



# **STATEMENT**

**of the**

**American Medical Association**

**Committee on Small Business**

**United States House of Representatives**

**RE: Medicare Physician Fee Cuts: Can  
Small Practices Survive**

**May 8, 2008**

**Division of Legislative Counsel  
202 789-7426**

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding today's hearing on "Medicare Physician Fee Cuts: Can Small Practices Survive."

We commend you, Chairman Valazquez, Ranking Member Chabot, and Members of the Committee for your strong efforts and leadership in recognizing the serious access crisis that looms as physicians face drastic payment cuts under the current fatally flawed Medicare physician payment update formula, called the sustainable growth rate (SGR). In addition, on top of these cuts, is the tremendous government-imposed regulatory burden incurred by physicians and their office staff on a daily basis, which ultimately takes physician time away from treating their patients.

The vast majority of physician practices are small businesses. In fact, 50% of physician practices have less than five physicians, and yet account for 80% of outpatient visits. Steep payment cuts under the SGR, along with numerous other challenges in the current health care environment, threaten the continued viability of these practices. Physicians are the foundation of our health care system, and thus it is critical that Congress address these challenges to ensure the continued delivery of quality health care in our country.

### **THE MEDICARE PHYSICIAN PAYMENT FORMULA IS FATALLY FLAWED**

Medicare payment rates for physicians' services are updated annually on the basis of the SGR, a fatally flawed formula that has resulted in steep Medicare physician payment cuts. The SGR formula sets a target and if Medicare spending on physicians' services exceeds this target, physician payment rates are cut. This target is linked primarily to growth in the gross domestic product (GDP), in addition to several other factors. The SGR is flawed because these factors do not take into account significant contributors to the growth in physicians' services, such as patient health care needs, technological advances, shifts in the provision of care from the hospital to the physician office setting, and government policies that, although beneficial to patients, increase Medicare spending on physicians' services. Though these factors are beyond physicians' control, when Medicare utilization of physicians' services exceeds the SGR target, physicians are unfairly penalized with cuts in their payment update. **Because of these fundamental defects of the SGR, Congress has had to scramble at the 11<sup>th</sup> hour in each of the last six years to forestall steep Medicare physician payment cuts.** Moreover, Congress has used a financing mechanism in the last two legislative interventions that results in deeper and deeper projected cuts for each subsequent year, thus making each year's legislative fix more costly than the previous one.

Some policymakers have advocated that a spending target is necessary to prevent "rapid" utilization growth in physicians' services, which they believe is a major cause of Medicare long-term financing problems. In fact, however, utilization of physicians' services has declined significantly in recent years. The 2008 Medicare Trustees report indicates that annual growth in the volume of Medicare physician services for 2005 and 2006 was just 3.6%, which is only about half the growth rate that the Trustees had projected in their 2006 report. In fact, the rate of growth in volume has been declining for several years in a row. Physicians are managing patients in their offices, which has resulted in fewer hospital and emergency room visits, and the growth rate for imaging services has also slowed as medical specialty societies have released guidance to physicians concerning the appropriateness of certain tests.

The physician community recognizes that efforts to improve the value of health care provided to Medicare beneficiaries are part and parcel of a long-term solution to the SGR problem. The AMA supports physician efforts to develop and implement clinical practice guidelines that promote appropriate utilization of services. We urge Congress to support funding for quality comparative effectiveness research that will improve health care value by enhancing physicians' clinical judgment and fostering the delivery of patient-centered care.

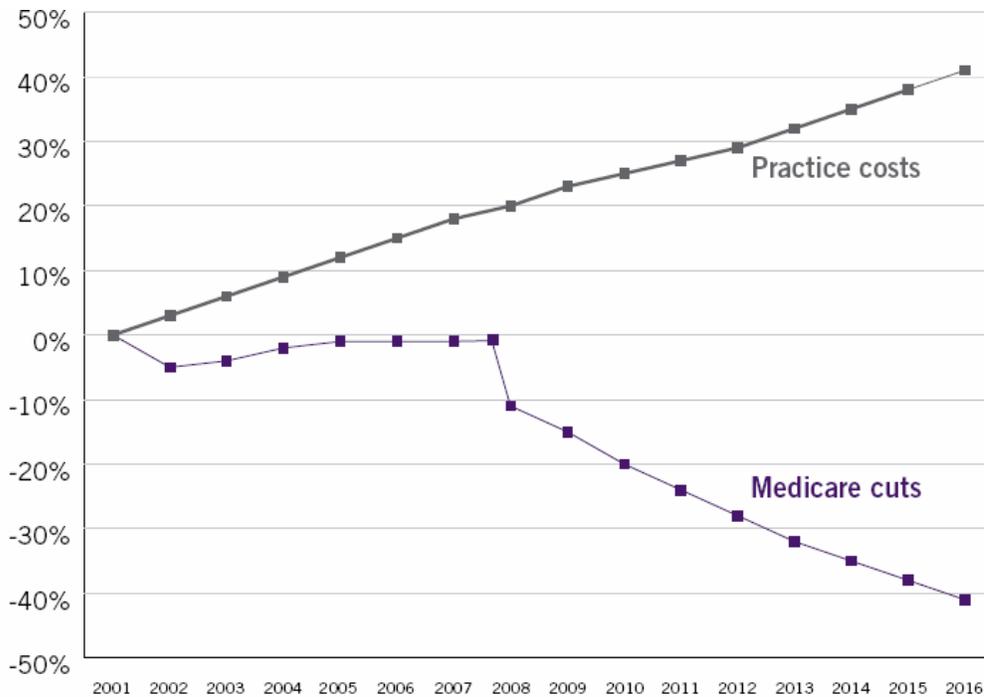
### **CONGRESS MUST TAKE IMMEDIATE ACTION TO AVERT THE JULY 2008 MEDICARE PHYSICIAN PAYMENT RATE CUT**

Despite well-intentioned Congressional efforts to avert Medicare physician cuts due to the flawed SGR, Medicare payment rates for physicians in 2008 are about the same today as they were in 2001. Further, Medicare physician payment rates are scheduled to be cut 10.6% on July 1, 2008, and an additional cut of 5% or more is projected for January 1, 2009. These will be part of a series of cuts totaling about 40% in the coming decade. Yet, even by the government's own conservative estimate, physician practice costs will increase nearly 20% during this time period. Physicians cannot absorb these steep losses.

**As of May 8, there are only 53 calendar days (and substantially less legislative days) remaining for Congress to address this problem before the 10.6% Medicare physician payment cut goes into effect. Congress must act now to enact 18 months of positive Medicare physician payment updates that reflect medical practice cost increases. Rapidly eroding margins are threatening the viability of medical practices, putting health information technology and other high-capital intensive purchases out of reach, and forcing the large cohort of practicing physicians over 55 years of age to weigh retirement.**

The steep cuts that are yielded by what is ironically called the "sustainable growth rate," would be unsustainable for any business, especially small businesses such as physician practices. Further, once Medicare implements a payment rate cut, it has a ripple effect and other payers that tie their rates to Medicare (including Medicaid, TRICARE, and various private payers) follow suit. In fact, the Military Officers Association of America (MOAA), which represents 5.5 million members of TRICARE (the government's health insurance for military families), recently sent a letter to Congress calling for positive Medicare physician payment updates. MOAA stated that "since TRICARE payment rates are tied to Medicare's rates, any such reductions will significantly deter more doctors from seeing any uniformed service beneficiaries – not just those over age 65." MOAA further added that when "our service members are sent in harm's way, the last thing they should have to worry about is whether their families will be able to find a TRICARE doctor."

The chart below shows the gap in Medicare payment to physicians from 2001 through 2016, as compared to increases in medical practice costs, as measured by the government's own Medicare Economic Index (MEI).



Cost data is from the MEI, a conservative index of practice cost growth maintained by the Centers for Medicare & Medicaid Services. Medicare physician payment data is from the 2007 Medicare Trustees report with 2008 adjustments to reflect Sec. 101 of P.L. 110-173.

### The Medicare Physician Payment Cuts Will Impact Patient Access

Numerous surveys project a crisis in patient access if Medicare payments fall further behind practice cost increases:

- In an AMA survey of almost 9,000 physicians, 60% said they would have to limit the number of new Medicare patients they treat if this year's pay cut is not stopped. Further, more than half of the surveyed physicians said they could not meet their current payroll with a 10% Medicare pay cut and would be forced to reduce their staff.
- The Medicare Payment Advisory Commission reports that 30% of Medicare patients looking for a new primary care physician already have trouble finding one.
- The Medical Group Management Association found that 24% of group practices already limit their acceptance of new Medicare patients.
- The Council on Graduate Medical Education is predicting the country will face a shortage of 85,000 physicians by 2020.
- An Association of American Medical Colleges workforce study found that 51% of physicians over 50 cite "insufficient reimbursement" as a "very important" factor in retirement decisions.

Although physicians want to continue providing care to all their patients, continued Medicare payment cuts make it difficult to do so, and thus the Medicare physician payment rate cuts

threaten the foundation of our health care delivery system. The Medicare physician payment formula must be addressed now to preserve care for our seniors and disabled patients. **We urge Committee Members and Congress to take action immediately to avert the pending Medicare physician payment rate cuts scheduled for July 1 and replace it with 18 months of Medicare physician payment updates that better reflect medical practice cost increases, and do not increase the size or duration of Medicare physician pay cuts in future years.**

**Immediate legislative action is also needed to avoid extensive administrative costs and related problems that 11<sup>th</sup> hour Congressional interventions cause for both the Medicare carriers and physicians. In order for the Centers for Medicare and Medicaid Services (CMS) to implement physician payment rate changes by July 1, 2008, the agency would need substantial lead time to meet a July 1 implementation date. Otherwise, CMS, Medicare carriers and physician practices must implement such changes on a retroactive basis, which becomes administratively confusing and costly.**

**If Congress fails to act to prevent the 10.6% cut scheduled for July 1, CMS should give physicians a period of time during which they are permitted time to change their Medicare participation or non-participation status.** If physicians' rates are cut, as small businesses, they may no longer be able to meet cover the cost of delivering care and thus need ample opportunity to determine the terms on which they can accept Medicare patients.

Medicare Physician Payment Cuts Impact Millions  
Of Patients, Employees And Physicians Across The Country

If Congress allows the projected Medicare physician pay cuts to go into effect, this could adversely impact millions of patients, physicians and the nearly three million individuals employed by physicians' offices and related businesses across the country. In New York, for example, physicians will lose about \$1 billion for the care of elderly and disabled patients over the 18 months from July 2008 through December 2009 due to the 10.6% cut in Medicare payments in July 2008 and an additional 5% cut in 2009, and that loss increases to \$19.3 billion by 2016 due to nearly a decade of projected cuts. Further, 177,520 employees, over 2.5 million Medicare patients and 180,226 TRICARE patients in New York will be affected by these cuts. Ohio physicians will lose \$490 million over the 18 months from July 2008 through December 2009 due to the projected SGR cuts, and \$9.4 billion by 2016. Further, 115,272 employees, over 1.6 million Medicare patients, and 160,415 TRICARE patients in Ohio will be affected by the SGR cuts. A solution to the SGR is needed now to protect these patients, employees and physicians across the country.

Medicare Physician Payment Updates Must Have Parity  
With Updates Of Other Medicare Providers

Only physicians and other health professionals (whose payment rates are tied to the physician fee schedule) face steep payment cuts. As physicians have been receiving below-inflation updates or a payment freeze, other Medicare providers' payment updates have kept pace with their costs increases. For example, CMS recently announced that the 2009 capitation rates for Medicare Advantage Plans will increase by 4.24% and 2009 hospital inpatient payment rates will increase 2.3%. There is no rational basis for the significant disparity in updates for other

providers and the steep payment rates cuts slated for physicians. Physicians and other health care professionals should have payment updates that keep pace with their cost increases, similar to the updates for other providers.

The Medicare Physician Payment Formula Undermines The Use  
Of Health Information Technology And Quality Initiatives

Widespread health information technology (HIT) adoption will transform the practice of medicine and provide physicians with a powerful tool by putting real-time, clinically relevant patient information and up-to-date clinical decision support tools in practitioners' hands at the point of care and will ultimately raise the overall quality and safety of patient care.

The Medicare physician payment formula, the SGR, however, undermines policymakers' vision of a Medicare health care system that uses HIT, as well as quality initiatives, to deliver the highest quality of care to Medicare patients. The SGR directly conflicts with this vision because quality initiatives, which rely on the use of HIT, often encourage greater utilization of physicians' services through the use of more preventive and chronic disease management services that policy experts predict will produce overall savings in the health care system through reduced use of other more intensive services such as hospitalizations. Yet, the SGR (or other similar spending target) penalizes physician service volume increases that exceed the target through additional payment cuts. These payment cuts, in turn, make it nearly impossible for physician practices, as small businesses, to make the substantial financial investment required for HIT and participation in quality improvement programs.

Indeed, a study by Robert H. Miller and others found that initial electronic health record costs were approximately \$44,000 per full-time equivalent (FTE) provider, and ongoing costs were about \$8,500 per FTE provider per year. (Health Affairs, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from \$37,056 to \$63,600 per FTE provider.

The AMA survey discussed above showed that with a 10% physician cut in 2008, two-thirds of physicians will defer investments in their practice, including the purchase of new medical equipment and information technology. If rates are cut by 40% by 2016, about 8 in 10 physicians will forgo these investments.

**To fulfill policymakers' vision of an HIT-based health care system, Congress must ensure that Medicare payments to physicians are premised on a stable physician payment system that provides positive physician payment updates and accurately reflects increases in medical practice costs. It is not practical or feasible to transition to a system that uses important initiatives, such as HIT and electronic prescribing, when physicians, especially those in small practices, must first ensure that they can keep their doors open in the face of steep Medicare physician cuts. Further, such initiatives require significant financial investment by the federal government to: (i) establish national HIT standards that ensure interoperability, privacy and security; and (ii) encourage widespread adoption of e-prescribing.** The current weakened economy highlights the importance of federal financial assistance in these respects since it is becoming more difficult for borrowers, including physicians as small businesses, to obtain loans to make high-cost capital purchases.

## PHYSICIANS FACE SIGNIFICANT OBSTACLES AND BUDGETARY PRESSURES FROM OTHER FACTORS

As discussed above, physicians have been hit with continual below-inflation payment updates, along with steep payment cuts scheduled for the near- and long-term. In addition, other factors also affect physician practices' bottom line:

- *Rural extender provisions should be extended:* Congress has temporarily provided an increase in certain counties' Medicare physician payments based on geographic location. This provision positively affects 58 of the 89 Medicare payment localities, including many in rural areas. Yet, this provision will expire on July 1 of this year. Another provision that would provide a 5% bonus for physicians practicing in physician shortage areas will also expire on July 1. **These provisions should be extended from July 1, 2008, through December 31, 2009.**
- *CMS should evaluate and make needed revisions to the Medicare Economic Index.* The current MEI has been around since 1973, and it measures increases in the prices of particular inputs used in physician practices. The actual composition of the inputs themselves, however, has not changed to keep pace with the way medicine is practiced today. For example, the number of staff needed per physician has risen dramatically since the 1970s, but the MEI looks only at increases in wages and benefits, not the number or type of staff employed. CMS should evaluate the MEI and make needed revisions to reflect the way medicine is practiced in the 21<sup>st</sup> century.
- *CMS should reduce or eliminate the productivity adjustment to the Medicare Economic Index:* Medicare physician payment updates also are based in part on changes in the MEI, which measures physician practice cost increases. In establishing the MEI each year, CMS adjusts it downward to account for assumed physician productivity increases. In 2008, the MEI is 1.8%, and CMS included a 1.4% productivity offset. Yet, there is no productivity adjustment applied to the hospitals or nursing home market basket, nor any other Medicare provider.

It is not reasonable to apply such an adjustment for physicians services. It would be nearly impossible for physicians to increase their productivity in treating patients in light of various Medicare initiatives that impose numerous time and paperwork burdens, thereby slowing productivity, not increasing it. Further, economists generally agree that productivity in the health care industry is much lower than in other industries. **We, therefore, have urged CMS to reevaluate and reduce this 1.4% productivity adjustment to the MEI, but CMS has declined to do so. We urge the Committee to press CMS to evaluate the productivity adjustment to the MEI and reduce or eliminate it accordingly.**

- Physicians must comply with a wide-array of government regulations and other initiatives, including those relating to the national provider identifier, recovery audit contractors, the Health Insurance Portability and Accounting Act, Part D drugs, quality improvement, and a host of regularly issued Medicare regulations that take extensive amounts of time to digest. All of these regulatory initiatives impose huge

costs on physicians and their office staff as they struggle to review, interpret and implement these initiatives, along with the added costs that often must be paid to attorneys, coding experts, consultants, accountants and other related professionals to assist in these endeavors and ensure proper compliance.

All of these pressures exacerbate the Medicare crisis that is looming due to the steep Medicare physician cuts scheduled for July 1 and projected to continue through 2016. Thus, it is imperative that Congress act now to stabilize the Medicare program. This is especially important considering that the first wave of baby boomers will begin entering the Medicare program in 2011, with enrollment growing from 44 million in 2011 to 50 million by 2016. A recent AMA poll found that eight out of 10 Americans are concerned that the Medicare cuts will harm access to care for seniors and baby boomers, and nearly three-quarters of Americans want Congress to act.

**Accordingly, we urge Committee Members and Congress to take immediate action to preserve the Medicare program for our nation's seniors by enacting Medicare physician payment updates from July 1, 2008, through December 31, 2009, that better reflect medical practice cost increases, and do not increase the size or duration of Medicare physician payment rate cuts in future years.**

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The AMA appreciates the opportunity to provide our views to the Committee on these critical matters that adversely impact all physicians, especially those in small practices. We look forward to working with the Committee and Congress to address each of these matters in order to preserve patient access to high quality, cost-effective care.