in the rural areas throughout the 20 plus counties we serve. There are also many forms of Community Support in which the Clinic is involved including charity care, patient assistance, and charitable donations. While it is not the desire of the Clinic to withdraw this support to offset the losses, the Clinic's ability to maintain the same level of support will be constrained.

BARRIERS TO NEW MARKETS

Marshfield Clinic is in the final stages of an internal analysis to determine the feasibility of entering the Medicare+Choice market. Our objectives as a system are to improve beneficiary choices and expand services in areas that are presently underserved throughout north, central and western Wisconsin. By entering the M+C program, we hope to help support the infrastructure needed to fund information system improvements and implement targeted care management for the population we serve. The start up costs of implementing a Medicare+Choice plan are significant, and the prospect of breaking even is challenging because the health conditions of Medicare beneficiaries in the Marshfield area are slightly more complex than the national average and risk adjustment is uncertain. It is also very difficult to market to Medicare beneficiaries when they are spread so far geographically. From a beneficiary perspective, the Marshfield's M+C plan holds great value because beneficiaries with MediGap insurance could receive a nearly identical benefit plan and save between $35 and $95 per person per month to join the plan. Unfortunately, the greatest challenge to this effort comes as a result of the Medicare fee-for-service payment cuts that have reduced the revenue the Clinic needs to take risks in bringing on line a new product. At this time, Marshfield is uncertain whether it is feasible in the present environment of pay cuts and SGR volatility to become a Medicare+Choice plan.

STABILITY OF THE MEDICARE PROGRAM THREATENED

I thought it important to quote from physician group practices around the country that have contacted MGMA to express their concerns. Each of these practices faces the daunting task of managing the 2002 cut and dealing with the uncertainty of how to plan for the future. These are but a few of the reports we received expressing concern over the existing situation:

- A 225 physician group practice in Pennsylvania stated "we will have to close some of our offices, forcing our elderly patients to travel a much greater distance to more centralized locations if these rate decreases continue."
- A group of 500 family physicians and internists responded that "we have restricted new Medicare patient access . . . this will become terrible for this needy and deserving population."
- A group of 180 physicians in New York said "we will need to discontinue senior outreach programs, thus not allowing us to sustain services at current levels."

- Several group practices in the Northwest reported "to survive, we will be limiting Medicare access."
- A group in southeastern Wisconsin summed up their planning in the following fashion. "We are already having discussions regarding the closure of the practice to new Medicare patients. Unfortunately, we see no other alternatives, particularly if the 2002 Medicare reduction stands. Without adequate reimbursement, we simply will not be able to continue to offer the level of care that our physicians expect of themselves without limiting access."
- One group of orthopedists in North Carolina reported "we will be forced to limit our exposure to Medicare recipients."
- A practice of over 400 physicians in Utah reported that "the reduction in payment places a significant, if not impossible, strain on our desire to provide services to the Medicare population within our community."

RECOMMENDATIONS

Last month, the Medicare Payment Advisory Commission voted to recommend that Congress repeal the current SGR system. MGMA strongly supports this recommendation.

MedPAC also recommended that annual Medicare physician payment updates be based on changes in input prices that reflect actual medical practice costs as opposed to linking physician payments to GDP. Using this formula, MedPAC recommended a 2.5 percent Medicare payment increase in 2003. MGMA strongly supports this framework but believes work remains on the development of accurate price measures to reflect true costs.

MGMA also agrees with MedPAC that if the Medicare Economic Index (MEI) is to be used to measure practice cost inflation, it must be improved. The MEI should be updated to include a number of significant costs borne by physician practices.

Mr. Chairman, over the past year this Committee has shown tremendous leadership in addressing onerous regulatory obligations faced by Medicare providers. MGMA testified before the Committee last year regarding the impact of some of these regulatory burdens which include: communication failures with Medicare contractors, increased requirements for documentation, conflicting Medicare rules, costly compliance programs, needle stick prevention rules, onerous privacy provisions, and the un-funded requirement that practices provide free interpreters for patients with limited English proficiency. In addition, practices in many states currently face a crisis regarding premium increases for professional liability insurance. The current MEI does not accurately measure these costs. MGMA pledges to work with Congress to improve the precision of these practice cost measurements.

As members of Congress, it is important for you to understand the global impact of changes to the Medicare fee schedule. In addition to the direct Medicare implications, physician group practices have contracts with private payers who benchmark their payment rates to the Medicare fee schedule. A drop in Medicare payments will mean a commensurate drop in reimbursement from numerous other payers linked to Medicare, damaging group practices ability to provide care to both Medicare beneficiaries and privately insured patients. The true test of a system is how well it takes care of those most in need. Presently the Medicare payment system places those most in need in jeopardy. Mr. Chairman, this Subcommittee has shown its leadership and understanding of this important point by its virtually unanimous cosponsorship of H.R. 3351 "Medicare Physician Payment Fairness Act."

We appreciate all of your hard work and, as you move forward, urge you to take the following steps to correct the existing system:

- Immediately halt the 5.4% physician payment cuts went into effect on January 1, 2002.
- Adopt MedPAC's recommendation to eliminate the SGR system.
- Develop a system so that Medicare payments match the real world costs of delivering efficient quality services to Medicare beneficiaries.

Mr. BILIRAKIS. Thank you. Thank you very much, Dr. Turney.

Thanks to all of you. You have really reinforced in such a great down to earth, real world way concerns that I think every member of this committee has regarding what has taken place with respect to physicians' update.

I know that we're all very anxious to at least improve or come up with a new formula, whether it be the MedPAC one or one that's going to be fair, that's going to be more real world and take

into consideration the concerns not only of the physicians, but obviously of the patients.

We're going to have to empty this room. So we're not going to have time to do what we want to do and that is to orally ask you questions. So what I'm asking the members to do is you have 48 hours to submit to us any questions you want to be forwarded to this Panel and then of course, staffs will be working on others. So I'm going to ask you to respond in a timely fashion to these questions we will be asking and at the same time implore upon you to make suggestions. You know, you've all apparently expressed support, as I understand it from your written testimony, for the MedPAC recommendation. We don't really know how that's going to go. I mean right now I would say that's probably leading the pack, but if you have any other thoughts, whether you have improvements upon that formula, or something in lieu thereof, whatever it might be, feel free to bring it to the committee's attention. I assure you we will spend an awful lot of time on this issue.

Mr. NORWOOD. Mr. Chairman, the answers to our questions will be placed in the record?

Mr. BILIRAKIS. The answers to our questions and the answers thereto, will be made a part of the record. So with your help we're going to try to get this problem solved once and for all. Obviously, you know, democracy works only if the public gets involved and as great as it is for you to be here, and your testimony as helpful as it is, getting your folks back home to lobby, lobby, lobby is really most of the answer to resolving any problem we may have up here.

Having said that, I will thank you on behalf of the entire committee. And I'm going to have to ask everybody other than maybe members of the press to vacate this room. Thank you very much. The hearing is adjourned.

[Whereupon, at 11:07 a.m., the hearing was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

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.

PREPARED STATEMENT OF AMERICAN ACADEMY OF OTOLARYNGOLOGY—HEAD AND NECK SURGERY

The American Academy of Otolaryngology—Head and Neck Surgery (AAO-HNS) is pleased to submit this statement for the record of the Energy and Commerce Subcommittee on Health's hearing on the future of Medicare's payment policy. AAO-HNS, representing more than 10,000 otolaryngologist—head and neck surgeons across the country, is the national medical association of physician specialists dedicated to the care of patients with disorders of the ears, nose and throat and related

structures of the head and neck. We are often referred to as ENT physician specialists.

On November 1, 2001, the Centers for Medicare and Medicaid Services (CMS) announced a 5.4% reduction in the Medicare physician fee schedule conversion factor that resulted in an across-the-board cut in Medicare physician fees. This significant decrease, which went into effect January 1, 2002, reduced the conversion factor from $38.2581 to $36.1992 and sparked a unified and exhaustive effort in the physician community to urge Congress and the Administration to provide relief from the payment cut. However, despite overwhelming support by a majority of the House and Senate, Congress adjourned on December 21, 2001 without addressing the physician payment update and left physicians struggling to cope with the largest payment cut since the inception of the fee schedule.

It has been only six weeks and yet the reduction in physician payments has had immediate ramifications for physicians and the patients they treat. Physicians in every state are losing thousands of dollars in Medicare reimbursements, with specialists taking the hardest hit. The loss of revenue compounded with rising practice costs and increasing medical liability premiums are forcing physicians to lay off staff, reduce services and treat fewer Medicare patients in an attempt to keep their practices afloat. The overwhelming number of state and federal regulations and the inherent cost of remaining current and compliant further exacerbate the problems facing physicians.

Unfortunately, these problems are not unique and will continue to adversely affect patients unless a permanent and equitable adjustment to the formula that determines physician payment is found. Linking physician reimbursements to the U.S. Gross Domestic Product (GDP) and the fluctuations of the nation's economy is an inaccurate measurement of the true cost of practicing medicine.

Otolaryngologists are committed to providing their patients with the highest quality of care, including the latest technologies and procedures available. The significant reductions in reimbursement coupled with rising practice expenses, may force physicians to increase patient volume thus spending less time with individual Medicare patients. Reluctantly, doctors may forsake the treatment of Medicare patients altogether to preserve the viability of their practices and their dedication to quality care. The unfortunate consequences of the cut will ultimately jeopardize Medicare beneficiaries' access to physician services.

We urge Congress to take immediate action to prevent any further erosion to an already fragile system. The best way to ensure access to high quality care to each and every Medicare beneficiary is to devise a permanent solution to the physician payment formula that reflects the real-world cost of treating patients.

The AAO-HNS is pleased that the Subcommittee is addressing the important issue of adequate Medicare reimbursements for physicians. We welcome the opportunity to work with the Subcommittee to address the flawed formula currently used to calculate the physician payment update.

Thank you for the opportunity to submit this statement.

AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS

February 15, 2002

The Honorable MICHAEL BILIRAKIS
Chairman
Energy and Commerce Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

DEAR CHAIRMAN BILIRAKIS: On behalf of the 21,000 osteopathic family physicians represented by the American College of Osteopathic Family Physicians (ACOFP), thank you for holding the hearing "Medicare Payment Policy: Ensuring Stability and Access Through Physician Payments."

The ACOFP appreciates the leadership role that you and the Committee took in 2001 to try to prevent the 5.4% cut in the Medicare fee schedule from taking place on January 1st. We continue to support strongly the "Medicare Physician Payment Fairness Act of 2001" (H.R. 3351) and look forward to working with you and the Committee to ensure its enactment. As you know, H.R. 3351 has over 315 cosponsors. We feel that any bill with this type of bipartisan support deserves immediate action.

As you begin to formulate a strategy, and potentially draft new legislation, the ACOFP offers the following recommendations:

- Immediately halt the 5.4% Medicare payment cut;
- Repeal the sustainable growth rate (SGR) system;

- Replace the Medicare payment update formula with a new system that reflects increases in practice costs, increased utilization and other relevant factors; and
- Work with the House Budget Committee to ensure that appropriate funds are set-aside in the budget resolution to replace the Medicare physician payment update formula, beginning in 2003.

The ACOFP also requests that the Committee seriously consider the recommendations made by the Medicare Payment Advisory Commission (MedPAC) regarding the development of a new payment formula. The ACOFP supports the MedPAC proposal and urges its consideration by the Committee.

Mr. Chairman, the ACOFP appreciates the invitation you extended to Congressman Doug Bereuter to share his thoughts on Medicare payment inequities. We have long supported legislation that would remove the geographic disparities in Medicare reimbursements. We support Rep. Bereuter's "Rural Equity Payment Index Reform Act" (H.R. 3569). It was evident by comments made during the hearing that a number of Committee members are concerned about payment policies that adversely effect rural areas. H.R. 3569 would raise all localities with a physician work adjuster below 1.000 to a floor of 1.000 over a five-year period. We believe that H.R. 3569 provides an opportunity to improve health care in rural areas and we encourage the Committee to consider it during its deliberations.

Mr. Chairman, thank you for the leadership you have displayed on these and many other health care issues. The ACOFP and our members stand ready to assist you and the Committee. Please contact Shawn Martin, Director of Government Affairs at (202) 414-0147 for additional information.

Sincerely,

LOUIS J. RADNOTHY, D.O., FACOFP
President

cc: The Honorable W.J. Tauzin, The Honorable John Dingell, The Honorable Sherrod Brown, ACOFP President-Elect, ACOFP Board of Governors, ACOFP Executive Director, Chairman AOA Council on Federal Health Programs, AOA Department of Government Relations

---

AMERICAN COLLEGE OF PHYSICIANS
AMERICAN SOCIETY OF INTERNAL MEDICINE
February 14, 2002

The Honorable MICHAEL BILIRAKIS
Chairman
Committee Energy and Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable SHERROD BROWN
Ranking Member
Committee Energy and Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

RE: Addendum to ACP-Aim's Statement for the Record for the February 14, 2002 Hearing, "Medicare Payment Policy: Ensuring Stability and Access Through Physician Payments."

DEAR REPRESENTATIVES BILIRAKIS AND BROWN: 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 physician organization in the United States. Internists provide care for more Medicare patients than any other medical specialty. ACP-ASIM wishes to extend its sincere gratitude to the Committee for its efforts in assuring stability and access in the health care system through adequate physician payment.

ACP-ASIM recently provided a statement for the record for the February 14, 2002 hearing entitled, "Medicare Payment Policy: Ensuring Stability and Access Through Physician Payments." We are writing today to elaborate and clarify our position on the MedPAC's recommendations that will be contained in their March 2002 Report to Congress. We would request that the Committee include this addendum along with our official statement in the interest of a complete and accurate hearing record.

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 (See the original ACP-ASIM statement for the hearing record).

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%. Such measures should be reported and acted upon by Congress prior to, and independent of, other needed Medicare reforms.

Again, ACP-ASIM wishes to thank the Committee and its members for their interest in ensuring adequate Medicare physician payment. We would appreciate the Committee including this addendum along with our official statement for the record. If we can be of assistance to the Committee throughout this process in any way, please do not hesitate to let us know.

Sincerely,

ROBERT B. DOHERTY
Senior Vice President, Governmental Affairs and Public Policy

---

PREPARED 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 is the most critical to our members. ACP-ASIM thanks Congressmen Michael Bilirakis, Chairman of the Subcommittee, Sherrod Brown, Ranking Member of the Subcommittee, and other members, for holding this important hearing to discuss ways to ensure stability and access in the health care system through adequate physician payment. We also want to extend special appreciation to Chairman W.J. "Billy" Tauzin and Ranking Member John Dingell for their 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.

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 update 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 affects 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 today, 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 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 costs of other overhead expenses are dramatically increasing. This culmination of events may force physicians to make difficult choices in order to continue to operate.

Facing the rising cost of practicing medicine, physicians may 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 retire. A recent American Academy of Family Physicians study confirmed that physicians are having to make tough decisions, citing that nearly 30 percent of family physicians are not taking new Medicare patients.

This will make it even more difficult for patients to gain access to an increasingly under-funded health care system. The effects of the most recent cut in reimbursement will most likely be hardest felt in rural areas. The problems that we see today will certainly only get worse unless the methodology in which physician payment is computed is immediately addressed.

In a survey sponsored by MedPAC and conducted by Project HOPE and The Gallup Organization in 1999 (Schoenman and Cheng 1999), many physicians expressed concerns about payment levels. About 45 percent of them said that reimbursement levels for their Medicare fee-for-service patients were a very serious problem, compared with 25 percent who reported reimbursement levels for private fee-for-service was a very serious problem.

Finally, many physicians who responded to MedPAC's 1999 survey reported that they had taken steps to reduce their practice costs. More than one-half said their

practice had reduced staff costs, and two-thirds said their practice had delayed or reduced capital expenditures. It should be noted that because this survey was taken *three years ago,* it does not reflect the current level of physician concern—which is likely to be even greater given the 5.4% reduction that went into effect on January 1, 2002.

More 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 or dropping all Medicare patients from their practice. 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.

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 Louisiana, for example, physicians' total Medicare losses will exceed $28 million. In Michigan, physicians are expected to lose $105 million. Surveys in both Louisiana and Michigan show that 80 percent of physicians in the over-50 age group are considering retirement or job changes. Florida physicians stand to lose more than $206 million, making it the second highest loss only to New York ($207 million) in physician payment reduction. And in Ohio, physicians' total Medicare losses will exceed $95 million, making Ohio the eighth ranked state in total Medicare losses.

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 ask the Secretary of HHS to have implemented 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 and 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 and 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 is only a price measure and productivity can 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 tying physician productivity in order to lower the physician payment update may be problematic. Due to increased compliance with federal regulations, such as Medicare paperwork and HIPAA mandates, this 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 2002, when factored in with a 0.5 percent productivity adjustment, the result yields a 2.5 percent payment increase.

SOLUTION

ACP-ASIM strongly supports 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. We believe, however, that there needs to be further examination of the MedPAC recommendation to apply a negative adjustment to the update for productivity growth. We agree that any productivity adjustment for physician services should be based on a several factors instead of being based on labor costs alone. ACP-ASIM also supports the Commission's recommendation to increase physician payment by 2.5 percent for 2003. Further, ACP-ASIM believes that consideration should be given to establishing an automatic default update, based on the revised MEI, should Congress decline to act on MedPAC's recommendation.

These necessary changes will not only put the physician payment system in line with other segments of the health care industry, but more importantly, these changes will allow for an accurate accounting for all factors that impact the cost of providing physician services. Further, these changes will also contribute to a more stable and predictable physician payment schedule for years to come.

Finally, ACP-ASIM continues to support legislation, H.R. 3351 and S. 1707, "the Medicare Physician Payment Fairness Act of 2001"—that would cut the SGR update to physicians to 0.9 percent, rather than the current 5.4 percent cut—or any other legislative vehicle that would bring immediate relief and halt the 5.4 percent payment cut.

CONCLUSION

ACP-ASIM is pleased that the Subcommittee is addressing the serious problems associated with the current SGR physician payment system. We strongly urge the Subcommittee to adopt the MedPAC recommendations in the March 2002 Report to the Congress, and ask the Subcommittee to halt the 5.4 percent cut that became effective on January 2002 as quickly as possible.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF RADIOLOGY

The American College of Radiology (ACR) welcomes the opportunity to submit written testimony for the record to the House Energy and Commerce Subcommittee on Health regarding its February 14, 2002 hearing entitled "Medicare Payment Policy: Ensuring Stability and Access Through Physician Payments."

The ACR is very concerned about the drastic reduction in the conversion factor and that this significant across-the-board cut could exacerbate existing access prob-

lems for Medicare beneficiaries, particularly in rural communities. The conversion factor reduction 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. This would be the fourth broad-scale reduction in physicians' and other practitioners' fees since 1992 and has brought the average increase in Medicare fees between 1991 and 2002 down to just 1.1 percent a year—or 13 percent less than the government's own estimate of practice cost inflation.

Over the last 10 years, physicians have been inundated with expensive new federal requirements and the gap between payments and costs has already led to access problems for Medicare beneficiaries in Atlanta, Phoenix, Albuquerque, Annapolis, Denver, Austin Spokane, northern California and Idaho. Experience with Medicaid has already shown the danger of unrealistic payment rates and Medicare is not immune from similar problems as has been made abundantly clear by Medicare+Choice plans' continued exodus from the program despite a guaranteed pay increase of at least 2% a year. Some 85% of elderly and disabled Americans rely on fee-for-service Medicare and for an increasing number, there is no other option available.

As devastating as the 2002 reductions in the Medicare Conversion Factor are, the College is deeply concerned about the very real possibility that there may be similar reductions in 2003. ACR, the Medicare Payment Advisory Commission (MedPAC) and other medical specialty societies agree that if changes are not made to the present conversion factor update formula, and future cuts in the conversion factor continue, the ability of physicians to continue to treat Medicare patients will be in serious jeopardy.

To address the problems described above, the "Medicare Physician Payment Fairness Act of 2001," H.R. 3351, was introduced in the House on November 27, 2001 by Rep. Michael Bilirakis (R-Fla.). This bill would create an opportunity for Congress to make systemic changes in the physician update system. Specifically, it would reduce the current $38.26 conversion factor by 0.9 percent. In addition, it would ask the Medicare Payment Advisory Commission (MedPAC) to make further refinements in the commission's earlier proposal to eliminate the expenditure target or Sustainable Growth Rate (SGR) that now helps determine annual updates in the conversion factor. HR 3351 currently has 316 cosponsors. The College fully supports this legislation.

The American College of Radiology is ready to work with the Subcommittee and all of Congress to ensure that this country's Medicare population continues to receive the care it deserves.

AMERICAN OSTEOPATHIC ASSOCIATION
February 15, 2002

The Honorable MICHAEL BILIRAKIS
Chairman
Energy and Commerce Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

DEAR CHAIRMAN BILIRAKIS: On behalf of the 48,000 osteopathic physicians represented by the American Osteopathic Association (AOA), thank you for holding the hearing "Medicare Payment Policy: Ensuring Stability and Access Through Physician Payments."

The AOA appreciates the leadership role that you and the Committee took in 2001 to try to prevent the 5.4% cut in the Medicare fee schedule from taking place on January 1st. We continue to support strongly the "Medicare Physician Payment Fairness Act of 2001" (H.R. 3351) and look forward to working with you and the Committee to ensure its enactment. As you know, H.R. 3351 has over 315 cosponsors. We feel that any bill with this type of bipartisan support deserves immediate action.

As you begin to formulate a strategy, and potentially draft new legislation, the AOA offers the following recommendations:

- Immediately halt the 5.4% Medicare payment cut;
- Repeal the sustainable growth rate (SGR) system;
- Replace the Medicare payment update formula with a new system that reflects increases in practice costs, increased utilization and other relevant factors; and
- Work with the House Budget Committee to ensure that appropriate funds are set-aside in the budget resolution to replace the Medicare physician payment update formula, beginning in 2003.

The AOA also requests that the Committee seriously consider the recommendations made by the Medicare Payment Advisory Commission (MedPAC) regarding the development of a new payment formula. The AOA supports the MedPAC proposal and urges its consideration by the Committee.

Mr. Chairman, the AOA appreciates the invitation you extended to Congressman Doug Bereuter to share his thoughts on Medicare payment inequities. We have long supported legislation that would remove the geographic disparities in Medicare reimbursements. The AOA supports Rep. Bereuter's "Rural Equity Payment Index Reform Act" (H.R. 3569). It was evident by comments made during the hearing that a number of Committee members are concerned about payment policies that adversely effect rural areas. H.R. 3569 would raise all localities with a physician work adjuster below 1.000 to a floor of 1.000 over a five-year period. We believe that H.R. 3569 provides an opportunity to improve health care in rural areas and we encourage the Committee to consider it during its deliberations.

Mr. Chairman, thank you for the leadership you have displayed on these and many other health care issues. The AOA stands ready to assist you and the Committee. Please contact Shawn Martin, Director of Congressional Affairs at (202) 414-0147 for additional information.

Sincerely,

JAMES E. ZINI, D.O.
President

cc: The Honorable W.J. Tauzin
The Honorable John Dingell
The Honorable Sherrod Brown
Members, Energy and Commerce Health Subcommittee
AOA President-Elect
AOA Board of Trustees
Chairman, AOA Council on Federal Health Programs
Members, AOA Council on Federal Health Programs
AOA Executive Director
AOA Senior Staff
AOA Department of Government Relations

AMERICAN PHYSICAL THERAPY ASSOCIATION
WASHINGTON, D.C. 30036
February 12, 2002

The Honorable MICHAEL BILIRAKIS
Chairman
House Energy and Commerce Committee
Health Subcommittee
2125 Rayburn House Office Building
Washington DC 20515

The Private Practice Section of the American Physical Therapy Association ("APTA-PPS") thanks you for your leadership in holding the February 14, 2002 hearing entitled, "Medicare Payment Policy: Ensuring Stability and Access through Physician Payment." APTA-PPS represents over 3,300 privately practicing physical therapists nationwide who have been negatively impacted by the reductions in the physician fee schedule announced by the Centers for Medicare and Medicaid Services ("CMS") last fall. As you know, while the term "Medicare Physician Fee Schedule" implies that the payment methodology principally affects physicians, physical therapists are also reimbursed pursuant to the fee schedule and accordingly suffer financially as a result of decreases in fee schedule payments. This is particularly problematic for many of our members who practice in rural areas where they are often the only source of critical rehabilitative care.

On November 1, 2001, CMS unveiled final payment policies and payment rates under the fee schedule for physicians and non-physician practitioners who treat Medicare beneficiaries. Among other things, the regulation included a 5.4 percent across the board reduction in payments for services including physical therapy. According to CMS, new economic data from a slowing economy and high levels of expenditures for practitioners' services produced a negative update for the base practitioner fee calculation for calendar year 2002. As a result, the factor used to update payment rates for individual services has gone down by 4.8 percent, and the conversion factor is still lower—5.4% below 2001 levels. The 5.4% decrease in the conversion factor became effective on January 1, 2002 and privately Practicing physical therapists are now feeling the financial pinch. CMS Administrator Scully has said

that CMS cannot address this problem without legislative authority. For this reason, Congress must act.

The Section strongly supports the tenants of the "Medicare Physician Payment Fairness Act of 2001" (HR 3351 and S 1707.) Despite strong support, this legislation, which would have reduced the cut in 2002 to 0.9% and required the Medicare Payment Advisory Commission ("MedPAC") to report to Congress on a replacement for the sustainable growth rate ("SGR") formula, did not pass last year. Nevertheless, we support legislation this year to lessen the impact of the 5.4 percent reduction in payments and to ease the burdens these reductions have placed on private practice physical therapists and their patients. The Section is aware of the recently issued Medicare Payment Advisory Commission recommendations on the physician fee schedule and the SGR formula and is currently reviewing them.

We commend the House Energy and Commerce Committee for holding this hearing and look forward to working with the Committee to ensure that our nation's Medicare beneficiaries receive the quality of care they deserve and to ensure that physical therapists are reimbursed at a level that will enable them to continue providing such care.

Sincerely,

JOHN HENDRICKSON
APTA-PPS President

AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY
MANCHESTER, MASSACHUSETTS
February 13, 2002

The Honorable MICHAEL BILIRAKIS
Chairman
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

DEAR CHAIRMAN BILIRAKIS: On behalf of the more than 7,000 members of the American Society for Gastrointestinal Endoscopy (ASGE), I am pleased to have the opportunity to submit these comments for the record of the hearing on Medicare physician payment issues scheduled for February 14. We greatly appreciate the Subcommittee's interest and concern about the problems that exist within Medicare's physician fee schedule. We strongly urge the Subcommittee to address these problems this year.

ASGE recommends that Congress act quickly to address several key issues in the physician payment system.

Congress should make every effort to immediately restore the conversion factor as suggested in H.R. 3351, the "Medicare Physician Payment Fairness Act of 2001". The technical changes and adjustments needed to create a new update mechanism will not be in place until 2003; however, physician practices are today living with the reduced resources that came from the current method of calculating the conversion factor. The crisis in professional liability insurance costs that is affecting physicians in a number of states is only one of many reasons to act this year.

The way Medicare updates the physician fee schedule each year is wrong. No other segment of the health care industry has experienced the same kind of swings in payment as physicians, who have watched their conversion factor rise by 4.5% in 2001 only to fall by 5.4% this year. Any notion that Medicare payments would be reasonably predictable went out the window with the current reduction. The fact that many observers anticipate a similar drop in the 2003 conversion factor calls for quick action by Congress. MedPAC and the physician community will soon make detailed recommendations for changes to the current sustainable growth rate system that governs the annual adjustments. We urge Congress to move rapidly to implement them.

It is very important to get to a payment system that has predictable outcomes and determines those outcomes in a manner that is easily understood. The system must accurately measure the factors that drive the cost of physician services. This does not exist in the current arrangement, and it is time to correct that failure.

Congress needs to take on the problem of the site of service differential in the physician fee schedule. This failed policy understates the value of procedures provided in hospitals and ambulatory surgery centers (ASC). This creates incentives to move services out of the hospital and ASC where quality of care is regulated, into

the unregulated office, without carefully examining whether the office should be the venue of choice.

ASGE recommends that the Centers for Medicare & Medicaid Services (CMS) either eliminate the site of service differential or make certain that the safety requirements for all settings are equal. Hospitals and ambulatory surgery centers must meet certain safety standards. None of these apply in the office setting; yet the risks of performing the procedure are equal in all settings.

The problems in Medicare's physician fee schedule are exacerbated by the current difficulties with the implementation of the hospital outpatient department prospective payment system. Despite Congressional efforts to address the needs of new technology and to correct problems with the way the Medicare rates are calculated, it was still necessary to delay the effective date of the 2002 rates. Nearly 60% of all gastrointestinal endoscopic services for Medicare beneficiaries are provided in the outpatient department, and many of them use newer technologies that should be subject to pass through payments. ASGE members are very concerned that this new Medicare system threatens the economic stability of hospital outpatient departments and that new medical advances will not be widely available to patients if hospitals cannot recover their costs.

ASGE is also concerned with the health of the ambulatory surgery center (ASC), where many endoscopic procedures are performed safely and effectively. CMS has not updated the list of procedures that will be covered when performed in that setting since 1995. This means that these centers are hard pressed to remain technologically current, and can no longer provide the level of care that Medicare beneficiaries have a right to expect. Congress needs to press CMS on this issue so that Medicare certified ASCs could once again provide modern medical care.

ASGE believes that a crisis has been building in the Medicare physician fee schedule since its establishment in 1992. The current reduction of 5.4% in the conversion factor is just the most recent example. The misguided effort to develop new practice expense relative value units continues to distort payments, as reimbursement for complex physician services provided in the hospital declines, while payments for simpler work done in the office increases dramatically. This shift cannot be sustained if we are to continue providing high quality, technologically superior care in the hospital. It is time for Congress to address this imbalance. A further irony is the fact that even with the shift in dollars, compensation for many office based services is still too low because Medicare can't, or won't, accurately account for the true costs of providing medical care.

Striking evidence of the failures of the fee schedule can be found in the low rates of colorectal cancer screening among Medicare beneficiaries, in the current debate over payments for outpatient cancer care, and in the numerous requests by Congress for the General Accounting Office to evaluate various problems arising in the payment system.

The physician fee schedule is not channeling Medicare's investment into the services and procedures that can save lives and improve the quality of life for our nation's senior citizens. Congress needs to make sure that Medicare resources are directed to assure that beneficiaries maintain ready access to life enhancing and live saving procedures. Our senior citizens expect nothing less.

Immediate action on these problems will go a long way to restore physician and patient confidence in Medicare. Failure to respond will only create more concern among those individuals dependent upon the program for their medical care. ASGE urges prompt action this year on these issues.

Thank you for your careful consideration of these views. I request that this letter be made part of the formal record of the hearing.

Sincerely,

DAVID A. LIEBERMAN, M.D.
President

PREPARED 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 Energy and Commerce Subcommittee on Health on the need to replace the Sustainable Growth Rate (SGR) methodology used to calculate the update for Medicare payments under the Physician Fee Schedule ("physician payment update"). We believe the SGR should be replaced with a methodology that assures adequate payments and stable updates for physicians who participate in Medicare. Appropriate and stable physician payments would ensure that Medicare beneficiaries have access to the complex and specialized care provided by academic physicians.

The AAMC comprises 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% of the nation's hospitals) operate certified trauma centers in conjunction with academic physician partners. Over one-quarter of our teaching hospital members offer burn care, about 89% provide AIDS treatment, and 77% deliver geriatric care (eg, treatment for Parkinson's or Alzheimer's disease) in partnership with faculty practices.

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

FLAWS IN THE 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% and 4.5% respectively), the 2002 payment update of negative 5.4% 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 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 specialty care 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% of a medical school's

total revenue, unstable Medicare payments could jeopardize beneficiary access to specialty care, as well as academic medicine's core missions of medical education, research, clinical services, and providing charity care.

As disparity grows between the costs of caring for patients and the rates at which payers reimburse for those costs, medical schools and teaching hospitals find it increasingly difficult to maintain their missions. Since private payers often tie their own rates to those set by Medicare, reductions in Medicare payments could drive additional declines in reimbursement.

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% to minus 0.9% and long-term relief by directing MedPAC to develop a replacement for the SGR.

The AAMC strongly endorses these bills and we applaud the Subcommittee's leadership—Chairman Bilirakis (R-FL) and Ranking Member Brown (D-OH)—for sponsoring H.R. 3351. We are pleased that a majority of Congress, including nearly all Energy and Commerce Committee members, are cosponsors of the bill. The AAMC and the deans of 86 medical schools—who have signed a letter on behalf of their faculty practices in support of S. 1707/H.R. 3351—thank you for your support and urge your continued leadership to ensure that the losses currently experienced by physicians are mitigated as quickly as possible.

In conclusion, Medicare beneficiaries—including those dually eligible for Medicaid—rely on academic physicians and academic medical centers to provide high quality, innovative, and accessible healthcare. They also rely on faculty physicians to develop the clinical advances and train the new generation of Medicare providers 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 you 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.

Thank you for your consideration.

COALITION FOR FAIR MEDICARE PAYMENT
WASHINGTON, D.C. 20005
February 14, 2002

The Honorable MIKE BILIRAKIS,
Chairman, Subcommittee on Health,
Committee on Energy and Commerce

DEAR CHAIRMAN BILIRAKIS: The Coalition congratulates you and ranking minority member Brown for your leadership in scheduling today's hearing on Medicare physician payment policy. We know that the testimony the Subcommittee will hear from physician and non-physician provider groups will demonstrate the seriousness of the looming access crisis brought about by the recent negative update in reimbursement under the Medicare Fee Schedule.

For almost all Coalition member organizations, the negative update represents only part of this critical problem. As you are aware, most physicians have recently experienced radical increases on the cost of professional liability insurance, and over the past four years, most surgical specialties represented in the Coalition have undergone very significant cuts in their reimbursement for practice expenses under the Fee Schedule.

Congress has the opportunity to help, now, by immediately halting the 5.4% Medicare reimbursement cut that took effect last month. Well over 300 members of the House have cosponsored S. 3351, introduced by you and Mr. Brown with the direct support of Committee Chairman Tauzin and Ranking Committee Minority Member Dingell. We urge early action on this feature of the bill.

The Coalition equally supports replacement of the current Medicare update formula with one which fully reflects increased annual costs to physician and non-physician providers in delivering care. We look forward to working with you on this issue in the weeks and months ahead.

Sincerely,

MICHAEL SCOTT, CHAIR
Coalition for Fair Medicare Payment

NATIONAL ASSOCIATION OF REHABILITATION PROVIDERS AND AGENCIES
RESTON, VIRGINIA 20190-5202
February 22, 2002

The Honorable MICHAEL BILIRAKIS
Chairman
House Energy and Commerce Committee
Health Subcommittee
2125 Rayburn House Office Building
Washington DC 20515

The National Association of Rehabilitation Providers and Agencies ("NARA") would like to thank you for your leadership in holding the Subcommittee's recent hearing entitled, "Medicare Payment Policy: Ensuring Stability and Access Through Physician Payment." NARA represents the interests of Medicare-certified rehabilitation agencies that furnish physical therapy, occupational therapy, and speech-language pathology services to Medicare beneficiaries. Many NARA members are small businesses that have experienced a significant negative impact from the fee schedule reductions announced by the Centers for Medicare and Medicaid Services ("CMS") last fall.

The term "Medicare Physician Fee Schedule" suggests that the payment methodology principally affects physicians. However, rehabilitation agencies that provide services to Medicare beneficiaries are also paid under the fee schedule pursuant to the Balanced Budget Act of 1997. The cuts have been particularly problematic for many of NARA's members who are small businesses operating in rural areas.

On November 1, 2001, CMS announced final payment policies and payment rates under the fee schedule for physicians and non-physician practitioners who treat Medicare beneficiaries. The regulation included a 5.4 percent across the board reduction in payments for services including physical, occupational, and speech-language pathology. The use of new economic data from an economy in recession and high levels of expenditures for practitioners' services have produced a negative update for the base practitioner fee calculation for calendar year 2002. Thus, the conversion factor is 5.4% below 2001 levels—a decrease that is severely impacting NARA's members.

NARA strongly supports the tenets of the "Medicare Physician Payment Fairness Act of 2001" (H.R. 3351 and S. 1707,) which despite strong support, did not pass last year. Nevertheless, we support legislation this year to lessen the impact of the 5.4 percent reduction in payments and to ease the burdens these reductions have placed on therapists and their patients. NARA is aware of the recently issued Medicare Payment Advisory Commission recommendations on the physician fee schedule and the sustainable growth rate ("SGR") formula, and is currently reviewing them.

The Administration has made it clear that it views payment adjustments through reforms in payment policy as something that must be budget neutral in both the short and long term. Given these budget constraints, we commend you for giving this matter priority and for holding this hearing. We look forward to working with the Subcommittee to ensure that our nation's Medicare beneficiaries receive the quality of care they deserve and that therapists are reimbursed at a level that will enable them to continue providing such care.

Sincerely,

GERALD GOLDSTEIN, MSA, *President*
National Association of Rehabilitation Providers and Agencies

---

RESPONSES FOR THE RECORD OF WILLIAM J. SCANLON, U.S. GENERAL ACCOUNTING OFFICE

QUESTIONS FROM HON. MICHAEL BILIRAKIS

Question 1. With the 5.4 percent negative update for physician payments this year, the rationale behind paying for physician services differently than other Medicare covered services has come into question. It seems as though there would be merit in having consistent payment methodologies across different service categories. What makes physician services different? Why was a different payment methodology put in place for physician services?

The principle behind Medicare's payment systems is to pay providers fairly and efficiently to achieve the ultimate goals of ensuring that beneficiaries have appropriate access to quality care and that the program remains sustainable in the long run. The consistent application of this principle may require tailoring payment systems to fit the circumstances different providers face. Currently, Medicare's payment systems vary across types of providers. Some have comparable elements, but

there are also divergent features to reflect differences in types of providers and services. In all cases, Medicare should establish and maintain appropriate payment levels that take these circumstances into account and reimburse providers fairly for the services they deliver.

The current physician payment method, which includes the use of spending targets, was introduced after Medicare spending on physician services grew at an average annual rate of more than 12 percent per beneficiary through the 1980s. Previous attempts to limit spending growth had only limited success because of large increases in the volume and intensity of services provided by physicians. The Congress recognized that expenditure growth of this magnitude was not sustainable and created a payment update mechanism that makes use of spending targets to curb Medicare expenditures for physician services.

Question 2. The current physician fee schedule update system includes a spending, or expenditure, target. Is it possible to reconcile the need for a spending target with assuring that payments keep pace with the needs of Medicare beneficiaries and the cost of providing care? Please explain. Are there other ways to address growth in the volume and intensity of services provided? If so, please provide a detailed description of these alternatives.

Under the current system, spending targets increase as the number of beneficiaries grows and the cost of providing services Uses. In addition, targets increase to permit real spending per beneficiary (volume and intensity) to grow as fast as the overall economy.

The current payment system was created after attempts to limit spending growth by moderating fee increases alone were unsuccessful. Spending targets have been in effect since 1992. Since that time, the volume and intensity of physician services has grown at an average annual rate of about 2 percent—much lower than prior periods—while virtually all physicians treated Medicare beneficiaries or, if accepting new patients, accepted those covered by Medicare.

Any payment system needs to be revisited periodically to ensure that it is still meeting its objectives. It is important, for example, to monitor service use in order to ensure that beneficiary access continues to be secure as updates change. Spending targets should always be viewed within the context of beneficiary needs. Targets may need to be periodically adjusted based on a reassessment of the spending necessary to ensure that Medicare continues to meet the needs of beneficiaries.

Question 3. The sustainable growth rate (SGR) system and its reliance on the gross domestic product (GDP) have been widely criticized. Specifically, cities have cited the failure of GDP to take into account the health status, the aging of the Medicare population, costs of technological innovations, or escalating costs of operating a medical practice. Why is GDP a part of the SGR system? Should the annual increase in the expenditure target for physician services be limited by the rate of GDP growth? Why or why not?

GDP is only one of four factors that determine the SGR expenditure targets. The other factors are included to help account for some of the cost-related elements you mentioned. They include the changes in the cost of inputs used to produce physician services (as measured by the Medicare Economic Index (MEI)), the number of Medicare beneficiaries in the traditional fee-for-service program, and the estimated effect that changes in laws or regulations win have on spending. The Congress designed the expenditure target formula to allow for increases in the volume and intensity of services delivered to each beneficiary. By including GDP in the formula, the Congress permitted volume and intensity to grow at the same rate as the economy. This decision reflects a policy choice about how much of the increase in society's wealth should be spent on physician services. In linking this growth to GDP, the Congress created a balance between growth in volume and intensity on the one hand and the need to limit growth in Medicare spending on the other hand. Without such limits, there is nothing to keep spending on physician services from consuming an increasing proportion of Medicare dollars and the federal budget. As I indicated earlier, however, it is important to periodically revisit the SGR target to ensure it remains aligned with beneficiaries' needs.

Question 4. With positive updates in 2000 and 2001 and flow a negative update in 2002, it is clear that the sustainable growth rate (SGR) system is some what uncertain. Should the SGR system be replaced? Is there any way to modify the current update system to make it less volatile and more predictable? For example, would a five-year average of GDP growth help? In your testimony, you mention narrowing the statutory update limits. Currently, they are 3 percentage points above MEI and 7 percentage points below MEI. How would you suggest the limits be narrowed?

My testimony outlined two ways the current update system could be made less volatile. First, greater rate stability could be achieved by revising how adjustments to the MEI are determined. For example, the current bounds of plus three and

minus seven percentage points around the MEI could be narrowed. Another approach would be to limit the adjustment as a share of the change in MEI—say to no more than a 75 percent increase or decrease. Alternatively, a hold harmless provision could be implemented to prevent rate decreases. Finally, some combination of these types of changes could be adopted. Any of these kinds of changes could increase rate stability, but they might also increase the amount of time necessary to bring actual spending in line with targeted spending.

Second, the update system could be made less volatile by linking spending targets to average increases in GDP over several years rather than a single year. By neither significantly lowering spending targets during a downturn nor unduly increasing them in a period of prosperity, spending targets would be less variable in the short term.

Question 5. To improve the precision of the measurement of prices within the SGR system, should additional factors that affect the cost of delivering physician services be included, such as new technology, aging of the Medicare population, site of service shifts, the intensity of services provided in physician offices, the preferences and needs of beneficiaries, and changes in physician practice patterns? If so, which factors should be included and why?

The Centers for Medicare and Medicaid Services (CMS)[1] uses the MEI to measure changes in physicians' cost of providing services. The MEI is a weighted average of annual price changes for inputs used to provide care, including physician time and effort (work), non-physician employees, and office expenses, and is adjusted for changes in labor productivity.

It is important that the MEI remain current—reflecting the changes in the cost of delivering services, including differences in the use of equipment and sites of service delivery. The Medicare Payment Advisory Commission has recommended that productivity adjustments should reflect all the factors involved in producing physician services, not just labor, and we agree with that recommendation.

The SGR system includes the changes in real per capita GDP to provide an allowance for growth in the volume and intensity of services that can reflect, in part, the health of the population and the development of new valued services. Accounting for changes in the age distribution of the Medicare fee-for-service population in the annual payment update formula would be feasible, but would require estimating which segment of the overall Medicare population will remain in the fee-for-service program and could introduce the kind of estimation errors that have been problematic this year. Estimating the cost effect of the aging of the entire Medicare population is straightforward, but these changes are likely to be gradual and so may be better addressed through periodically revisiting the appropriateness of the overall target. It may also be interesting to note that as the large number of baby boomers start to join Medicare, the average beneficiary age and hence, cost per beneficiary, will initially decline.

Question 6. In your testimony, you highlighted the need for improved data to monitor the effect of the negative update on beneficiary access to care. How would you suggest such data be improved?

Ensuring that the use of spending targets does not compromise appropriate access to services is a key concern. As I mentioned in my testimony, more timely data on beneficiary access and physician participation in the program are essential to monitoring the adequacy of program payments. Data are also needed that allow evaluation of beneficiary access at the state and local level to detect access problems that could be masked by national aggregation. By regularly reviewing Medicare claims data, CMS could quickly detect changes in providers' billing patterns and potential beneficiary access problems. CMS would need to make information from claims available more quickly, but increased data timeliness is also an imperative for overall program management improvements.

The advantage of using claims data to monitor access is that it could help to identify potential access problems in specific locations or among certain specialties. In addition, claims data are already collected for payment purposes. Information from claims data could be augmented with information gathered from a beneficiary survey, such as the Medicare Current Beneficiary Survey, to determine the extent to which supplemental insurance coverage, income levels, or other factors also affect beneficiary access to physician services.

---

[1] In June 2001, the agency formerly known as the Health Care Financing Administration (HCFA) was renamed the Centers for Medicare and Medicaid Services (CMS). These responses refer to the agency as HCFA when discussing actions taken before the name change and as CMS when discussing actions taken since the name change.

QUESTIONS FROM HON. CHARLIE NORWOOD

Question 1. Do you believe that physicians are, generally, reimbursed at a rate that is below the cost of the treatment provided?

Unlike other providers, physicians do not file cost reports that can be used to compare the costs of providing physician services to Medicare payments. A physician's time is the largest single component of the cost of his or her services. On average, 55 percent of the fees in Medicare's fee schedule are for physician work. Given this inability to compare payments and costs for physician services, the question that needs to be asked in setting payments is whether they are sufficient to secure appropriate access. Payment rates that are too low can impair beneficiary access to physician services, while payment rates that are too high add unnecessary financial burdens to Medicare.

Information on physicians willingness to see Medicare patients is dated but overall indicates that providers are willing to accept Medicare patients, and thus Medicare payment for services. However, as I discussed in my testimony, more timely data are critical to monitoring beneficiary access to the program and responding if data indicate that access is jeopardized. As health needs change, technology improves, or health care markets evolve, spending targets and resulting payment rates may need to be adjusted periodically to ensure appropriate payment rates and beneficiary access to services. Informed decisions about appropriate payment rates and rate changes cannot be made unless policymakers have detailed and timely data on beneficiaries access to needed services.

Question 2. Do you believe that is the case for any specific physician or any specific treatment?

Medicare's physician fee schedule establishes payments for more than 7,000 different services, such as office visits, surgical procedures, and treatments. Since 1992, HCFA, now CMS, has been phasing in a new fee schedule that bases the payment for each service on the amount of resources used to provide that service relative to all other services.[2] The implementation of the resource and methodology for determining practice expense has been the subject of considerable controversy, partly because of HCFA's adjustments to the underlying data and basic method and partly because payment changes were required to be budget-neutral—which means that total Medicare spending for physician services was to be the same under the new payment method as it was under the old one.

As a result, if Medicare payments to some specialties increased, payments to other specialties had to decrease.

As we discussed in our October 2001 report on physician practice expense payments, such redistributions have in fact occurred, prompting concern from various specialties that their revised practice expense payments, a component of the total physician payment, are too low.[3] Oncologists (cancer specialists) claim that their practice expense payments are particularly inadequate for certain office-based services, such as chemotherapy administration. In that October 2001 report we made several recommendations regarding the determination of the practice expense component of the physician fee schedule. One of the effects would be to increase payments to oncologists for some services. We believe that implementing these recommendations would help ensure that practice expense payments better reflect differences in the costs of providing services. At the same time, we recognize the limitations of the data used to set fees. We are working on a reported mandated by the Congress to assess how these data can be improved.[4] That report will be issued later this year.

QUESTIONS FROM HON. SHERROD BROWN

Question 1. Under the current payment formula for physician services, the Sustainable Growth Rate (SGR) acts as an expenditure target. In other words, the SGR works to control the growth in Medicare payments for physician services. Could you explain exactly how this works and how an expenditure target is different from a cap on expenditures?

---

[2] The Medicare physician fee schedule has three components: the physician work component, the practice expense component, and the malpractice component. In 1999, the three components accounted for approximately 55 percent, 42 percent, and 3 percent, respectively, of the average fee.

[3] *Medicare Physician Fee Schedule Practice Expense Payments to Oncologists Indicate Need for Overall Refinements* (GAO-02-53, Oct. 31, 2001). This study was mandated in section 213 of the Medicare, Medicaid, and SCIHP Balanced Budget Refinement Act of 1999 (P.L. 106-113, Appendix F, 113 Stat. 1501, 1501A-350).

[4] The study was mandated in section 411 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554, Appendix F, 114 Stat. 2763, 2763A-508).

The SGR sets overall spending targets for physician services and is used to determine fees for services paid for under the physician fee schedule so that, over time, total spending equals the spending targets. The target under the SGR system for a given year is not considered a cap because it can be exceeded in that year. The SGR target does not limit expenditures, but rather is taken into account when setting payment rates for the next year. The fee schedule update reflects the success or failure in meeting the spending target. If prior expenditures have exceeded the established target, the update for the upcoming year is reduced. If expenditures were less than the target, the update is increased.

Question 2. The SGR, or expenditure target on payments for physician services, is intended to control the volume and intensity of services provided. Has the growth in volume and intensity of services actually been controlled, and, if so, was it due to the SGR or other factors?

As my testimony indicated, between 1992 and 2000, volume and intensity grew at an average annual rate of about 2 percent. In contrast, between 1985 and 1991, immediately before the introduction of spending targets, volume and intensity of services per beneficiary increased at an average annual rate of about 9 percent. Because a number of changes may have affected spending for physician services, it is impossible to isolate the precise effect the SGR has had on growth in volume and intensity of services provided. However, the SGR and its predecessor the Volume Performance Standard were designed and implemented to impose discipline on the growth in volume and intensity of physician services. Because the use of the spending targets to set payment rates coincided with a period of slowed growth in volume and intensity, the role of targets cannot be dismissed as an important factor in controlling growth in Medicare spending for physician services.

Question 3. At the hearing, several witnesses stated that Medicare payments for physician services need to reflect the actual costs of providing services to beneficiaries. However, Medicare has moved away from cost-based reimbursement. Congress does not necessarily want to return to basing payments on costs, which does not encourage efficiency. Could you explain how payments that reflect the costs of providing services are different than cost-based reimbursements

The cost-based reimbursement that Medicare has wisely moved away from is one where individual providers could increase their revenues by increasing the costs of delivering services. It was inherently inflationary and has been recognized as such for decades. At the same time, it is necessary to have payments that reflect the costs of delivering services. Otherwise, providers may not be willing to deliver services and we may not be able to ensure appropriate beneficiary access to those services.

The difference between the new method of setting payments to reflect costs and the old method of malting payments based on reported costs, is that under the new method individual providers cannot increase their revenue simply by reporting higher costs. The hospital prospective payment system (PPS) is a prime example. Before the PPS, each hospital was paid its actual costs of providing services, subject to certain limits. Payments under the PPS reflect the average costs of delivering particular services for all hospitals in an earlier period of time. The payments are updated to reflect changes due to inflation, service delivery, and other factors, to ensure that they continue to reflect the costs of an efficient provider.

Question 4. I have heard concerns voiced about the current way we evaluate beneficiary access. The best indicator we have for beneficiary access today in 2002, is a survey of beneficiaries from 1999. Whether or not seniors had access to doctors in 1999 seems a poor measure of whether seniors will have access in 2002, when reimbursements have changed significantly. How do we get better measures of beneficiary access and participation? Or are we stuck with relying on old data and anecdotes and trying to guess what's going on?

Ensuring that the use of spending targets does not compromise appropriate access to services is a key concern. As I mentioned in my testimony, more timely data on beneficiary access and physician participation in the program are essential to monitoring the adequacy of program payments. Data are also needed that allow evaluation of beneficiary access at the state and local level to detect access problems that could be masked by national aggregation. By regularly reviewing Medicare claims data CMS could quickly detect changes in providers' billing patterns and potential beneficiary access problems. CMS would need to make significant improvements in the timeliness of the availability of information from claims, but those improvements are also imperative for improved overall program management. Our prior work on the state of information technology systems at CMS indicated that malting

necessary improvements to these crucial systems may require a larger administrative budget.[5]

The advantage of using claims data to monitor access is that it could help to identify potential access problems in specific locations or among certain specialties. In addition, claims data are already connected for payment purposes. Information from claims data could be augmented with information gathered from a beneficiary survey, such as the Medicare Current Beneficiary Survey, to determine the extent to which supplemental insurance coverage, income levels, or other factors also affect beneficiary access to physician services.

Question 5. A number of witnesses on the second panel mentioned that they are particularly concerned with how the 54% cut in physician payments could hurt access to care for beneficiaries living in rural areas. Could you discuss how this cut could disproportionately affect beneficiaries living in rural areas? Does CMS have any data on how this payment reduction could affect beneficiaries living in rural areas?

GAO does not have data to evaluate whether the physician payment reduction in 2002 will disproportionately affect beneficiaries in rural areas. I expect that CMS would have difficulty generating these data as well. Your question highlights the need for CMS to monitor claims data to detect potential access problems at the community level.

Queston 6. Many people, including the Medicare Payment Advisory Commission, are recommending that Congress eliminate the SGR and replace it with another formula to calculate updates to physician payments. However, there isn't a clear answer as to what the SGR should be replaced with. Could you outline some of the questions that Congress needs to answer in developing a replacement for the SGR system? What type of information does Congress need before making decisions, and what type of policy questions will Congress need to answer?

As I outlined in my testimony, a physician payment update policy must balance concerns about program sustainability with the need to maintain adequate payment rates to ensure that beneficiaries have access to physician services. Because the paramount consideration in setting payment rates is ensuring appropriate beneficiary access to services, timely and detailed data on Medicare beneficiary service use are essential to achieving this balance. Congress could consider whether CMS currently has the resources to generate these data in a timely manner and communicate the importance of this task to the agency.

Since targets were established, spending growth for physician services that was viewed as unsustainable has been greatly moderated. Before considering a completely new system, Congress may want to consider whether modifications to the SGR system could address its perceived shortcomings, such as year-to-year rate instability. When contemplating an entirely new system, Congress may want to consider whether the new system will be able to restrain spending growth and help ensure the long-term sustainability of the program. The approach Medicare tried before 1992 constrained fee increases, but not overall spending.

RESPONSES FOR THE RECORD OF THEODORE LEWERS, TRUSTEE, AMERICAN MEDICAL ASSOCIATION

QUESTIONS FROM CHAIRMAN BILIRAKIS:

Question 1. In your testimony, you mentioned that errors made by the Centers for Medicare and Medicaid Services (CMS) in 1998 and 1999 have shortchanged physicians by $20 billion to date. Could you explain this further? It was my understanding that CMS is required by statute to correct past projection errors. Is that not the case? What happened with the 1998 and 1999 errors? How do these past errors factor into this year's payment reduction?

In annually calculating the SGR, estimates by the Centers for Medicare and Medicaid Services (CMS) for GDP growth and enrollment changes in 1998 and 1999 have shortchanged funding for physicians' services by $20 billion to date. CMS projected that Medicare+Choice enrollment would rise by 29 percent in 1999 and that fee-for-service enrollment would fall by 4.3%, 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 the costs of treating about 1 million beneficiaries. Nevertheless,

[5] *Medicare: Information Systems Modernization Needs Stronger Management and Support* (GAO-01-824, Sept. 20, 2001).

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. Without these 1998 and 1999 projection errors, the 5.4% Medicare payment cut in 2002 would have been smaller, and, unless remedied, these errors will continue to negatively impact annual physician updates.

CMS acknowledged its 1998 and 1999 projection errors at that time, but concluded it did not have the authority under the law to correct its mistakes. We disagreed, and supported a clarification under the Balanced Budget Refinement Act of 1999 (BBRA) requiring CMS to fix past projection errors as actual data becomes available. The BBRA, however, applied with respect to SGR projections after the 1999 update.

Question 2. In your testimony, you indicated strong support for repealing the sustainable growth rate (SGR) and replacing it with an inflationary adjustment. However, in the past, the American Medical Association (AMA) has supported refining the SGR to reduce payment volatility, including the adoption of a five-year average for growth in the gross domestic product (GDP) and the tightening of current statutory update limits. How would these refinements reduce payment volatility? Are these options the AMA continues to support?

While those refinements might reduce payment volatility, they would not eliminate the possibility of multi-year payment cuts that put elderly and disabled Americans' access to high quality health care at risk. In fact, CMS is currently projecting such a wide divergence between target and actual spending that narrowing the limits on payment updates would mean only that physicians would face perhaps a decade-long payment freeze instead of the current projection of a nearly 20% cut over four years.

Further, refining the sustainable growth rate (SGR) would leave in place the current expenditure target system, which is a flawed concept. The AMA has always been opposed to this type of system. Simply tinkering with the SGR formula will not remedy the fact that if the Medicare program is not adequately funded, physicians will be forced to ration care to their patients. Further, maintaining a payment update system that is linked to the U.S. Gross Domestic Product (GDP) is inherently flawed. The GDP is a measure of the economy that bears little relationship to the health needs of Medicare beneficiaries. Indeed, incidence of disease does not lessen with downturns in the economy.

The improvements to the payment update formula that were part of the Balanced Budget Act of 1997 (BBA) and the BBRA were as much change as we were able to accomplish at those times. It is apparent, however, that even these refinements to an expenditure target system have not eliminated the problems with the target. We agree with MedPAC that the goals of controlling patients' use of services while maintaining payment updates that keep up with the cost of inflation are simply incompatible.

Question 3. The current physician fee schedule update system includes an expenditure target. It is my understanding that the target was put in place to curb spending growth due to significant increases in the volume and intensity of physician services provided in the 1980s. You testified in strong opposition to an expenditure target system. Are there other ways to address growth in the volume and intensity of physician services provided? If so, please provide a detailed description of these alternatives.

Physicians' services are the only segment of the Medicare program that are subject to an expenditure target. No other provider is paid on this basis. An expenditure target assumes that physicians have a collective incentive to control the volume of services. This is incorrect, however, because aggregate spending targets do not create direct incentives for any individual physician.

In large part, the volume and intensity of physician services is driven by technological advances and other improvements in clinical practice that have extended and improved the lives of Medicare beneficiaries. Any restrictions on the availability of such services to the elderly should be determined through national policy and not by individual physicians who are trained, and indeed have a Hippocratic Oath, to provide appropriate treatment for each of their patients. Imposing an expenditure target that attempts to ration care indirectly is failed public policy.

If CMS believes that some new services are not of any benefit to the elderly, it need not approve coverage for these services. If, on the other hand, CMS believes physicians are providing services that are not necessary in individual cases, it has a wide array of tools—such as utilization review and physician profiling—available to detect and eliminate abusive billing practices.

Question 4. The Medicare Economic Index (MEI) is a common component of both the SGR system and the proposed update system you have discussed in your testi-

mony. You have identified a number of flaws in the current composition of the MEI. How can the MEI be improved so that it more accurately represents increases in the cost of operating a medical practice, including premium rate increases.

In the early 1970s, 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. Indeed, physicians have very limited ability to increase productivity. Economic and societal factors have forced physicians to see and treat as many patients as possible within a single day. At a certain point, it is virtually impossible to increase productivity through increased patient visits or medical procedures.

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.

We agree with the general framework of MedPAC's recommendations. We also believe that MedPAC should be directed to look at other aspects of the MEI—such as the treatment of liability insurance premiums, which we do not believe are adequately reflected under the current formula—to determine if additional changes are needed. We look forward to working with the Subcommittee to implement the details of a new payment update system.

Question 5. At its January meeting, the Medicare Payment Advisory Commission reported that there is no evidence indicating that beneficiary access has been impaired as a result of the 2002 negative update. For example, most physicians are still participating in Medicare. However, much of the testimony today mentions access. How do you reconcile this? Is there an access problem?

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." Clearly, the 5.4 percent cut is significantly lower than 0.1 percent.

The 5.4% cut took effect on January 1, and MedPAC met on January 16 and 17. It was at this time that MedPAC reported that there is no evidence indicating impaired beneficiary access. Yet, there was virtually no way that the Commission could have had any information on how the negative update was affecting access at that time. In fact, what the Commission concluded in January was that access seemed to be adequate in **1999** and that there was insufficient information to draw a conclusion about access at the current time. In its just-released annual report, MedPAC said that "payments for 2002 may be too low raising concerns about beneficiary access to care."

Further, although it may be too early to clearly understand the full impact of this cut, there are early warning signs that must be recognized and that indicate significant problems. For example, 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. In addition, there have been many press reports about reduced access resulting from the 5.4% cut that are very alarming. We have attached a sampling of those reports for your review.

Further, CMS predicts that under the current system the updates over the next three years will be, respectively, -5.7, -5.7 and -2.8. This is roughly a 20% cut in Medicare payments over 4 years (2002 through 2005), and this number increases to almost 30% when you account for medical inflation. Moreover, the 2005 conversion factor predicted by CMS would be lower than the conversion factor in 1993. **Physicians will be paid less in 2005 than they were in 1993.** A 20 to 30 percent pay cut over four years would add to the already significant pressures on physicians to discontinue or limit the provision of services to Medicare patients.

Question 6. With positive updates in 2000 and 2001 and now a negative update in 2002, it is clear that the current update system is volatile and unpredictable. How would you fix the physician fee schedule update system to prevent instability in payment changes from year to year and ensure that Medicare beneficiaries continue to receive the quality care they deserve?

As discussed above, we wholeheartedly agree with MedPAC's recommendations to replace the SGR system. We believe that the current update system should be replaced with one that:

- Eliminates the use of the SGR or any other expenditure target;
- Uses a more realistic productivity assumption in calculating the MEI; and
- Bases annual updates primarily on the revised MEI but allow MedPAC to recommend and Congress to adopt higher or lower updates.

We look forward to working with the Subcommittee and Congress on the details of a new payment update system that better reflects increases in practice costs.

QUESTION FROM RANKING MEMBER BROWN:

Question 7. Many providers are concerned about Medicare payment reductions that are scheduled to occur this year or next. In some cases, these are reductions that were enacted in the Balanced Budget Act of 1997 (BBA). In other cases, these reductions will occur because temporary payment increases implemented since the BBA are scheduled to expire. However, it seems that the problem with the physician payment system is different. In this case, there are major problems with the underlying formula used to update payments to physicians. Instead of figuring out how to offset a planned reduction, Congress is going to have to figure out how to rewrite a formula. Could you comment on how the problem with physician payments is unique.

The two giveback bills, the BBRA and the Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act of 2000 (BIPA), generally adjusted specific payment updates for hospitals, home health agencies and other providers that had been set by Congress in the BBA. Congress does not set physician updates; they are set by a formula that runs on automatic pilot. Legislation to address the physician update problem would replace a system with the flaws in the underlying payment structure. This is needed to ensure that Medicare payments appropriately reflect increases in practice costs. Otherwise, as CMS predicts, the current system will produce negative updates over the next three years, which would be, respectively, -5.7, -5.7 and -2.8. This comes to almost a 20% cut in Medicare payments over 4 years (2002 through 2005), and this number increases to almost 30% when you account for medical inflation. The 2005 conversion factor predicted by CMS would be lower than the conversion factor in 1993. Congress did not intend for the SGR payment system to pay physicians less in 2005 than they were in 1993. Further, a 20 to 30 percent pay cut over four years would add to the already significant pressures on physicians to discontinue or limit the provision of services to Medicare patients, thereby creating a significant access problem.

QUESTIONS FROM REPRESENTATIVE NORWOOD:

Question 1. Do you believe that physicians, generally, are reimbursed at a rate that is below the cost of the treatment provided?

Question 2. Do you believe that is the case for any specific physician or any specific treatment?

In many cases, Medicare payments are below the cost of providing a service. More significantly, however, is the fact that over the last 11 years, Medicare payments to physicians have been significantly less than increases in practice costs. The 5.4% cut, effective on January 1, 2002, 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).

Further, CMS predicts that under the current system the updates over the next three years will be, respectively, -5.7, -5.7 and -2.8. This is roughly a 20% cut in Medicare payments over 4 years (2002 through 2005), and this number increases to almost 30% when you account for medical inflation. Moreover, the 2005 conversion factor predicted by CMS would be lower than the conversion factor in 1993. **Physicians will be paid less in 2005 than they were in 1993.** A 20 to 30 percent pay cut over four years would add to the already significant pressures on physicians to discontinue or limit the provision of services to Medicare patients.

These cuts impact all physicians and other health care practitioners whose rates are tied to the physician fee schedule, as well as the health system as a whole. For example, many physician practice plans affiliated with an academic institution provide substantial support to the teaching program. We understand that the current cuts, as well as any potential future cuts, are seriously impacting these practice plans. This, in turn, can impact the viability and quality of the teaching program, which has far-reaching implications.

In addition, the Marshfield Clinic in Wisconsin recently reported, based on their internal analysis, that the Clinic recovers only about 70% of its costs in providing Medicare Part B services, and, that for FY 2002, Medicare revenue will decrease as a percent of costs to approximately 68.5%. Further, the Medical Group Management Association (MGMA) conducted a survey of its members and found that average total operating costs from 1999 to 2000 increased by 6.2%.

Finally, these Medicare cuts are exacerbated by the fact that physicians are experiencing sharp increases in professional liability premiums.

These trends cannot be sustained.

RESPONSES FOR THE RECORD OF MARTHA MCSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDCARE

QUESTIONS OF HON. MICHAEL BILIRAKIS

Question 1. In your testimony you state that "the parts of the country that are designated Health Professions Shortage Areas (HPSAs) or Medically Underserved Areas (MUAs) are also the areas with the lowest physician reimbursement." Cay you explain this further? Is there data that indicates beneficiaries in these areas already have greater barriers to access to care?

Areas that are designated Health Professionals Shortage Areas, for a variety of reasons have not attracted sufficient numbers of physicians. Although some of them are urban areas with sufficient Medicare physician reimbursement levels, many of them are in fact rural areas. Rural areas in particular have low levels of Medicare physician reimbursements. Many members of the Subcommittee on Health of the Energy and Commerce Committee remarked during their opening statements that their rural districts have very low Medicare physician reimbursements levels. The situation is the same with Medically Under served Areas, those areas with insufficient numbers of all health care providers. Far too many of them are rural areas with low Medicare physician reimbursement. The problem feeds on itself: Medicare reimbursements stay low, or decrease (as happened this year), therefore physicians do not locate in these areas, and they remain HPSA and MUA.

Question 2. Have your members seen a different in access between primary and specialty care physicians? If so, do you know why?

They have not reported any difference to us.

Question 3. With positive updates in 2000 and 2001 and now a negative update in 2002, it is clear that the current update system is volatile and unpredictable. How would you fix the physician fee schedule update system to prevent instability in payment changes from year to year and ensure that Medicare beneficiaries continue to receive the quality care they deserve?

Medicare beneficiaries need a system that will ensure they continue to have access to quality care. This means access to a physician and sufficient time with the doctor as well. We believe Congress, with advice from MedPac, physicians groups and other knowledgeable parties, can arrive at a formula that is fair to beneficiaries, physicians and taxpayers. These are the parties most appropriate to determine how to fix the formula

QUESTIONS OF HON. CHARLIE NORWOOD

Question 1. Do you believe that physicians are, generally reimbursed at a rate that is below the cost of the treatment provided?

No, not generally. However, with inflation the cost of everything goes up, not down. Certainly, physicians cannot have cuts in payments when their cost of operations is going up.

Question 2. Do you believe that is the case for any specific physician or any specific treatment?

As a consumer and beneficiary organization, we only hear from Medicare beneficiaries. Our members have not reported this to us. We have not heard from physicians.

QUESTIONS OF HON. SHERROD BROWN

Question 1. Medicare fee-for-services is the plan of choice for about 85 percent of seniors. In any given year, almost all seniors receive Part B services, the most common of which are physician service. Given these facts, it is particularly important that Congress work on revising the physician payment formula to ensure that payments are appropriate. Otherwise, we could end up in a situation where tens of millions of beneficiaries are at risk due to instability in Medicare physician payments.

What do you think could happen to seniors if large numbers of physicians either dropped out of Medicare of decided not to accept new Medicare patients?

This would certainly create a crisis situation for seniors. The doctors who continue to accept Medicare would quickly find their practice full, reaching the saturation point they would not be able to accept any more patients. We know that seniors could not self-pay; most are on low fixed incomes. Nor should they have to self-pay this was the situation Medicare was designed to prevent. Seniors would have no place left to go for treatment. Without physician management, senior's chronic conditions would quickly escalate to acute episodes requiring long in hospital stays or surgery. Persons with high blood pressure would have strokes, persons with heart problems would have heart attacks and those with diabetes would have all of the complications that result from that disease. Treatment in hospital for acute epos ides and for surgery cost far more than years of routine physician visits. This would ultimately cost the Medicare system far more than increasing payments to physicians.

Question 2. If Congress does not fix the problem with the physician payment formula in the Medicare fee-for-service system, I worry that physicians could decide to drop out of the Medicare program. I'm afraid that we could end up with a have-and-have-not situation, where seniors with less money would have less access to physician services than seniors who can pay physicians with private funds. One of the fundamental tenets of the Medicare program is that all seniors are treated equally, regardless of their ability to pay. How important is it for Medicare to ensure that seniors of all income levels have access to the same level or care?

This is crucial. We don't want to develop 2 Medicare systems, one for the rich and one for the poor. In fact, Medicare was developed to ensure that all seniors have access to the same level of quality care. We don't want to means test Medicare.

Question 3. Physicians and other practitioners—including nurse practitioners, physician assistants, and more—are really the foundation of the Medicare fee-for-service system. We need to maintain adequate payments for these providers so we can keep the fee-for-service system strong. Could you elaborate on how important the fee-for-service Medicare program is to seniors?

The Medicare fee-for-Service system is literally a lifesaver for seniors. As you stated, 87% of seniors remain in the traditional Medicare program, enrollment in Medicare Plus Choice plans is down from an all time high of 15% down to 13%. This is despite years of CMS trying to attract Medicare Plus Choice plans and trying to enroll beneficiaries in the plans. Plans have proven to be very unbelievable; they withdraw from particular coverage areas, raise premiums and copays and decrease benefits. The Medicare Plus Choice Plans have throw the lives of many seniors into total disarray by abruptly dropping hundreds of thousands of seniors from their plans leaving these seniors scrambling to find alternative coverage. Fortunately, fee-for-service Medicare was there to provide essential coverage. What would almost one million seniors (933,000) have done in 2001 if traditional Medicare were not there when the Medicare Plus Choice Plans withdrew? We must make sure seniors never have to face this by keeping traditional Medicare strong and viable. The M+C experience proves we cannot rely on private companies to provide critical lifesaving coverage for seniors. Private companies are about profits. We cannot rely on private companies to ensure high quality health care; this is our collective responsibility as a people, otherwise know as the government's responsibility. Therefore, alternatives can be made available, but the bedrock of Medicare must be fee-for-service and we must continue to strengthen and improve this program.

RESPONSES FOR THE RECORD OF ALLISON WEBER SHUREN, THE AMERICAN COLLEGE OF NURSE PRACTITIONERS

RESPONSES TO QUESTIONS PRESENTED BY THE HONORABLE MICHAEL BILIRAKIS

Questions #1: In your testimony, you talk about "practices that will stop offering vaccines, other injections, and blood drawing services as they simply can no longer afford to do so." What options are left for beneficiaries to obtain these necessary services?

Response #1: Though the 5.4% cut is a very recent change, members of the American College of Nurse Practitioners (ACNP) are reporting that it is already affecting access, and the willingness or ability of nurse practitioners and physicians to invest in additional personnel, equipment, and other inputs. We have heard repeatedly of practices that will stop offering vaccines, other injections, and blood drawing services as they simply cannot afford to do so. For example, an NP in New York informed us that her practice is planning on cutting certain conveniences already,

such as offering laboratory and EKG services on site. As a result, Medicare beneficiaries will now be required to go to an outside laboratory and to a Cardiologist for an EKG. Beneficiaries now will be forced to travel in order to have such diagnostic tests, and our members fear that many Medicare beneficiaries will simply choose not to have necessary procedures performed.

Question #2: You are representing nurse practitioners—allied health professionals who are padia set percentage of the physician fee schedule. Are there other allied health professionals whose payment rates are based on the physician fee schedule? If so, please identify them.

Response #2: A number of allied health professionals receive payments under the Medicare program that are based upon the physician fee schedule. According to Section 1833 of the Social Security Act, the allied health professionals who are reimbursed under the Medicare program and the percentages they receive of the physician rate are listed below:

a. Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Medical Nutrition Therapists are reimbursed at 85% of the physician rate.
b. Certified Nurse Midwives are reimbursed at 65% of the physician rate
c. Certified Registered Nurse Anesthetists are reimbursed at 80% of the physician rate
d. Psychologists are reimbursed at 80% of the physician rate
e. Clinical Social Workers are reimbursed at 100% of the physician rate for covered diagnostic tests (according to the *Part B Answer Book,* 2002 Edition)
f. Assistants at Surgery are reimbursed at 85% of the physician rate
g. Occupational and Physical Therapists are reimbursed at 100% of the physician rate

Question #3: You have identified a number of flaws in the current composition of the Medicare Economic Index (MEI). How can the MEI be improved so that it more accurately represents increases in the cost of operating a medical practice, including premium rate increases?

Response #3: There appears to be broad support for a number of steps Congress can take to address the existing concerns with the Medicare Economic Index (MEI). First, the MEI must be refined to include non-labor productivity as a factor. At present, the MEI only recognizes growth in labor productivity. In addition, the MEI must also be adjusted to be a forecast that reflects cost changes for the coming year and take into account, among other things, the tremendous increases in malpractice premiums being experienced in state after state; increased practice operational costs; and the expenses associated with developing, implementing and maintaining compliance programs; and the new HIPAA Privacy Standards. When the government imposes additional burdens on providers, the MEI must reflect the real cost of complying with those burdens.

Question #4: The current physician fee schedule update system includes an expenditure target. It is my understanding that the target was put in place to curb spending growth due to significant increases in the volume and intensity of physician services provided in the 1980s. You testified in strong opposition to an expenditure target system. Are there other ways to address growth in the volume and intensity of physician services provided? If so, please provide a detailed description of these alternatives.

Response #4: The Medicare Payment Advisory Commission (MedPAC) released a report in March 2001 encouraging Congress to replace the SGR. In light of this recommendation, MedPAC also addressed the issue of controlling spending for physician services, with which we concur. The report states, "If volume growth reemerged as a concern, a better strategy might depend on: 1) trying to achieve appropriate use of services through outcomes and effectiveness research; 2) disseminating tools for applying this research, such as practice guidelines; and 3) developing evidence-based measures to assess the extent to which knowledge is being applied (PPRC 1994)."

Question #5: I appreciate your support of this Committee and our efforts to reform the methodology behind the update for physician services. In your testimony, you list several steps Congress can take to address the current situation. How would you prioritize those and how would you rank the costliness of those priorities?

Response #5: Our recommendations as reported at the February 14 hearing in order of priority are: 1) Remove and replace the SGR system. 2) Refine the MEI to include non-labor productivity as a factor; 3) Adjust the MEI to be prospective in nature rather than retrospective; and 4) Correct erroneous estimates from previous years—the current situation permits such arbitrary and capricious results that taint the system and undermine basic confidence in the Medicare program.

We understand that modifying the system to alleviate the 5.4% cut may entail a considerable price tag; however, Congress must take action. Even if providers and

practices are able to withstand a one time 5.4% cut, the compounding nature of reimbursement cuts as projected by the Centers for Medicare and Medicaid Services (CMS) for the next five years is staggering. According to CMS projections, providers will be operating at a -18.3% cut by 2005. The estimated decline in reimbursement will make it impossible for providers to operate within the Medicare program, thereby damaging our seniors insurance system and threatening the access to care they deserve.

Question #6: With positive updates in 2000 and 2001 and now a negative update in 2002, it is clear that the current update system is volatile and unpredictable. How would you fix the physician fee schedule update system to prevent instability in payment changes from year to year and ensure that Medicare beneficiaries continue to receive the quality care they deserve?

Response #6: The Sustainable Growth Rate (SGR) system must be eliminated. The automatic spending target mechanism needs to be replaced with a mechanism whose focus is to, in some rationale manner, determine the increased or decreased costs associated with providing services. As currently structured, the spending target operates as an automatic tax on physician fee schedule providers that can jeopardize the availability of health care to our elderly without any benefit of Congressional debate, nor an opportunity for providers, patients, and patient advocates to discuss whether such a cut or other alternatives are appropriate from a policy perspective. Why are health care professionals automatically singled out to bear a disproportionate burden of a diminished Gross Domestic Product? We have no problem with health care providers sharing in the burden to balance federal expenditures in tough budget times, but we should have the opportunity at those moments to engage with Congress and the public regarding alternatives to such cuts, and the pertinent policy issues driving the perceived need to decrease Medicare payment rates--particularly, where the cut is so devastating as to risk the ability of the program to protect the very individuals it was designed to assist.

RESPONSES TO QUESTIONS PRESENTED BY THE HONORABLE CHARLIE NORWOOD

Question #1: Do you believe that physicians are, generally, reimbursed at a rate that is below the cost of the treatment provided?

Response #1: The Balanced Budget Act of 1997 granted Nurse Practitioners the statutory authority to bill directly under the Medicare program, but according to the Social Security Act, Nurse Practitioners are only reimbursed at 85% of the physician rate for delivering the exact same services. Therefore, Nurse Practitioners automatically receive a lower Medicare reimbursement for the services performed.

Furthermore, Nurse Practitioners and physicians who provide, or who are part of groups that provide, technical component services such as ultrasound and other basic diagnostic testing for their Medicare beneficiaries, experienced an additional 4 to 6 percent cut in practice expense reimbursement associated with these services this year. This cut was implemented by CMS without any notice in last year's proposed rule, and became apparent only after health care providers around the country began to calculate payment rates based on the Final Fee Schedule published November 1, 2001. Given the instability of the update factor and the practice expense formula, Nurse Practitioners cannot help but fear additional cuts next year unless these problems are addressed. If the update factor suffers another 3% decrease next year that would leave Nurse Practitioners, just 10 months from now, receiving as much as 23% below the level of reimbursement that other providers received just two months ago. If we consider the change in payment for technical component services that number could rise to 29%.

In addition, in sharing your question with our members, we received various feedback. Some members mentioned specific treatments which they felt are underpaid, while others stated that everything under the Medicare program is reimbursed well below the accepted range of payment.

Question #2: Do you believe that is the case for any specific physician or any specific treatment?

Response #2: ACNP members shared a number of specific examples of services whose Medicare reimbursement rates do not cover the cost of the treatment. Our members comments are listed below:

"..flu influenza immunization. CMS reduced the payment this year at the same time the cost of the immunization went up 27%!!! The flu immunization program immunization rates have decreased over the past two years per CMS claims data...Therefore, many providers are not providing this service for their patients."

"I can say that services provided for these [subacute] patients under the Medicare Skilled Nursing regulations are under-reimbursed. We struggle to keep this much needed, very effective, program going."

"I think that e&m [evaluation and management] codes for nursing home rounds are underpaid for NPs (99311, 99312, 99313, 99301, 99302, 99303)."

"Everything we do is reimbursed at well below the accepted range of payment—and that's when we get paid."

"I think reimbursement for any medicare visit is too little, especially for primary care. We do a lot with physicals, scheduling bone density tests, mammograms, colonoscopies, etc. All of this teaching, planning and time spent doing a physical, health promotion is given little credit."

RESPONSES FOR THE RECORD OF THOMAS R. RUSSELL, AMERICAN COLLEGE OF SURGEONS

QUESTIONS FROM THE HONORABLE MICHAEL BILIRAKIS

Question 1. The Medicare Economic Index (MEI) is a common component of both the current sustainable growth rate (SGR) system and the proposed update system you have discussed in your testimony. You have identified a number of flaws in the current composition of the MEI. How can the MEI be improved so that it more accurately represents increases in the cost of operating a medical practice, including premium rate increases?

The purpose of the MEI is to measure changes over time in the prices of the various components involved in providing physician services. The American College of Surgeons believes that the current MEI methodology contains technical deficiencies and urges Congress to direct the Secretary of Health and Human Services (HHS) to make needed changes. As you know, the MEI is important because it is the basis for the annual inflation updates to the physician fee schedule.

Over the last several years, the College has shared its MEI concerns with the Health Care Financing Administration (HCFA) and the Centers for Medicare and Medicaid Services (CMS) in commenting on proposed agency regulations and in other communications, but the problems persist. We do not believe that the MEI as currently structured provides an appropriate measure on which to base annual adjustments in the physician fee schedule.

The MEI continues to have essentially the same structure that it has had since its inception in 1972. Today, however, the Medicare program pays for physician services totally differently than it did in 1972. At that time, physicians were paid their reasonable charges, and the MEI's principal role was to limit the portion of the annual increases in charges that Medicare would recognize in its reimbursement. The portion of charges not recognized by Medicare was owed by the beneficiary. In contrast, physicians today are paid based on a government-set fee schedule, and—importantly—physicians face strict limits on the amount that can be balance-billed to the beneficiary. The College strongly believes that HCFA should reexamine the structure of the MEI rather than continue to make only minor changes in an index that was developed 30 years ago in a different Medicare payment context. At a minimum, we urge four changes.

Recommendation—The price proxy used to measure changes in the physician earnings component of the MEI should be the employment cost index (ECI) for professional workers, not the average hourly earnings (AHE) for total non-farm workers.

The component of the MEI designed to track changes in the cost of the physician work component of the fee schedule uses the average hourly earnings of all *non-farm workers* rather than the more appropriate category of all *professional workers.* To support its use of the non-farm worker category as the proxy, CMS has cited Committee report language from 1972. The report language states that "*it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality*." And, "*. . . Initially, the Secretary would be expected to base the proposed economic indexes on presently available information on changes in expenses of practice and general earnings levels*." CMS also states its own conclusion that "*there is an obvious concern about circularity if increases in prevailing charges are linked to increases in physician charges, which are then tied to increases in physician income*."

The College disagrees with the CMS position and emphasizes two points: (1) the Committee's concern about charge-based reimbursement is not relevant since implementation of the resource-based physician fee schedule; and (2) an index based on the earnings of *all* professional workers would have been sufficient to address the Committee's concern because physicians comprise a small proportion of all professional workers. Because physicians represent less than 3 percent of all professional workers in the economy, the circularity point is without basis. The College also

notes that, in contrast, a significant portion of the hospital market basket, which is used as the basis for the annual update in the inpatient prospective payment system (PPS) rates, derives from the actual wages and salaries of civilian hospital workers. If there is any case to be made regarding circularity, this would seem to be the prime candidate.

The College believes it would be much more appropriate for Medicare to use the rate of growth in the incomes of all professional workers as the basis for adjusting payments to physicians, rather than using an index based on all non-farm workers in the economy. According to CMS estimates used in its most recent rulemaking on the MEI, basing the physician earnings portion of the MEI on increases in the incomes of all professional and technical workers would have produced an average annual MEI of 2.4 percent for the period 1992-1997, compared to an average 2.2 percent under the all-worker proxy used by HCFA. The College strongly urges the Committee to direct CMS to make this long overdue change effective January 1, 2003.

Recommendation—The non-physician employee compensation component of the MEI should be adjusted using a price proxy that reflects the increase in skill mix in physicians' offices.

CMS acknowledges that there has been a substantial shift in the skill mix in physicians' offices over the last few years, yet it continues to measure price changes using an economic statistic that holds the skill mix constant. The agency's rationale for this decision is that the use of higher skilled labor reflects the fact that work formerly performed in the hospital is now done in ambulatory settings. CMS continues its reasoning as follows: "*Skill mix shifts that reflect rising intensity of outputs in physician offices are automatically paid for by higher charge structures for the more complex mix of service inputs. Physicians performing more complex services may hire more skilled employees, and, thus, may tend to charge more for their services.*"

The College does not understand the CMS argument, or its relevance to physician reimbursement under the fee schedule. Medicare pays for physician services based on rates set by the government, not based on charges. In addition, much of the increased care provided by surgeons in their offices is for the post-surgical care of patients. These office visits cannot be separately billed under Medicare policy because they are included in the global surgical period. It is clear, however, that responsibility for much of this portion of patient care has shifted to the physician office as patients are discharged from the hospital significantly earlier in their recovery than in the past. These patients' care requirements are significantly greater and they necessitate both a higher skill mix in physicians' office staff and the use of more costly supplies and equipment. Physicians' services to these patients are supported by their own office resources not by hospital staff and supplies as was the case when hospital stays were longer.

The College emphasizes that payments under the Medicare fee schedule already fail to cover physicians' actual practice expenses, a gap that has widened for surgeons under the recently implemented resource-based formula for practice expenses. And the problem is compounded by the agency's continuing failure to recognize shifts in skill mix in its design of the MEI. We urge the Committee to direct CMS to remedy this problem by adopting an index, such as one based on the average hourly earnings of health care workers, that recognizes skill mix shifts. This change also should be effective January 1, 2003.

Recommendation—The productivity adjustment should be removed from the MEI and treated as one of the other factors affecting the cost of providing physician services.

The MEI, liked the hospital market basket, is an index designed to measure changes in prices affecting the cost of physician for services. Unlike the hospital market basket, however, the MEI is not a pure price index because it includes an offset for increased productivity. The offset was included originally for technical reasons to avoid paying physicians twice for productivity improvements: once in wage growth reflected in the MEI and a second time in the additional services they are able to provide due to their enhanced productivity.

In its March 2002 report to Congress, the Medicare Payment Advisory Commission (MedPAC) also recommended removing the productivity adjustment from the MEI. The College agrees with MedPAC that productivity improvements should be considered as part of the other factors affecting the cost of providing physician services. These other factors, which include items such as changes in medical science and technology, site of service, practice patterns and patient severity, often will tend to more than offset productivity growth. Removing productivity would make the MEI a pure form of what it is intended to be: a price index. It also would make

the measure consistent with the market basket indices used for other Medicare services such as hospitals and nursing homes.

The College believes that CMS could implement this change January 2003 and urges the Committee to direct the agency accordingly.

Recommendation—Medicare should use a forecast of the MEI to make the annual update adjustments to the physician fee schedule.

Currently the fee schedule update for a calendar year is based on changes in the MEI that occurred two years prior. This practice causes an unnecessary lag in the MEI update and means that it does not reflect current experience. When malpractice premiums are skyrocketing as they currently are, the MEI is woefully out-of-date and will take two years to catch up. The College believes that this is both unacceptable and unnecessary. Looking again to the hospital market basket as a model, this index is used on a forecast basis to make the annual updates in hospital rates under both the inpatient and outpatient prospective payment systems. Future updates are adjusted for the forecast error made in earlier estimates.

The College urges the Committee to direct CMS to change the way the MEI is used to measure price changes so that it is a forecast of the change in the MEI for the coming year. Forecast errors would be accounted for in future years' adjustments. This change should be implemented January 2003.

In summary, the College strongly believes that the MEI as currently used by CMS does not provide an adequate basis for updating the physician fee schedule. The agency continues to rely on decisions it made in the early 1970s about the appropriate structure of the index although implementation of the physician fee schedule and limiting charge has dramatically changed the way physicians are paid and created a different context for the MEI.

Question 2. The SGR system compares cumulative total spending for physician services with a spending target. It is my understanding that the target was put in place to curb spending growth due to significant increases in the volume and intensity of physician services provided in the 1980s. Are there other ways to effectively address growth in the volume and intensity of physician services? If so, please provide a detailed description of these alternatives.

The College understands that Medicare, like other healthcare payers, wants to reimburse only for services that are necessary to provide quality healthcare to its beneficiaries. The program seeks mechanisms that promote appropriate utilization and financial accountability. But your question about how to achieve this is a very difficult one. Before sharing our thoughts on your question, I would like to address two assumptions that underlie mechanisms like the SGR and its predecessor, the Medicare Volume Performance Standard (MVPS).

The first assumption of these approaches is that physician spending is out-of-control, that unnecessary services are being provided. Data from the CMS actuaries show that from 1985 through 2000, allowed physician charges per aged Medicare enrollee grew at an average annual rate of 6.1 percent. Since implementation of the physician fee schedule in 1992, the average annual increase has been 4.1 percent (1992-2000). By comparison, hospital outpatient spending per enrollee increased an average annual 9.6 percent from 1985 through 2000 and an average annual 7.7 percent from 1992 through 2000. For both of these periods, average annual increases in physician spending were about 3.5 percentage points lower than the comparable increases for hospital outpatient spending. In other words, growth in physician spending has been low to moderate. Regarding the corollary assertion that physicians are providing unnecessary services, there simply are no data or other evidence to corroborate this.

The second assumption is that the SGR is an effective system to control physician spending. It is not. Although it is true that the SGR can reduce Medicare spending by imposing onerous price cuts as it is doing this year, there is no evidence that it promotes more appropriate utilization. In fact, going back to its predecessor, the MVPS, many have questioned whether such mechanisms can provide an incentive for appropriate utilization of physician services. Critics believe the approach is fundamentally flawed and note several problems that negate any incentive value. For example, because the target is national in scope, no single physician or physician practice can effectively control whether the target is met. [For this reason, the original Medicare fee schedule legislation included an option for group volume performance standards that would allow group practices to opt out of the national system and be subject to separate targets set for the group. This option has not been implemented.]

Beyond these very fundamental structural problems are other serious issues: the scope of the SGR includes services other than physician services, further weakening incentives; the target is set not based on the need for physician services, but on arbitrary external factors like economic growth; adjustments based on the SGR are

made as much as two years after the fact—too far removed to affect behavior; when the adjustments are actually made, they could make payments in that year inappropriately low or unnecessarily high.

Policies like the SGR are crude attempts to control spending based on arbitrary expenditure targets. Better strategies are needed to support appropriate utilization and discourage unnecessary utilization of services. The College does not have a magic bullet for such a strategy. This is a difficult issue that has perplexed physicians and insurers for years. We do believe, however, that the solution lies in the collection and use of better information and appropriate models of care. For example, the government, in collaboration with physicians and others, should continue to develop evidence-based models of care and techniques to gauge the extent to which the models are being applied. The goal should be, as MedPAC has observed, to achieve appropriate use of services through outcomes and effectiveness research and through the dissemination of tools, such as practice guidelines, for applying this research.

The College also believes that the medical community can make much greater use of data that compares treatments and results with appropriate care models and with experience of other practitioners. These data should be used as part of a non-threatening, continuous quality improvement program, not to hit physicians over the head or penalize them. Physicians are highly committed professionals who seek the best for their patients. Physicians will respond to comparisons and other information. We live in an information age of rapidly increasing capacity and creativity, yet the practice of medicine is only recently beginning to take advantage of the opportunity that information technology affords. The College strongly believes that this is the path to pursue. It is a course that will not threaten beneficiary access to needed services, unlike the path of expenditure targets.

Question 3. With positive updates in 2000 and 2001 and now a negative update in 2002, it is clear that the SGR system is volatile and unpredictable. How could you fix the physician fee schedule update system to prevent instability in payment changes from year to year and ensure that Medicare beneficiaries continue to receive the quality care they deserve?

To address the many problems caused by the SGR and the current fee schedule update mechanism, the College urges the Committee to adopt the approach contained in the MedPAC recommendations. This is an approach modeled on the update mechanisms used for other Medicare services. Moreover, it is policy that has been applied since 1982 for hospital inpatient services without instability in payment levels or other major problems.

Recommendation—Eliminate the SGR update methodology and replace it with an annual update based on factors influencing physicians' costs of efficiently providing patient services. The update formula should not include any performance adjustment factor based on an expenditure target.

Like MedPAC, the College believes that the physician update should be based exclusively on Medicare beneficiaries' need for services and the cost of providing those services. Access to physician services under Medicare and payment for those services should not be limited, or even threatened to be limited, in any manner that could impede beneficiary access to the high quality care that Medicare has made possible for 36 years. Physician services provide the core of all patient care. They are essential for achieving quality care and, in addition, we believe they are the most cost-effective of all services included in the Medicare program.

Under this recommendation, MedPAC and the Secretary would establish an update framework similar to ones used for other Medicare services. In addition to changes in input prices (as measured by the MEI), the framework would include components to reflect changes in all other factors affecting the cost of delivering physician services. These other factors include changes in the volume and intensity of physician services due to new technology, site of service shifts, and practice patterns, among others. Physician updates would be based solely on beneficiary needs and the cost of providing physician services. **I emphasize that under this recommendation, the SGR would be repealed and it would not be replaced with any expenditure target or similar adjustment mechanism.**

MEDICAL GROUP MANAGEMENT ASSOCIATION
March 6, 2002

The Honorable MICHAEL BILIRAKIS, *Chairman*
House Committee on Energy and Commerce
Subcommittee on Health
Washington, DC 20515-6115

DEAR CHAIRMAN BILIRAKIS: Please find attached, MGMA's answers to member questions related to MGMA board member Dr. Susan Turney's testimony before the Health Subcommittee during its February 14, 2002 hearing regarding Medicare Payment Policy.

Again, thank you for holding the hearing on this important issue. If MGMA can be of further assistance concerning this or any other matter, please feel free to contact Anders Gilberg, MGMA government affairs representative at 202-293-3450

Sincerely,

WILLIAM F. JESSEE MD CMPE
President & CEO

QUESTIONS FROM CHAIRMAN BILIRAKIS:

Question: In your written testimony you mentioned that the impact of the 2002 payment cut will be felt beyond the Medicare program can you elaborate on this?

Many private health insurance plans that contract with Medical Group Management Association members' group practices use the Medicare Resource Based Relative Value System (RBRVS) as a benchmark to set private rates. Practices often negotiate contracts with insurers as a percentage of Medicare. In addition, a number of state Medicaid programs use the Medicare reimbursement framework as a proxy to set and annually update payment rates. As a result, any change to the Medicare RVUs and/or conversion factor will be felt beyond Medicare as other private and public payers adjust their rates accordingly.

The ripple effect of the cut can be further illustrated using the Marshfield Clinic as example. Marshfield Clinic derives revenue principally from physician services, and its sources of revenue are limited to Medicare, Medicaid, BadgerCare (Wisconsin program for uninsured families), commercial insurance, and payments made by individuals who are not covered by any commercial or public source. Payments from Medicare, Medicaid and BadgerCare are regulated and fall considerably short of the cost of providing the services. Medicare is the largest component of the public payer mix. Medicare shortfalls require the Clinic to increase commercial charges to offset the losses created by federal programs. This is particularly challenging in areas where Medicare beneficiaries are in greater relative abundance, because the losses are spread across a relatively diminishing population of workers and individuals.

The crisis in Medicare reimbursement is becoming increasingly precipitous, as more and more seniors transition into the Medicare program, overwhelming other sources of revenue. Nationwide, according to the National Bipartisan Commission on the Future of Medicare there are presently 3.9 workers for every Medicare beneficiary. In the 20 county Marshfield Clinic service area, which covers more than one-third of the land mass of the State of Wisconsin, the regional micro-economy is depressed because there are only 3.04 workers for every Medicare beneficiary, a ratio not expected on a national basis by the Bipartisan Commission until 2017. In some counties in the Clinic service area the ratio is already below 2 to 1. I have enclosed a map that shows the ratios of employed workers to Medicare beneficiaries in Wisconsin.

It is also important to note that Medicare fee-for service payments in Wisconsin are among the lowest in the nation. Wisconsin's premiums for commercial insurance, on the other hand, according to the *ModernHealthCare* Dec. 24, 2001 issue, are the 7th highest in the nation, and are ranked above Maryland and DC. We do not believe that this is a coincidence.

In Marshfield's service area, Federal underpayment is one of the principle causes of high premiums for commercial insurance, and as premiums increase the number of uninsured individuals also increase. In addition, costs that are shifted to other sectors of the economy have created tensions between rural and urban providers, primary care and specialty care clinicians, doctors and HMOs, providers and the employer purchasing community, and retirees and workers. In effect federal payment shortfalls are the source of many of the problems in the health care delivery system. These problems will trouble the country until the federal government takes steps to establish parity between federal and commercial pricing.

Question: You testified that the Marshfield Clinic has been thinking about entering the Medicare+Choice market. How does the SGR system factor into the Marshfield Clinic's concerns about implementing a Medicare+Choice plan?

In 2001, the Clinic had net earnings as a percent of revenue of 1.58% on revenue of $527 million. We calculate that the revenue impact of the Medicare Payment rule will be negative $2.8 million for CY2002. In the pro forma analysis of the Medicare+Choice market and the rollout of the M+C plan the Clinic assumes that enrollment will not reach a critical mass to allow the plan to break even and expand services to needed areas until the second or third year of operation. In 2002 we expect to lose an additional $2.5 million if we enter the M+C market. With such slim margins, even very slight changes in other revenue streams take on a magnified consequence. We have assumed that we will enroll 5000 Medicare beneficiaries in the first year of operation and 5000 more in the second year. If these enrollment projections are not met the M+C plan losses may be significantly higher forcing the Clinic to exit M+C prematurely. This is not a desirable outcome for the Medicare program, Medicare beneficiaries in M+C or traditional Fee-for-Service, or for the Marshfield Clinic.

Question: In your testimony you mentioned that payment volatility plays havoc with your planning and budgeting initiatives because of your slim margins. Can you help the Subcommittee understand how early in your budget planning process you need to know what the next year's Medicare update will be to enable you to properly plan and develop your budget?

Like the federal government, the Marshfield Clinic initiates budget planning for the coming fiscal year in January. In the past we have relied on update predictions announced at the Medicare Payment Advisory Commission in March and subsequently confirmed in the Medicare physician fee schedule NPRM published in June or July. Usually the Clinic budget is finalized and approved by the Marshfield Clinic's Board in August. Like the federal government, the fiscal year for the Clinic begins October 1. Changes announced in November that are significantly different from those announced in July force the Clinic to spread the impact of the period from October—January on the remaining three quarters of the fiscal year—a task made more difficult because there are fewer months in which to accomplish the expense reductions.

Question: I understand that the Marshfield Clinic serves a large rural area in northern Wisconsin. How will the current Medicare payment reduction affect your ability to serve rural communities in your service area?

As a matter of policy the Clinic provides services to everyone regardless of their ability to pay. Many rural communities that lack physician services have asked the Marshfield Clinic to provide services in their area. The Clinic has established telemedicine services to extend care into many of these areas. The problem is the cost of staffing clinic satellite locations. The largest component of the Marshfield Clinic's budget is related to staffing. The Clinic presently has 102 physician positions open and unfilled in settings where services are needed but funding is limited. Physician recruiters have advised the Clinic that it will need to pay a premium to attract the physicians it needs. Shortages in the critical medical specialties of anesthesiology, radiology, orthopedics and dermatology are driving up the costs of recruiting and resulting in delays in related areas of medical service. The Clinic also has 237 other staff vacancies in all of the fields that are essential components of a large integrated system of care. Recruiting efforts take place in local, regional, state, and national markets.

It is particularly distressing to the Clinic that the most cost effective response to the Medicare payment cut is to freeze hiring especially in the more remote areas that the Clinic serves. These areas may have significant access problems but do not have the necessary volumes of patients to make services viable. It is even more distressing that the Clinic's ability to provide charity care is further constrained by reductions in Medicare payment. Consequently Medicare payment reductions fall on those least capable of dealing with health problems. This is very shortsighted.

Question: You have identified a number of flaws in the current composition of the Medicare Economic Index (MEI). How can the MEI be improved so that it more accurately represents increases in the cost of operating a medical practice, including premium rate increases?

The MEI should be updated to include accurate measures for a number of significant costs borne by physician practices. These costs include regulatory burdens such as: increased requirements for documentation, conflicting Medicare rules, costly compliance programs, needle stick prevention rules, onerous privacy provisions, and the unfunded requirement that practices provide free interpreters for patients with limited English proficiency. In addition, practices in many states currently face a

crisis regarding premium increases for professional liability insurance. The current MEI does not accurately reflect these costs.

From 1992-2000, MGMA's national practice cost survey indicates that total operating costs per physician in an average multi-specialty group practice rose 31.7%. During that same period, the MEI increased 21.2% and, finally, Medicare payments increased only 13%. While the MEI is a more accurate reflection of real world inflation costs than recent Medicare payment updates, it should be updated to better reflect medical specific economic cost inflation.

Question: With positive updates in 2000 and 2001 and now a negative update in 2002, it is clear that the current update system is volatile and unpredictable. How would you fix the physician fee schedule update system to prevent instability in payment changes from year to year and ensure that Medicare beneficiaries continue to receive the quality of care they deserve?

No other payment system under Medicare fluctuates with the Gross Domestic Product (GDP). Only physician fees are fixed to move in line with the overall economy. As the economy fluctuates, so do physician payments under the SGR system. The fact remains that Medical costs are not necessarily tied to the growth of the overall economy

MGMA urges Congress to take three immediate steps to address the current volatile and unpredictable SGR update system.

1. Halt the 2002 5.4% reduction to the Medicare fee schedule,
2. Eliminate the current Sustainable Growth Rate system, and
3. Implement a new methodology that bases Medicare reimbursement on a formula that links annual Medicare updates to actual practice costs.

QUESTIONS FROM REPRESENTATIVE NORWOOD:

Question: Do you believe that physicians are, generally, reimbursed at a rate that is below the cost of the treatment provided?

Medicare reimbursement is significantly below the cost of providing physician services. Marshfield Clinic recently worked with the General Accounting Office to evaluate Medicare chemotherapy reimbursement and oncology practice expense payments. In conjunction with the evaluation Marshfield Clinic also conducted an internal analysis to determine to what extent the Medicare program covers the cost of providing services to Medicare beneficiaries. Our analysis demonstrates that the Clinic presently recovers only about 70% of its costs in providing Medicare Part B services. We do not believe that we are unique, but suspect that the shortfalls in Medicare revenue are common for physicians providing Medicare Part B services.

To calculate the percent of its Medicare allowed costs for which Medicare reimbursement is received, Marshfield accountants eliminated all expenses and revenues received that might potentially be questioned by the Medicare program. Our methodology for FY 2000 follows principles applied in our annual FQHC cost report that was audited by external auditors and submitted to the state. (Marshfield Clinic in conjunction with Family Health Center Inc. functions as a federally qualified health center (FQHC) under the Medicaid Program.) For the purposes of this analysis all expenses and revenues from activities such as the outreach lab, veterinary lab, research and education, rental property and optical and cosmetic surgery departments were removed. Our accountants also removed all non-Medicare "Allowed" costs related to our bad debt, interest expenses, marketing programs, government affairs activities, National Advisory Council, goodwill amortization and other miscellaneous costs.

For FY 2000 Medicare Revenue was 71.52% of Costs for Fee for Service Medicare. For FY 2001 Medicare revenue (un-audited) as a percent of costs goes down to 70.59%. For FY 2002 we project that Medicare revenue will decrease as a percent of costs to approximately 68.5%.

The current shortfall between payments and cost is in part due to payment updates that were lowered in anticipation of volume offsets. These national decisions assume that increasing volume in response to tightening reimbursement takes place uniformly across the country. To the extent that rural areas, particularly those with a shortage of physicians could not or did not participate in enhancing volume in response to tightening payment constraints they suffer a "fix" for a problem that didn't exist. We urge you to take steps to remedy this inequity as soon as possible.

Question: Do you believe that is the case for any specific physician or specific treatment?

It is difficult to answer this question definitively without a mechanism for isolating costs to specific services. Marshfield Clinic provides more than 4000 services. In aggregate we know that Medicare services are provided below cost.

The Clinic presently has 102 physician positions open and unfilled in settings where the services are needed but funding is limited. Physician recruiters have advised the Clinic that it will need to pay a premium to attract the physicians it needs. Shortages in the critical medical specialties of anesthesiology, radiology, orthopedics and dermatology are driving up the costs of recruiting for these specialties and may result in limited access to care or delays in receiving treatment by the specialist who can best address a patient's needs.

For the present discussion it is important that Congress make the distinction between payment adequacy and update adequacy. Even if Congress makes wise decisions to fix the annual physician payment updating formula, it still must address the underlying problem that the baseline from which Medicare payment starts is still significantly below the cost of providing services.

These circumstances are further aggravated in rural areas because the physician work adjuster reduces Medicare physician payments in rural localities. This disparity in payment is an aspect of Medicare law should be revised without delay.

QUESTIONS FOR ADMINISTRATOR SCULLY FROM HON. MICHAEL BILIRAKIS, CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON ENERGY AND COMMERCE

Question 1. With the 5.4 percent negative update for physician payments this year, the rationale behind paying for physician services differently than other Medicare covered services has come into question. It seems as though there would be merit in having consistent payment methodologies across different service categories. What makes physician services different? Why was a different payment methodology put in place for physician services?

Response: Based on the recommendations of the Physician Payment Review Commission (PPRC), one of MedPAC's predecessor organizations, in 1989, Congress first established a volume control mechanism in the Omnibus Budget Reconciliation Act of 1989 as part of the major reform of Medicare's payment for physicians' services. The three key parts of the legislation were: (1) a fee schedule that redistributed payments among types of services and geographic areas, (2) beneficiary financial protections (limits on balance billing); and (3) a volume control mechanism, called the Medicare Volume Performance Standard (MVPS). The MVPS was established because of the concern about large increases in expenditures for Medicare physicians' services through the 1980's. These large increases in expenditures were on top of growth in the number of Medicare enrollees and inflation.

Physicians are different from other providers in several respects. It has long been recognized that physicians are the gatekeepers to health care, influencing the volume and intensity of services they furnish as well as directing the utilization of other services. Physicians can order and receive reimbursement for services (such as lab and diagnostic tests) that they do not necessarily personally perform. In addition, Medicare's payment for providers such as hospitals, skilled nursing facilities and home health agencies is bundled. In contrast, physicians bill for each individual service provided. For example, even though spending is twice as much for hospitals as for physicians, there are about 500 units of service for hospitals in comparison to about 7,000 units of service for physicians. Under a bundled payment system, the reimbursement amount is the same regardless of the volume and intensity of services furnished. With a fee-for-service system, the system under which physicians are paid by Medicare, the total payment is dependent upon the volume and intensity of services furnished.

The MVPS was an annual system of targets. If expenditures exceeded the target, the physician fee schedule update was reduced two years later. If expenditures were less than the target, the physician fee schedule update was increased two years later. This system allowed expenditures to grow for inflation, enrollment, and any policy changes that would increase or decrease expenditures. In addition, it included an allowance based on historical volume trends for physicians' services less a "performance adjustment factor." OBRA 1993 tightened the MVPS because large performance adjustments in two years led to a belief that the MVPS was too loose.

The MVPS was replaced with the Sustainable Growth Rate (SGR) in the Balanced Budget Act of 1997. The SGR made two major changes to the nature of the system. First, the system was made cumulative. This eliminated the annual rebasing under the MVPS. That is, if expenditures exceeded the target for a year under the MVPS, the update for a year would be reduced, but for the next year, the actual base expenditures (including the excess expenditures) were the new starting point for applying the target and measuring expenditures. The SGR eliminated the annual rebasing feature. Second, like the MVPS which was based on four factors (price, population, a volume/intensity factor and policy changes that would increase or decrease

expenditures, less a performance adjustment factor), the SGR also is based on the same four factors. The difference is that under the MVPS the volume/intensity factor was the 5-year historical average of Medicare physician volume and intensity of services. SGR changed that volume intensity factor to real gross domestic product (GDP) per capita. Having accounted for price and population, real GDP per capita is the allowance for growth in the volume and intensity of physicians' services.

Question 2. The current physician fee schedule update system includes a spending, or expenditure, target. Is it possible to reconcile the need for a spending target with assuring that payments keep pace with the needs of Medicare beneficiaries and the cost of providing care? Please explain. Are there other ways to address growth in the volume and intensity of services provided? If so, please provide a detailed description of these alternatives.

Response: My number one priority is to ensure that Medicare beneficiaries have access to the care they need. That includes making sure that we maintain the fiscal integrity of the Medicare program to so that it is solvent for the beneficiaries of today and the many new beneficiaries that will soon be added as baby boomers become eligible.

The current physician spending target is intended to increase rates based on the cost of providing care with an adjustment either up or down depending upon on how expenditure growth compares to target rates of increase. In the past few years, the system led to updates that increased Medicare payment rates above inflation in physician costs. Unfortunately, for the next few years, the system will lead to adjustments below inflation in physician costs.

It is possible to reconcile the need for a spending target with assuring that payments keep pace with the needs of Medicare beneficiaries and the cost of providing care. While the SGR has largely been working as designed, it has produced large short-term adjustments and instability in year-to-year updates. One way to improve stability in the SGR system would be to substitute a multi-year rolling average of real per capita GDP in place of single year GDP used in the current system. Real per capita GDP can fluctuates in the short term and lead to large differences in the year-to-year change to physician fee schedule rates. Using multi-year real per capita GDP would link the physician expenditure growth to long run trends in economic growth with less oscillation from one year to the next in the physician fee schedule update.

Question 3. The sustainable growth rate (SGR) system and its reliance on the gross domestic product (GDP) have been widely criticized. Specifically, critics have cited the failure of GDP to take into account health status, the aging of the Medicare population, costs of technological innovations, or escalating costs of operating a medical practice. Why is GDP a part of the SGR system? Should the annual increase in the expenditure target for physician services be limited by the rate of GDP growth? Why or why not?

Response: Like the MVPS, the SGR growth target is comprised of four factors: (1) changes in prices, (2) changes in the fee-for-service population, (3) changes in the volume and intensity of services, and (4) changes in law or regulation. Under the MVPS, the volume and intensity factor was the historical 5-year average of volume and intensity of Medicare physicians' services, less 4 percentage points. The SGR changed the volume and intensity factor to the real gross domestic product (GDP) per capita.

The 1996 Annual Report to Congress from PPRC indicates the policy rationale for using real GDP per capita rather than historical physician volume and intensity as the basis for the volume and intensity factor.

> "The use of historical trends, and a fixed deduction of 4 percentage points may lead to unrealistic and arbitrary performance standards. High or low expenditure growth eventually becomes part of the historical trend in volume and intensity used to calculate the default performance standards. As a result, reducing volume and intensity growth increases the conversion factors in the short term, but lowers the performance standards over the long term, making them more difficult to meet."
>
> "Linking the performance standard formula to projected growth of real GDP per capita, instead of a five-year historical trend with a fixed deduction of 4 percentage points, would provide a realistic and affordable goal that links the budget targets to the economy as a whole. Projected GDP growth is an appropriate choice because it represents the economy's capacity to grow, while avoiding the effects of business cycles. Real, rather than nominal, GDP growth should used since the formula already accounts for input price inflation; per capita growth should be used because the formula incorporates enrollment growth."

Since real GDP per capita measures real growth in the economy, and other factors such as technology are difficult to measure, it is appropriate to base the volume and intensity component of the SGR on real GDP per capita. (In 1995 PPRC recommended adding 1 or 2 points to real GDP per capita to allow for advancements in medical capabilities.)

Question 4. With positive updates in 2000 and 2001 and now a negative update in 2002, it is clear that the SGR system is unstable. Should the SGR system be completely replaced? Is there any way to modify the current update system to make it less volatile and more predictable? For example, would a five-year average of GDP growth help? What about changing the statutory update limits?

Response: It is important to note that the SGR system is operating largely as designed, constraining the rate of growth in Medicare physician spending and linking it to growth in the overall economy, as well as to taking into account physician control over volume and intensity of services. As such, it is not necessary to do away with the SGR entirely. We need to refine it and make it more stable. Use of average of real GDP per capita over a number of years would help make the system more stable. Revision of the statutory limits on performance adjustments could also be considered.

Question 5. To improve the precision of the measurement of prices within the SGR system, should additional factors that affect the cost of delivering physician services be included, such as new technology, the aging of the Medicare population, site of service shifts, the intensity of services provided in physician offices, the preferences and needs of beneficiaries, and changes in physician practice patterns? If so, which factors should be included and why?

Response: We have examined the impact of the aging Medicare population on Medicare expenditures for physicians' services. To date, the aging of the population has had a very small effect on year-to-year changes in Medicare expenditures for physicians' services. However, it may become more important in the future as the baby boom generation becomes eligible for retirement and later as the generation ages. PPRC also studied this issue and made similar findings. At this time, the law governing physician payment is prescriptive and does not specifically allow the target to be adjusted for the aging of the Medicare population.

It is difficult, if not impossible, to measure the effect on year-to-year changes in Medicare expenditures for physicians' services that might result from changes in technology, changes in site of service, changes in physician practice patterns, or changes in the needs and preferences of beneficiaries. Basing the SGR volume and intensity factor on real GDP per capita, or growth of the overall economy, is intended to capture these factors. Real economic growth per capita was intended as a proxy for the many factors that lead to expenditure growth other than inflation, Medicare enrollment, and policy changes that could increase or decrease Medicare expenditures.

Question 6. In your testimony, you mentioned that current law does not give the Centers for Medicare and Medicaid Services (CMS) administrative flexibility to adjust physician payments when the formula produced unexpected payment updates. How would you propose addressing this inflexibility?

Response: While the SGR has largely been working as designed, it has produced large short-term adjustments and instability in year-to-year updates and, currently, projected negative updates for the next few years. The SGR system could be revised and stabilized through the use of a multi-year rolling average of the real per capita GDP factor rather than using the factor for a single year. While the current formula does not give us administrative flexibility to make changes, we want to work with Congress on changing the overall payment system in a budget-neutral way.

Question 7. In January, the Medicare Payment Advisory Commission (MedPAC) voted to recommend adjustments to the Medicare update system to better account for actual physician practice costs, including a 2.5 percent payment increase in 2003. CMS actuaries have reported that it would cost $127.7 billion over ten years to adopt the MedPAC recommendations. Please provide a detailed explanation of the basis of this cost estimate.

Response: The MedPAC proposal for updating Medicare payments to physicians would:

(1) Eliminate the Sustainable Growth Rate (SGR) system. Thus, there would be no performance adjustments beginning in 2003. In addition, the legislated adjustments from BBRA would be removed; and

(2) Use multifactor productivity in the calculation of the Medicare Economic Index (MEI), rather than the current labor productivity factor. This will increase the yearly update by 0.5 to 1.0 percent per year.

Medicare physician payments are increased on January 1 of each year by the MEI, adjusted by a performance adjustment which compares actual physician

spending to target physician spending under the SGR system. Elimination of the SGR system would result in significant increases in currently projected physician fee schedule updates. Currently, we are estimating the physician fee schedule update to be negative for each of the next four years, including updates of -5.7 percent for 2003 and 2004. MedPAC's proposal would result in physician fee schedule payments of between 2.0 percent and 2.5 percent per year. A summary of these updates is shown in the table below.

Estimated Physician Updates

[In percent]

Calendar Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Current Law	-5.7	-5.7	-2.8	-0.1	1.6	1.8	1.7	1.3	1.0	0.4
MedPAC's Proposal	2.1	2.0	2.0	2.5	2.2	2.1	2.1	2.4	2.3	2.3

In addition to the costs identified above, our actuaries assume that the underlying growth in the volume and intensity of physicians' services would be increased by 1 percent per year due to the elimination of the SGR. Since Medicare spending for physicians is currently more than $40 billion per year, there is a sizeable cost associated with large changes to the physician fee schedule update. Our actuaries estimate that this proposal will increase Medicare spending by $127.7 billion over the next ten years.

Question 8. The President identified the need to fix the physician payment update in his fiscal year 2003 budget. You also have expressed a willingness to work with Congress to develop a budget neutral fix. Please provide the Subcommittee with a detailed explanation of the various options the agency is studying to fix the update formula, including the estimated cost of each option.

Response: We believe that considerations of sustainability and of our urgent priorities in Medicare argue strongly that, if changes in the physician payment system are undertaken this year, they should be undertaken carefully and implemented in a way that does not significantly worsen Medicare's long-term budgetary outlook. The Administration supports reforms in physician payment that lessen volatility, and further believes that any short-term payment problems can be addressed at a much lower cost than the MedPAC recommendation implies. We are happy to provide technical assistance to help Congress smooth out the physician payment system in a budget neutral way.

QUESTIONS FOR ADMINISTRATOR SCULLY FROM HON. SHERROD BROWN, RANKING MEMBER, SUBCOMMITTEE ON HEALTH, COMMITTEE ON ENERGY AND COMMERCE

Question 1. How much money does CMS believe is necessary to fix the problem with the physician formula?

Response: There are a number of options that range in cost from $17 billion to more than $127 billion, depending on the approach selected. While we appreciate MedPAC's efforts to develop proposals to improve the physician payment system, we do not believe their ideas are the appropriate starting point for a discussion of Medicare provider payment—$127 billion is simply too much. However, we are happy to work with Congress to develop a budget neutral way to address concerns about inconsistencies in physician payment updates.

Question 2. What specific changes does CMS recommend that Congress make to the physician payment system to fix the problem with the current formula?

Response: We believe that considerations of sustainability and of our urgent priorities in Medicare argue strongly that, if changes in the physician payment system are undertaken this year, they should be undertaken carefully and implemented in a way that does not significantly worsen Medicare's long-term budgetary outlook. The Administration supports reforms in physician payment that lessen volatility, and further believes that any short-term payment problems can be addressed at a much lower cost than the MedPAC recommendation implies.

Question 3. Which particular providers does CMS recommend that Congress reduce payments in order to make the fix for physicians budget neutral? Please describe the particular policies that CMS recommends be implemented to reduce spending for each provider listed. What data or other evidence does CMS have to support such payment reductions to each of the particular provider groups?

Response: While the President's Budget did not contemplate any particular provider payment changes, we are willing to consider limited adjustments to payment systems and to work with you to develop a comprehensive package that is budget neutral across providers. We will not support any package of provider payment

changes unless it is budget neutral in the short- and long-term. To this end, we recognize that some provisions in law that, in the past, have restrained growth in payments are about to expire, and extension of these provisions is one potential way to ensure a budget neutral package of reforms.

QUESTIONS FOR ADMINISTRATOR SCULLY FROM HON. BENNIE G. THOMPSON

Mr. Secretary, it is my understanding that under the current Medicare Sustainable Growth Rate (SGR) update formula, the center for Medicare and Medicaid Services (CMS) is projecting that physician payments will be cut by 17% over the next four years due to the 5.4% cut that went into effect on January 1, 2002. If we assume conservatively, an inflation rate over 3%, this would result in a real dollar cut of 25% percent over the next five years. If physicians are forced to endure this cut, coupled with inflation, they will be forced to cut services in some manner in order to sustain their businesses. Mr. Secretary, I represent a rural, heavily impoverished district, where it is already hard enough for my constituents to locate and receive adequate health care. Under this cut, physicians in my state of Mississippi will lose more than $22.5 million. With 9.2 physicians per 1,000 beneficiaries, Mississippi already has the fewest doctors per Medicare beneficiary than any other state with the exception of North Dakota. I would hate for this daunting task to be compounded even more due to physicians having to limit the number of Medicare patients they see, due to the relocation of service in order to serve a younger area with far fewer Medicare eligible patients, or due to the cease of investment in new technologies that may prove critical in the diagnosis or treatment of ill patients.

Question 1. Is my understanding of the dollar impact of the current flawed formula correct?

Response: The physician fee schedule update for 2002 was -4.8 percent. The 2002 conversion factor is $36.20. We currently estimate that in 2003, the physician fee schedule conversion factor update would be -5.7 percent. In 2004, we estimate the physician fee schedule conversion factor would be -5.7 percent. And, in 2005, we estimate the physician fee schedule conversion factor update would be -2.8 percent.

However, we also estimate that overall Medicare physician spending will total $66.3 billion in 2002, a growth rate of 2.4 percent. We estimate that in 2003, overall Medicare physician spending will total $67.1 billion, a growth rate of 1.1 percent. In 2004, overall Medicare physician spending will total $68.0 billion, a growth rate of 1.5 percent. And, in 2005, overall Medicare physician spending will total $70.4 billion; a growth rate of 3.5 percent.

You can see that, under current law, although the physician payment update will be reduced, Medicare spending for physicians' services will continue to increase.

Question 2. If so, is it your view that physicians that provide services to Medicare patients can absorb a reduction of 25% in their fees without having any adverse impact on access for beneficiaries?

Response: We have no compelling evidence that there is a problem with the overall adequacy of provider payments, nor that Medicare beneficiary access to overall care has been negatively impacted, although we recognize that recent short-term adjustments in the Medicare physician payment system have been substantial. Clearly, we will continue to monitor the situation to ensure that America's elderly and disabled have access to the health care they need.

Question 3. And given the magnitude of this reduction, is the administration willing to reconsider its position that any "fix" to the problem must be budget neutral?

Response: The Administration is willing to work with Congress to consider limited modifications to Medicare's provider payment systems in order to address payment issues in a budget neutral manner. As we all consider changes, we need to be cautious and recall that any increases in spending will be borne, in part, by beneficiaries in the form of higher premiums and coinsurance payments. We believe it is possible to develop a fiscally responsible package of provider payment adjustments that remain budget neutral. We are happy to begin to work with you to provide technical support for such a package.

Question 4. Do you believe that the way the rate is determined needs to be changed? And if so, how do you propose that the rate be fixed to take into consideration the ability of physicians to provide quality health care under Medicare? What can we do legislatively to help you in this endeavor.

Response: While the underlying fee schedule and relative value system have been successful, the update calculation has produced large short-term adjustments and instability in year-to-year updates. As you know, last fall I spent about a month working every day with many of the physician groups, including the American Medical Association, to see if I had the administrative flexibility to change the formula, and it was abundantly clear that legally we cannot change it. Such a change has

to come from Congress. I want to work with you and the physician community to smooth out the yearly adjustments to the fee schedule in a way that is budget-neutral across all providers, and I look forward to providing as much technical support to you as I can.

United States General Accounting Office

Testimony

Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

MEDICARE PHYSICIAN PAYMENTS

Spending Targets Encourage Fiscal Discipline, Modifications Could Stabilize Fees

Statement of William J. Scanlon
Director, Health Care Issues

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss modifications to Medicare's method for updating its payments to physicians, which in 2001 totaled about $41 billion.[1] As you know, more than a decade ago to control rapid increases in Medicare spending for physician services, the Congress implemented a physician fee schedule and a fee update formula to moderate spending growth relative to specified spending targets. These spending targets increase annually to account for growth in the costs of providing physician services, the growth in the overall economy, and changes in the number of Medicare beneficiaries, while physician fees are adjusted for changes in the costs of providing services and how actual cumulative spending compares to the cumulative targets. In November 2001, however, the Centers for Medicare and Medicaid Services (CMS) announced that updating Medicare's fees for 2002 with this formula will cause the fees to decline 5.4 percent from what was paid in 2001.[2] The Congress has been concerned that fluctuations in physician payments and payment reductions may over the long run jeopardize beneficiary access to physician services. As a result, it asked the Medicare Payment Advisory Commission (MedPAC), which advises the Congress on Medicare payment issues, to study the possibility of eliminating spending targets and modifying the method for updating physician fees.

As you consider refinements to Medicare's method of updating physician payments, it is important to remain mindful of the need to ensure Medicare's sustainability for future generations of beneficiaries. In view of the coming surge in the Medicare-eligible population through the aging of the baby boom generation, projected program spending threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Furthermore, the slowdown in Medicare spending growth we saw in recent years appears to have ended. At the same time, the fiscal discipline imposed on provider payments continues to be challenged, and interest in modernizing the Medicare benefit package to include prescription drug coverage and catastrophic protection has increased. Together, these developments will impede efforts to achieve the fiscal restraint that the Comptroller General and others have warned is essential to the program's sustainability.

In the context of these broader interests, I will discuss (1) Medicare's use of spending targets as a means of moderating the growth in physician service expenditures, (2) the factors used in computing those targets that resulted in the reduced fees for 2002, and (3) adjustments to determining and applying spending targets that could moderate swings in physician fees, while ensuring payments are adequate to maintain physicians' ability to provide high-quality care to Medicare beneficiaries. My comments are based on previous and ongoing work on Medicare spending trends and Medicare payment methods, including the physician fee schedule.

---

[1]The $41 billion represents total Medicare payments to physicians, including beneficiary cost sharing. This statement refers to both calendar and fiscal years. We will use "fiscal year" where appropriate; other references to years, except where noted, are to calendar years.

[2]Until June 2001, CMS was known as the Health Care Financing Administration (HCFA). We will continue to refer to HCFA when referring to the organizational structure and operations associated with that name.

In brief, moderating Medicare's spending growth on physician services while setting payment rates adequate to ensure beneficiary access to care is not a straightforward matter. Medicare spending on physician services grew rapidly through the 1980s, at an average annual rate of more than 12 percent, even though physician fees were subject to some limits. The spending growth was driven by increases in the volume of services provided to each beneficiary and by increases in the intensity of services provided.[3] Recognizing that expenditure growth of this magnitude was not sustainable, the Congress attempted to impose fiscal discipline through a physician fee schedule and a payment update mechanism that incorporates spending targets. Physician fees are updated to reflect the increased costs of providing services with the updates adjusted up or down depending on whether actual spending has fallen below or exceeded the targets. The targets themselves are adjusted annually to account for changes in the costs of providing services, the number of Medicare beneficiaries, and the gross domestic product (GDP). Since the introduction of this fee system in 1992, annual increases in the volume and intensity of services provided per beneficiary have moderated significantly. In 2002 the system resulted in Medicare's physician fees being reduced 5.4 percent below the fees paid in 2001, despite an estimated 2.6 percent increase in the cost of physician inputs.[4] This reduction is to account for historical cumulative spending that exceeded the target by $8.9 billion, or 13 percent of estimated 2002 spending. Several factors contributed to the disparity between actual and targeted spending, including the correction of substantial errors in past spending estimates and the revision of targets for prior years. The current update mechanism could be modified to moderate fluctuations in physician fees and to ensure adequate payments, while retaining the fiscal discipline created by having a spending target. Such modifications would need to balance concerns about preserving fiscal discipline on physician spending with the need to maintain adequate payment rates to ensure that beneficiaries have access to physician services. Because the paramount consideration in setting payment rates is ensuring appropriate beneficiary access to services, timely and detailed data on Medicare beneficiary service use are essential to achieving this balance.

BACKGROUND

Total Medicare spending for physician services depends on actual payment rates, the volume of services provided, and the mix of those services. Medicare spending goes up when the price paid to physicians for each service increases, when the number of services provided rises, or when more intensive, and therefore more expensive, services replace less intensive ones.

[3]The intensity of services is the quantity and quality of resources used in providing them.

[4]Inputs for physicians' services are, for example, staff salaries and overhead.

Since 1992, Medicare has paid for physician services using a fee schedule. The fee for each service is a dollar conversion factor, adjusted to reflect the resources required for that service relative to the resources required to provide all other physician services, and the differences in the costs of providing services across geographic areas.

Along with the fee schedule, the Congress enacted a system of spending targets designed to control growth in total spending for physicians' services. The Sustainable Growth Rate (SGR) system was created in the Balanced Budget Act of 1997 and revised in the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA).[5] It replaced the first system of spending targets, implemented in 1992, known as the Volume Performance Standard. The SGR system sets spending targets for physician services and adjusts payment rates to bring spending in line with those targets. The SGR target for total spending is based on spending in an initial, or base, year and the estimated growth in real per capita GDP each year and three other factors that affect overall spending on physician services—the changes in the cost of inputs used to produce physicians' services (as measured by the Medicare Economic Index (MEI)), the number of Medicare beneficiaries in the traditional fee-for-service program, and expenditures that result from changes in laws or regulations.

The spending target for physician payments is applied by incorporating it into the adjustment to the conversion factor that determines the payment amount per service. The conversion factor is determined annually by adjusting the previous year's conversion factor by the change in the MEI, to account for the cost of inputs for physician services, and adjusting this product on the basis of the relationship between the cumulative SGR target and Medicare physician spending. The conversion factor update is greater than the MEI when physician spending has been below the targets and is less than the MEI when physician spending has been higher.

SPENDING TARGETS ESTABLISHED TO MODERATE RAPID RISE IN OUTLAYS FOR PHYSICIAN SERVICES

In response to escalating Medicare expenditures, the Congress made major changes in Medicare payment policies, beginning first by enacting the hospital inpatient prospective payment system, which was implemented in 1983, and then the Medicare physician fee schedule, implemented in 1992. When enacting the fee schedule, the Congress recognized that setting fees alone would not sufficiently restrain physician spending growth. Despite some constraints on physician fees since the 1970s, spending on physician services had grown dramatically in the 1980s as a result of increases in the volume and intensity of services provided. The Congress, therefore, provided that annual physician fee increases would depend upon whether total Medicare physician spending exceeded or fell short of cumulative spending targets. Since the implementation of the fee schedule and spending targets, the rise in Medicare spending

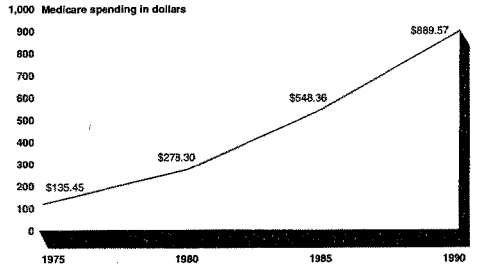
[5]Pub. L. No. 105-33 § 4503, 11 Stat. 251, 433 (to be codified at 42 U.S.C. § 1395w-4(f)). Pub. L. No. 106-113, Appendix F, § 211, 113 Stat. 1501, 1501A-345 (to be codified at 42 U.S.C. 1395W-4)).

for physician services has slowed significantly, reflecting lower growth in the volume and intensity of these services.

Spending on Physician Services Grew Rapidly Before 1992

Before the physician fee schedule was implemented, Medicare payments for physicians' services were largely based on historical charges. Although during the 1970s the Congress introduced some controls on annual payment rate increases, Medicare spending for physician services continued to rise. This was also true in the 1980s—between 1980 and 1990, for example, Medicare spending per beneficiary for physician services grew at an average annual rate of more than 12 percent, tripling from $278 to $890 (see fig. 1).

Figure 1: Medicare Spending for Physicians' Services, per Beneficiary, 1975-1990



Note: Amounts represent Medicare spending, net of beneficiary cost sharing, for the year ending June 30.

Sources: Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *1998 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Washington, D.C.: Apr. 28, 1998), pp. 51-2; and HCFA, *A Profile of Medicare: Chartbook 1998* (Washington, D.C.: 1998), p. 64.

Much of the spending growth resulted from increases in the volume of services provided to each beneficiary and the substitution of more intensive and expensive services for less intensive and expensive ones. The Physician Payment Review Commission, which was charged with advising the Congress on Medicare physician payment issues, observed, "[b]y the late 1980s. . . volume and intensity growth had become the primary cause of higher program spending. In fact, from 1986 until 1992, while physician payment rates grew by less than 2 percent annually, the volume and intensity of services rose by almost 8 percent per year."[6]

[6]Physician Payment Review Commission, *1995 Annual Report to Congress* (Washington, D.C.: Physician Payment Review Commission, 1995).

The Congressional Budget Office in 1986 stated that "[b]oth the price and the volume of services must be controlled to constrain costs . . . ."[7] Spending targets were needed to limit growth in volume and intensity of physician services. In 1989 testimony, Health and Human Services Secretary Louis W. Sullivan said "Medicare physician spending has increased at compound annual rates of 16 percent over the past 10 years. And in spite of our best efforts to control volume and reign in expenditures, Medicare physician spending is currently out of control. . . An expenditure target. . . sets an acceptable level of growth in the volume and intensity of physician services."[8]

Spending Targets Created Incentives to Moderate Growth in Volume and Intensity of Services

The Congress introduced spending targets for physician services in conjunction with the physician fee schedule in 1992 to help constrain the rise in Medicare spending for physician services. The targets incorporated limited growth in the volume and intensity of services and were revised each year based on estimates of changes in the number of Medicare beneficiaries and physician input prices. If actual spending exceeded the targeted amounts, future payment rates would be reduced, relative to what they would have been if actual spending had equaled the targets, to offset the excess spending. If actual spending fell short of the targets, future payment rates would be increased.

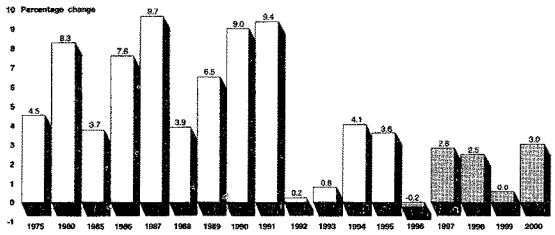
Since 1992, the growth in the volume and intensity of physicians' services per Medicare beneficiary has moderated (see fig. 2). Between 1992 and 2000, the average annual increase in Medicare spending due to changes in volume and intensity of services per beneficiary was about 2 percent. In contrast, between 1985 and 1992, immediately before the introduction of spending targets, volume and intensity of services per beneficiary increased at an average annual rate of about 9 percent.

---

[7]Congressional Budget Office, *Physician Reimbursement Under Medicare: Options for Change* (Washington, D.C.: Apr. 1986).

[8]Testimony before the Subcommittee on Medicare and Long-term Care, Committee on Finance, U.S. Senate, 101st Congress, 1st Session (June 16, 1989).

Figure 2: Changes in Volume and Intensity of Medicare Physician Services, per Beneficiary, 1975-2000



Notes: Data are for beneficiaries in the traditional fee-for-service program only.

From 1975 through 1995, volume and intensity of services changes are based on Medicare outlays for all physician services. From 1996 through 2000, volume and intensity of services changes are based on Medicare outlays for physician services covered by the fee schedule.

Sources: *1998 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund*, pp. 51-2; *A Profile of Medicare:Chartbook 1998*, p. 64; and Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, *2001 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund* (Mar. 19, 2001), http://www.hcfa.gov/pubforms/tr/smi2001/tabiig2.htm accessed Feb. 9, 2002.

SEVERAL FACTORS ASSOCIATED WITH 2002 FEE REDUCTIONS

The application of the SGR system in 2002 resulted in a 5.4 percent reduction in physician payment rates, despite an estimated 2.6 percent increase in the costs of inputs used to provide physician services. The reduction occurred because estimated cumulative physician services spending since 1996 exceeded the target for cumulative spending by approximately $8.9 billion, or 13 percent of projected 2002 spending. In part, the payment update reflects adjustments made to the spending targets for previous years for revisions in GDP estimates and for more accurate actual spending statistics. Correcting these errors in previous years' targets and spending totals to reflect more recent data resulted in larger physician payment increases in those years than if accurate data had been used, and they contributed to the size of the reduction in payments in 2002.

The SGR system sets spending targets for physician services and adjusts payment rates to bring spending in line with those targets. Conceptually, if spending equals the targeted amount, physician payment rates are updated to keep pace with the percentage change in input prices as measured by the MEI. If spending exceeds the target, the change in payment rates is smaller than the change in input prices. If spending falls short of the target, payment rates are allowed to grow faster than the rise in input prices.

By adjusting payment rates when prior-year spending has been too high, the SGR system moderates the growth in Medicare outlays for physician services.

The SGR adjustments to the input price update are determined by how much the cumulative physician spending since 1996 differs from the cumulative spending target since then. Spending and targets must both be estimated from information available each November when payment rates are set for the following year. Previously, those estimates were then used in subsequent years. Based on requirements in the BBRA, however, HCFA implemented a process for revising the most recent two years of spending and target estimates. Because the annual targets are determined by changes in four factors—the number of fee-for-service beneficiaries, real per capita GDP, input costs, and the effect of changes in laws or regulations—a revision to any of those factors, or to estimates of prior spending, can change the spending estimate. The SGR adjustments to the input price update can then take effect because of growth in the volume or intensity of services delivered, resulting in spending deviating from targets, or because of revised estimates for prior years' targets and spending.

In setting payment rates for 2002, CMS updated its estimates of past spending and recalculated past targets. The net effect of both revisions indicated that Medicare outlays were an estimated $8.9 billion too high. The SGR is designed to recover this excess amount by lowering payment rates in 2002 and future years. CMS' original estimates of spending since 1998 were too low, in part because the agency had not included all appropriate claims in making these estimates. The original spending targets for 2000 and 2001 were too high, largely because the Bureau of Economic Analysis in the Department of Commerce revised its GDP and GDP growth estimates for those years.

To some extent, the reduction in payment rates this year corrects for inaccuracies in previous estimates that produced physician fees that were too high in 2000 and 2001. In both years, payment rates increased by more than the change in input prices because the information available at the time those rates were established suggested that physician spending had been held below the targets. In 2000, payment rates increased 5.4 percent, while input costs increased 2.4 percent; in 2001, payment rates increased 4.5 percent, while input costs increased by 2.1 percent. The reason that 2002 payment rates fall 5.4 percent while input prices increase by 2.6 percent is that the revised estimates revealed that spending exceeded the targets in previous years. The reduction would have been almost 4 percentage points greater, but the SGR system limits how much fees can be adjusted for the differences between actual and target spending.

AVOIDING LARGE PAYMENT SWINGS IN SYSTEM BASED ON SPENDING TARGETS

Several measures could moderate the fluctuations in physician payment rates. Although these modifications to the SGR could mitigate the possible impact of rate instability or reductions in beneficiary access to needed services, doing so could also lessen the ability of spending targets to encourage fiscal discipline. Available data indicate that access is adequate, but more timely and detailed information is critical to promptly recognize potential deteriorations in access.

Moderating Fluctuations in Physician Payment Rates

The SGR system is designed to limit the fluctuations in payment rates, but its design could be modified to achieve greater rate stability. The BBRA specified that adjustment to realign spending with the targets cannot cause payments to fall by more than 7 percentage points below, or increase by more than 3 percentage points above, the percentage change in input prices. In addition, spending deviations from past targets are not corrected in a single year but are spread over several years. Greater rate stability could be achieved by narrowing the range over which rates could change from one year to the next. Similarly, the corrections for spending deviations could be spread over longer periods of time.

Modifying how spending targets are set could also reduce year-to-year fluctuations in rates. Currently, the changes in GDP for a single year are used to establish the spending target. The difficulty in accurately estimating GDP has contributed to the problem of fluctuations in the target. In addition, linking annual changes in the targets to annual changes in GDP ties the target to the business cycle. GDP growth rates are higher during periods of prosperity and lower during downturns—a commonly used definition of a recession is a decline in real GDP for two successive quarters. But health care needs of Medicare beneficiaries are not cyclical. Neither significantly lowering spending targets during a downturn nor unduly increasing them in a period of prosperity is appropriate. Linking the determination of spending targets to average levels of GDP over several years would help eliminate much of the cyclical variation.

Any changes to the SGR must balance the desire for greater rate stability with the need for fiscal discipline. Spending targets create a feedback mechanism between physicians' behavior and payment rate increases. However, spending targets do not create direct incentives for any individual physician, since it is the collective behavior of all physicians that determines the payment adjustments that result from missing the spending targets. The primary value of spending targets in instilling fiscal discipline is the signal they send that affordability of the program is an important concern in establishing Medicare policies. Limiting the size of the payment adjustment for missed spending targets or to corrections in prior years' targets, and lengthening the time over which those adjustments are incorporated, could partially mute the signal targets send and erode some of the fiscal discipline they encourage. On the other hand, excessive rate fluctuations can be difficult for providers and may ultimately affect beneficiaries' access

to physician services if rate fluctuations cause too many providers to decline to participate in the program.

Monitoring Beneficiary Access to Physicians

Ensuring that the use of spending targets does not compromise appropriate access to services is a key concern. Spending targets that are updated principally by the growth in GDP and other factors may not reflect fully changes in medical care and the markets for these services. It is therefore important to monitor service use to assess whether appropriate access for beneficiaries is secured, especially if fees are reduced. Such monitoring needs to involve recent experience so that if spending targets need adjustments, those adjustments are done promptly to ameliorate any problems.

Information on physicians' willingness to see Medicare patients is dated but overall does not indicate access problems. Data from the 1990s show that virtually all physicians treated Medicare beneficiaries or if accepting new patients, accepted those covered by Medicare. According to data from the American Medical Association (AMA), 96.2 percent of all nonfederal physicians (excluding residents and pediatricians who do not normally serve Medicare patients) treated Medicare beneficiaries in 1996, an increase from the 94.2 percent AMA reported in 1994. A 1999 survey sponsored by MedPAC found that 93 percent of physicians who were accepting any new patients were accepting new patients covered by Medicare.

Payment rate decisions should not be made in a data vacuum. As health needs change, technology improves, or health care markets evolve, spending targets and resulting payment rates may need to be adjusted periodically, not by a formula designed for annual updates, but by specifying a new base year target calibrated to ensure appropriate access. Payment rates that are too low can impair beneficiary access to physician services, while payment rates that are too high add unnecessary financial burdens to Medicare. Informed decisions about appropriate payment rates and rate changes cannot be made unless policymakers have detailed and recent data on beneficiaries' access to needed services.

CONCLUDING OBSERVATIONS

The SGR mechanism uses information about physician spending in relation to cost increases, changes in the number of beneficiaries, and growth in the overall economy to impose fiscal discipline on Medicare outlays for these services. This mechanism provides a signal when spending threatens to grow out of control and in that sense is analogous to what the Comptroller General has called for in testimony on several occasions with regard to the entire Medicare program. The demographic changes facing the nation require policymakers to look ahead and assess both current and future Medicare spending in relation to the entire federal budget and the economy—first to understand the urgent need for fiscal discipline, then to make choices to ensure the sustainability and affordability of the program. A mechanism like the SGR provides a benchmark for assessing the trend in physician spending and can prompt actions to bring that spending in line with overall program goals. In assessing the options for updating

physician payments, the program's prospects for long-term sustainability should be paramount. Meeting that challenge will involve difficult decisions that will likely affect beneficiaries, providers, and taxpayers.

- - - - -

This concludes my prepared statement. I would be happy to answer any questions that you or Members of the Subcommittee may have.

GAO CONTACTS AND STAFF ACKNOWLEDGMENTS

For more information regarding this testimony, please contact me at (202) 512-7114 or Laura A. Dummit at (202) 512-7119. James Cosgrove, Kathryn Linehan, Lynn Nonnemaker, and Hannah Fein also made key contributions to this statement.

(290172)