

October 3, 2003

Thomas A. Scully, Administrator
Centers for Medicare & Medicaid Services
Room 445-G Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Attention: File Code CMS-1476-P

Dear Administrator Scully:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS or the Agency) proposed rule entitled "*Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2004,*" 68 Fed. Reg. 49030 (August 15, 2003). The AAMC represents approximately 400 major teaching hospitals and health systems; more than 88,000 clinical faculty members (academic physicians); the 126 accredited U.S. medical schools; 96 professional and academic societies; and the nation's medical students and residents.

We appreciate the Agency's effort to undertake the difficult task of updating the Medicare Economic Index (MEI) to more accurately reflect recent substantial increases in professional liability insurance (PLI) premiums. The AAMC is also heartened by the Agency's decision to address the inclusion of drugs in the Sustainable Growth Rate (SGR) calculation in the near future. However, we are troubled that the actual increase in PLI premiums in the market is not fully captured even in the rebased MEI. We also have concerns about the impact of the proposed 4.2% reduction in the fee schedule on the Medicare population, their access to care and the effects on Faculty Practice Plans (FPPs). Finally, we have misgivings about the reductions in Work Relative Value Units (WRVUs) and Practice Expense Relative Value Units (PERVUs) to compensate for the increase in PLI Relative Value Units (PLIRVUs).

Clinical faculty members (academic physicians) play a unique and multifaceted role within the physician community and in the larger health care system as well. In addition to their traditional roles as educators, researchers and consultants, faculty members are also clinicians, providing a significant volume of services to Medicare beneficiaries. Indeed, nearly one-sixth of all physicians providing Medicare services are academic physicians. Medicare reimbursements are an important source of faculty practice plan income, providing, in some cases, one-third of faculty practice plan revenues. These revenues, on average, represent about 35 percent of a medical school's total revenue. Medicare payments play a significant role in the fiscal health of academic medicine and the proposed cuts would greatly deteriorate the economic viability of faculty practice plans and academic medical centers.

Changes to the Physician Fee Schedule Update Calculation and the Sustainable Growth Rate (SGR) - Medicare Economic Index (MEI)

Rebasing of the MEI from 1996 to 2000

CMS has proposed rebasing the MEI from a base year of 1996 to 2000. This will result in a change to the MEI of one-tenth of one percent (an MEI of 2.5% instead of 2.4%), which translates into a proposed Conversion Factor (CF) reduction of 4.2% rather than 4.3%. However, adjusting for the budget neutrality provisions of section 1848(c)(2)(B)(ii)(II) in the CF rather than in WRVUs would result in a reduction of 4.5% in the conversion factor. CMS has noted that a reduction in WRVUs and a reduction in the CF will have the same impact in terms of budget neutrality.

Reducing the conversion factor rather than WRVUs does not significantly increase or decrease 2004 payments on an individual CPT code level. A sample of high volume CPT codes was examined to determine the relative differences of WRVU vs. CPT changes on payments. A range of -0.45 percent to +0.34 percent was identified. A sample of codes is included in Table 1 below. Table 1 compares payments for a fairly common series of CPT/HCPCS codes under the two proposals to maintain budget neutrality (a reduction in WRVUs and a reduction in the CF). Thus, payments resulting from the 4.5% reduction in the CF rather than as reduction in WRVUs is within a relatively narrow range of differences.

Table 1: Reimbursements: RVU Reduction vs. Conversion Factor Reduction*

CPT/ HCPCS	Description	Payment if RVUs are reduced (Estimated CF = \$35.2406)		Payment if CF is reduced (Estimated CF = \$35.1302)			Percent Difference between RVU and CF Changes **	
		Non Facility	Facility	Non- Facility	Facility	Non-Facility	Facility	
99202	Office/Outpatient visit new	\$61.02	\$43.95	\$61.13	\$43.91	0.18%	-0.45%	
99204	Office/Outpatient visit new	\$127.61	\$99.04	\$127.87	\$99.07	0.20%	0.03%	
99211	Office/Outpatient visit established	\$20.63	\$8.44	\$20.73	\$8.43	0.48%	-0.12%	
99214	Office/Outpatient visit established	\$77.31	\$53.62	\$77.64	\$53.75	0.43%	0.24%	
61697	Brain aneurysm repair, complex	NA	\$3,220.25	NA	\$3,228.02	NA	0.24%	
47122	Extensive removal of liver	NA	\$2,859.23	NA	\$2,865.96	NA	0.24%	
33863	Ascending aortic graft	NA	\$2,420.27	NA	\$2,425.68	NA	0.22%	
33935	Transplantation, heart/lung	NA	\$3,389.04	NA	\$3,396.34	NA	0.21%	

*Note: In order to compare the impact of changes to RVUS vs. changes to the CF, calculations are based on Relative Value Units only as listed in Addendum B of the NPRM and do not include Geographic practice Cost Index (GPCI) adjustments and thus do not represent final total payments.

**Positive values indicate higher payments when CF is reduced.

The Resource Based Relative Value System (RBRVS) and its component Relative Value Units (RVUs) were designed to establish a national system for valuing the resources required to deliver medical services across all specialties and to preserve equitable relativity among specialties. Across the board adjustments to RVUs resulting from budget neutrality requirements have the potential to erode the underpinnings of the RBRVS system and may result in long term impacts that do not necessarily reflect changes in the practice of medicine or resources required to deliver medical care. Normally, RVUs are adjusted after careful review of data indicating changes in efficiency or other transformations in the practice of medicine that the resource based relative value system was designed to capture. In contrast, changes in the conversion factor from year-to-year are designed to capture economic changes and to compensate for extraordinary changes in prices or volume. While we appreciate the agency's efforts to more accurately account for the rapid increases in PLI premiums in recent years, the proposed reductions in WRVUs to maintain budget neutrality have the potential to have a negative impact on academic medical centers and faculty practice plans for a much longer period than a single year adjustment to the conversion factor. This results from the fact that the current systems and process for reviewing WRVUs will not require an annual follow-up review of the 0.35 percent WRVU reduction. On the other hand, the CF is reviewed and modified annually.

Further, the advent of the RBRVS system has enabled many medical groups and faculty practice plans to link compensation (and presumably some degree of pay equity/scales that are based on a national, relative system) to RVU-based productivity calculations. Changes to RVUs that occur because of efficiency improvements or changes in the practice of medicine and that maintain the relative balance of effort and resources measured across all specialties are in keeping with the philosophical bases for such compensation plans. Thus, changes to RVUs that are made across the board and for national budget neutrality reasons are not in keeping with the philosophical bases of the RBRVS system or compensation models. Therefore, AAMC recommends that CMS make any necessary budget neutrality adjustments through modifications to the CF, not the WRVUs.

Professional Liability Insurance (PLI) Estimated Increases Under the Rebased MEI

AAMC appreciates CMS' proposal to modify the methodology used to calculate the Medicare Economic Index (MEI) to more appropriately adjust for increases in PLI premiums over the past few years. The proposed change is a greatly appreciated first step in addressing the increasingly large share of physician reimbursement dedicated to PLI. However, the forecasted 6.6 percent increase for 2004 shown in Table 9, "Forecasted Annual Percent Change in the Proposed Revised and Rebased Medicare Economic Index, 2004-All Categories," is significantly less than increases in PLI premiums that our constituents' have experienced. In a recent AAMC survey on PLI, our respondents indicated an average increase in premiums of approximately 50% over the past year. The AAMC would suggest that the Agency expand beyond using "voluntary (data) from a few national commercial carriers via letter" and incorporate some of the premium data available from the National Association of Insurance Commissioners cited in the recent report, *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates* (GAO-03-702) by the Government Accounting Office. This would allow the MEI to reflect the true state of PLI premium increases more accurately than relying on voluntary information from insurers.

For the reasons cited above, the methodology proposed to keep the newly weighted MEI within the budget neutrality requirements of section 1848©(2)(B)(ii)(II) is not appealing. The proposed across the board reduction of 0.35 percent in WRVUs is less desirable than an overall CF reduction of 0.30 percent.

Geographic Practice Cost Index (GPCI)

AAMC also appreciates the considerable time and effort that the Agency has put into recalculating the Geographic Practice Cost Index (GPCI) to more accurately reflect the sharp increases in PLI premiums in the past few years. However, AAMC is concerned that this revision is once again at the expense of physicians. In the NPRM, CMS noted that under the proposed rule, the physician earnings weight will decrease from 54.500% in 2003 to 52.466% in 2004 a decrease of 2.034% while the PLI component was increased by 0.665%. The new weights may be an artifact of the data used to update the GPCIs. For example, the Agency's method for calculating the physicians' earnings component has the potential to bias the results. CMS stated in the NPRM: "we elected to use the all-education sample because its larger sample sizes made it more stable and accurate in the less populous areas. Although it could be argued that physicians' earnings might more closely approximate the earnings of professionals with advanced degrees, the differences between the all-education and advanced degree indices were negligible in all but a few of the smallest localities. We believe that the small sample sizes of advanced-degree occupations in these small localities would produce inaccurate results." It is not entirely apparent from this description why a sample, albeit small, that is actually representative of the population is less reliable than a large sample that does not represent the population and we therefore recommend that CMS use the measures based on advanced-degree occupation.

New HCPCS G Codes

CMS proposes the addition of several new G codes related to monitoring heart rhythms and treatment of End Stage Renal Disease (ESRD). Currently, there are complex and numerous requirements for appropriately coding and documenting services provided to Medicare patients. Given that the CPT code list already includes over 7,500 codes, it is critical that the creation of new G codes be limited. We strongly recommend that, to the greatest extent possible, existing CPT codes continue to be used.

The creation of some of these G codes is tied to CMS decisions to include certain services as covered services under Medicare. These specific decisions are of greater impact than the related expansion of G codes. Specifically, any services deemed by CMS to become covered services should be included in projected growth in expenditures expected from "changes in law and regulation", not just those changes resulting from specific legislative acts. On one level it is helpful to physicians to be able to treat Medicare patients who have coverage for a broad array of medically necessary services. This obviates the need for physicians to explain to patients that services are indicated but coverage is not available. However, it is not helpful to have physicians indirectly pay for that coverage by excluding those services from projected volume growth levels. Under the SGR system, this means that anticipated expenditures for such services do not

yield increases in the projected target-spending amount, but actual payments are included in the determination of actual expenditures. Thus, when actual to target expenditures are compared, the likely result is a downward adjustment of future years' payments to physicians in order to get actual and target figures back in alignment. We therefore recommend that CMS continue to explore methods for including the expenditures for changes in law and regulation and coverage decisions in the SGR system.

Removal of Drugs from the SGR

AAMC encourages the Agency to address CMS' current treatment of expenditures related to drugs. Drugs are not included under the physician fee schedule. However, the actual expenditures for drugs are included in target spending calculations under the SGR. The explanation for the inclusion of drug expenditures in the calculation of actual expenditures has been that it is necessary for ensuring that physicians, who control drug prescribing, do not unnecessarily or inappropriately prescribe drugs. We do not believe that physicians are unnecessarily or inappropriately prescribing drugs and no data have been produced to date to indicate such patterns. The physician community would welcome data on specific trends in this realm that indicate patterns of prescribing that might be addressed by professional education or other efforts.

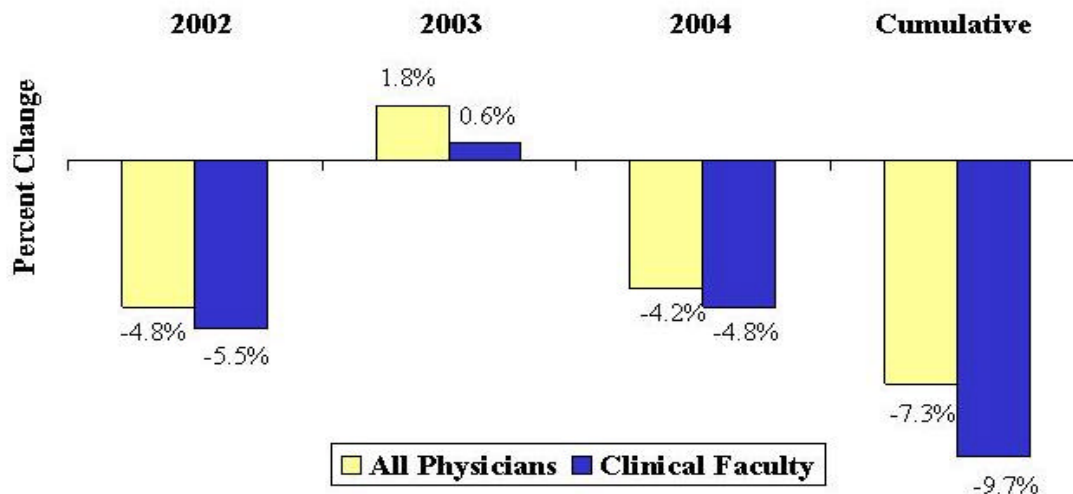
The Impact of Fee Schedule Reductions and Faculty Practice Plans

Faculty Practice Plans are impacted in a number of ways by cuts in the Medicare Physician Fee Schedule. Two of these are of particular concern: declining Medicare revenues and increased Medicare patient volumes as community physicians withdraw from Medicare. Recent evidence from a variety of sources, including 2002 and 2003 surveys conducted by the American Medical Association (AMA), illustrate physician participation trends (AMA Jan 2003). The AMA found that in 2002, approximately 92 percent of respondents indicated that they would participate in Medicare. This figure dropped to 79 percent in 2003. Further, of the 79 percent, 52 percent reported that they will be obligated by a contract or organizational policy to participate; this figure is up from 41 percent in 2002. The survey showed that even participating physicians (2002 survey) made other significant changes in their practice that had the potential to limit access, including a reduction in working hours (14%), ceasing certain services (41%) and increasing referrals of complex cases (38%).

These findings indicate a potential trend toward increased referrals of patients and/or specific services to large medical group/systems and academic medical centers. Specifically, physicians who report an obligation by contract or organizational policy to participate in Medicare are likely to be physicians employed by medical groups, systems or academic medical centers. If such entities are continuing to maintain, reaffirm or even increase policies requiring employed physicians to participate in Medicare, while self-employed physicians are decreasing participation or the provision of certain services, the consequence will be increased volumes of Medicare patients treated by large groups and academic medical centers.

An increase in Medicare patients treated by or referred to academic medical centers is not an issue per se. However, as the chart below shows, faculty practice plans experience greater impacts from reductions in the fee schedule and lower benefits from increases in the fee schedule. This is due to the nature of the Medicare patient population treated by faculty practice plans and the care they require, coupled with the reductions in the CF and changes in the RVU values for complex care. Thus, the increased volumes, combined with declining Medicare reimbursement, may further erode the fiscal viability of faculty practice plans.

Fee Schedule Changes 2002 to 2004: All Physicians vs. Clinical Faculty*



*Note: 2002 & 2003 based on actual estimates from CMS and AAMC/UHC;
2004 figures for *All Physicians* are CMS estimates;
2004 figures for *Clinical Faculty* are AAMC projections based on past trends.

Thank you for this opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health care community. If you have questions concerning these comments, please feel free to call Robert Dickler, Senior Vice President or Denise Doderer, Assistant Vice President, both of whom may be reached at 202-828-0568.

Sincerely,

Jordan J. Cohen, M.D.

cc: Robert Dickler
Denise Doderer