



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

Gordon Wheeler, Chair
gwheeler@acep.org
(202) 728-0610

Lucia DiVenere, Vice-Chair
ldivenere@acog.org
(202) 863-2510

Statement of Elizabeth A. Davis, MD, FACS
Ophthalmologist in private practice
Clinical Assistant Professor
University of Minnesota
Minneapolis, Minnesota
on behalf of the
Alliance of Specialty Medicine
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Mr. Chairman, Members of the Subcommittee, in addition to serving as a partner in a private ophthalmology practice in Minneapolis, Minnesota, and as a Clinical Assistant Professor at the University of Minnesota, I am the Chair of the American Society of Cataract and Refractive Surgery's (ASCRS) Young Physicians and Residents Committee and a member of the ASCRS Government Relations Committee. I am here today representing the Alliance of Specialty Medicine – a coalition of 13 societies, including ASCRS, representing more than 200,000 specialty physicians. I am pleased to have this opportunity to testify before the Subcommittee on the issue of Medicare payment to physicians, and in particular on the issue of the flawed Sustainable Growth Rate (SGR) formula and to offer possible solutions.

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

American Academy of Dermatology Association • American Association of Neurological Surgeons • American Association of Orthopaedic Surgeons
• American College of Cardiology • American College of Emergency Physicians • American College of Obstetricians and Gynecologists
American Gastroenterological Association • American Society for Therapeutic Radiology and Oncology
American Society of Cataract & Refractive Surgery • American Urological Association • Congress of Neurological Surgeons
National Association of Spine Specialists • The Society of Thoracic Surgeons

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

Why the SGR Formula Is Flawed

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

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

Recent Congressional Action

Although the problems with the SGR were, in some respects, anticipated when the law was passed in 1997, the first detrimental effects were not experienced until 2002, when physicians received a 5.4 % reduction to the conversion factor. Since then, the flaws of the SGR formula have been so pronounced that Congress has been forced to pass two temporary measures to keep the system from falling apart completely, and we are again faced with a 4.4% reduction January 1, 2006 – and significant reductions beyond.

In 2003, after the Centers for Medicare and Medicaid Services delayed a second payment reduction for 3 months, Congress passed the first law, which required CMS to fix accounting mistakes that were made during 1998 and 1999. Fixing these errors restored \$54 billion to the Medicare physician payment system and prevented another year of reductions in reimbursement, but the legislation **did nothing to fix the overall problems** that plague the formula.

With physicians anticipating a 4.4 % reduction in 2004, Congress again acted and included a provision in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) that mandated an increase of at least 1.5% in both 2004 and 2005. Although we appreciate the leadership of this committee in preventing the reductions and the eventual intervention of Congress, the statutory increase did nothing to change the underlying formula. In fact, while the statutory update in the MMA prevented the additional reductions for 2004 and 2005, no additional funds were provided to pay for this temporary fix, therefore exacerbating the problem. As a result, the money used to fund the increase in these updates must be paid back to the Medicare program, with interest, over the next 10 years.

Reimbursement Rates in 2006 and Beyond

In fewer than 50 days, Medicare physician payments will be cut by 4.4%, followed by significant reductions until 2012, and rates will not return to their 2002 level until well after 2013. In other words, physicians will receive less reimbursement in 2013 than they did in 2002 for the exact same procedure, regardless of inflation and increased practice costs. Although reimbursement will likely be cut by more than 30 % under the current formula during that time period, it is estimated that costs for providing services will rise by close to 20 %. Such cuts will further inhibit each physician's ability to provide services to Medicare beneficiaries as many physicians will simply be unable to afford to treat Medicare patients.

The Solution

As I have previously stated, Congressional action has delayed the imminent meltdown of the Medicare program and has allowed some breathing space to evaluate approaches to fixing the payment update formula. Although we prefer that Congress repeal the SGR and replace it with system that takes into account the actual cost of providing care to Medicare patients, such as the Medicare Economic Index (MEI), we recognize that this is unlikely this year given the current fiscal constraints facing the Congress. Providing short-term relief, therefore, is absolutely necessary to maintain access to care for beneficiaries and to stabilize the Medicare program until the SGR problem is solved.

We also believe that it would be unwise to legislate a punitive pay-for-performance system for Medicare at this time. We clearly understand that the Administration and Congress are intent on moving the Medicare program into a quality-reporting and value-based purchasing system. However, the SGR and a value-based purchasing or pay-for-performance system are incompatible. For physicians to embrace a value-based purchasing system, the SGR must be replaced with a more equitable and stable payment system so that physicians can invest in health information technology and pilot test data collection methods and quality measures as steps toward establishing a pay-for-performance system that actually improves care for Medicare patients. Moving too rapidly by legislating pay for performance now without first resolving the SGR, especially a pay for performance program that is not supported by the physician community, amounts to replacing one broken system with another. Again, pay-for-performance is unworkable applied on top of the current unstable payment system. Simply put, value-based purchasing and the SGR are not compatible and cannot work together.

Pay for Performance

The Alliance's member specialty physician organizations are continually striving to offer the highest specialized quality care to all Medicare beneficiaries.

Over the past 8 months, the members of the Alliance of Specialty Medicine have worked diligently to prepare physicians for a value-based purchasing system. We have cooperated with the CMS on the initial development of quality measures that could be voluntarily reported through a claims-based system. In fact, physician specialty organizations played a role in developing the newly announced CMS Voluntary Physician Reporting Program (PVRP) and look forward to working with CMS to address some concerns that we have with the selected measures and process. All specialty groups in the Alliance have made tremendous progress in developing quality measures and preparing their physician members for this new payment system, and we stand ready to continue our involvement as the process moves forward.

We also continue to believe that quality reporting measures should be evidence based developed by the specialty societies with expertise in the area of care in question, and based on factors physicians can directly control. Quality measures must be pilot-tested and phased in across a variety of specialties and practice settings to help determine what does and does not improve quality. This is critical as we move to a system that produces a more efficient, reliable, and stable patient system.

Therefore, the Alliance understands that there is an opportunity to work with Congress and the Administration to enhance quality measurement for the specialty care provided to our Nation's seniors and individuals with disabilities. Patient safety and quality care are the cornerstones on which all patient care is delivered by the more than 200,000 specialty physicians the Alliance represents and the millions of patients they care for each year. We stand ready to continue to work with Congress and the Administration and ask that the following issues be addressed:

- The physician payment reductions scheduled for January 1, 2006, and future years be prevented.
- Before a mandatory value-based purchasing program is put into place, the current SGR system must be replaced with a system that is more predictable and recognizes the true costs of providing physician services to Medicare beneficiaries.

- Any new value-based purchasing program must be non punitive and use consensus-driven, evidence-based quality and efficiency measures developed by the medical specialties, and it must be phased-in over several years.
- All quality and efficiency measures should be consensus drive and pilot tested across a variety of specialties and practice settings.

CONCLUSION

CONGRESS MUST FIND A SOLUTION TO IMPLEMENT A RATIONAL MEDICARE PHYSICIAN PAYMENT SYSTEM, AND THE ALLIANCE OF SPECIALTY MEDICINE LOOKS FORWARD TO WORKING WITH YOU TO DEVELOP A SYSTEM THAT IS MORE PREDICTABLE AND ENSURES FAIR REIMBURSEMENT FOR PHYSICIANS AS WELL AS CONTINUED BENEFICIARY ACCESS TO QUALITY SPECIALTY HEALTH CARE.