



November 16, 2005

The Honorable Nathan Deal
Chairman
Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

The American Medical Group Association (AMGA) respectfully submits the enclosed comments for the Subcommittee's consideration during the November 17, 2005 hearing: Medicare Physician Payment: How to Build a More Efficient Payment System.

AMGA is committed to assisting the Congress in transforming the Medicare program into a value-based purchasing organization. Representing multi-specialty medical groups, AMGA members' experience is care coordination across physician specialties and settings, team concept, and utilization of health information technology allows them to potentially thrive in a well crafted value-based purchasing environment.

AMGA is an association that represents medical groups, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA members' 65,000 physicians deliver health care to more than 50 million patients in 40 states, including 15 million capitated lives. As integrated systems of care, AMGA members are already implementing sophisticated information technologies, providing evidence-based, coordinated care to patients with chronic conditions, and attaining improved clinical outcomes. AMGA members are involved with virtually every facet of the health care delivery system and employ many nationally recognized leaders in the healthcare field.

Value-Based Purchasing Efforts

AMGA appreciates Congressional and CMS' desire to transform Medicare into a value-based purchaser of care. We note that CMS recently announced the implementation of its Physician Voluntary Reporting Program which may lay the foundation for transforming Medicare in to a value-based purchaser. CMS has touted its work with physicians and their specialty societies to develop measures related to the quality and efficiency of physician furnished care. A similar approach is found in current "pay for performance" legislation introduced by Senators Charles Grassley (R-IA) and Max Baucus (D-MT) and legislation introduced by Representative Nancy Johnson (R-CT).

We agree that this is a worthwhile approach. However, we believe that testing the efficacy of these measures should be conducted in the medical group setting. Multi-specialty medical groups provide care across specialties, and provide care to patients with multiple co-morbid conditions. Thus, medical groups are best suited to determine if single disease guidelines are effective across the various physician specialties as well as patients with multiple chronic conditions.

Additionally, we strongly urge Congress and CMS to broaden its approach from the collection and use of single medical specialty/disease guidelines and measures and begin to focus on strategies that encourage the provision of coordinated care.

As you know, in 1999, almost half (48%) of Medicare beneficiaries aged 65 or older had at least 3 chronic conditions; more than twenty percent (21%) had 5 chronic conditions. Costs for treating these high service volume patients accounted for 89% of Medicare's annual budget. Consequently, devising strategies to care for these patients is critical for Medicare's financial viability. Though collecting single specialty/disease guidelines will increase quality care for some patients, this strategy fails to address the needs of beneficiaries with multiple conditions. Further, if CMS and Congress intend to use single specialty/disease specific guidelines to "measure" physician performance, physicians that adhere to these guidelines when treating patients with multiple conditions will, at best, create unsustainable treatment regimes for their patients. At worst, patients could be harmed as these guidelines often recommend contrary treatment protocols. Related to this, if Medicare bases physician "performance" on adherence to single specialty/disease measures, it may create incentives for physicians to only treat patients suffering from one disease or focus on treating younger, healthier Medicare beneficiaries.

AMGA strongly recommends that the Congress and CMS begin to develop policies that encourage physician led care coordination across care settings and disease conditions. We urge Congress and CMS to create a care management fee payment mechanism that reimburses providers for services such as: follow up/reminder phone calls; patient registries; coordinating social/mental services; patient self education; medication management; and others. We believe that these strategies will lead to improved care for these beneficiaries and will also result in decreased utilization and duplication of services.

Volume Testing

It has been suggested that implementation of physician process measures will likely result in an increase in physician service volume which, under the current SGR formula, would lead to a further reduction of unit payments to physicians. These process measures are targeted at the under-use of physician services, not overuse. Currently, however, there are no accepted "efficiency" measures which address the potential overuse of physician services. AMGA and its members would be happy to work with you and CMS to develop these measures which, we believe, would begin to address the serious variation in health care spending currently happening in our health care system.

Sustainable Growth Rate

We would also like to take this time to address the issue of the Sustainable Growth Rate (SGR). As you know, Medicare's payment update formula for physician reimbursement is flawed. From 1991–2003, the average annual reimbursement increase was only 1.1%, causing physician reimbursement rates to lag 14% behind practice cost inflation as conservatively estimated by CMS. Even the 1.6% update for 2003 was only about half the 3% rise in practice cost inflation. As a typical illustration, one AMGA member group practice reports that their FY2000 Medicare revenue was 71.52% of cost for fee for service; in FY2001 it was 70.59%; in FY2002 it was 67.7%; and in FY2003 it was 65.76%. This downward spiral of Medicare revenue as a percentage of the cost of providing services must be stopped in order to retain sufficient provider participation for beneficiaries' access to quality care. Because these inadequate Medicare payment rates are used as benchmarks for commercial insurance and Medicaid reimbursement rates, low payment levels cause harm beyond Medicare access problems. In effect, this country has a national government medical service rate-setting system, where private payers and Medicaid set their rates based on Medicare rates.

AMGA believes that Medicare beneficiaries will begin to face real access to care issues once the mandated 4.4% cut to the physician payment update occurs. We understand that the Medicare Payment Advisory Commission (MedPAC) has long asserted that cuts in the update do not lead to access problems, however, a recent AMGA survey of its members indicate that this may not be the case in the future.

Survey results demonstrated that while large medical groups continue to provide high quality care to Medicare patients, access problems will occur in 2006 and beyond. The survey showed that if CMS cuts the physician payment update by 4.4% in 2006, fifty six percent of medical groups will limit their acceptance of new beneficiaries. None of the sixty medical groups indicated that they would stop accepting all new beneficiaries in 2006.

If the projected 5% cut in 2007 occurs however, twenty five percent of medical groups indicated that they will not accept ANY new beneficiaries. Thirty six percent of medical groups will limit some beneficiary access in 2007, while thirty eight percent of medical groups would still accept all Medicare beneficiaries. If cuts of more than twenty five percent occur over 6 years, as currently projected, the number of groups not accepting any new beneficiaries remains at fifty percent. However, those medical groups accepting all new beneficiaries falls from 23 to 10 medical groups.

We believe the survey results are significant because solo practitioners and small physician groups tend to be the first practitioners to limit their access to Medicare beneficiaries because of decreased Medicare reimbursements. However, the AMGA survey demonstrates that even large multi-specialty medical groups will not be able to absorb such steep cuts to the physician update.

The Honorable Nathan Deal
November 16, 2005
Page 4

In order to appropriately reimburse physicians under the Medicare fee schedule, AMGA recommends that CMS replace the SGR system with updates based on a formula similar to the Medicare Economic Index. This would allow updates to be based on the cost of providing services.

Thank you very much for your consideration of our views on this critically important matter. We firmly believe that medical groups deliver high quality and efficient healthcare. We would be happy to work with you as you continue to test appropriate payment mechanisms that result in transforming Medicare into a value-based purchasing system. If we can provide you with any further information or assistance related to this matter, please feel free to contact me or Chet Speed at cspeed@amga.org.

Sincerely,



Donald W. Fisher, Ph.D
President and Chief Executive Officer
American Medical Group Association

cc: Kenneth Brin, MD, PhD, Director of Cardiology, Wilkes-Barre, Geisinger Health System
Francis Jay Crosson, MD, Executive Director, The Permanente Federation