January 5, 2009

Glenn M. Hackbarth, JD
Chairman
Medicare Payment Advisory Commission
601 New Jersey Avenue, NW
Suite 9000
Washington, DC 20001

Dear Chairman Hackbarth:

The undersigned organizations deeply appreciate that the Medicare Payment Advisory Commission (MedPAC) is preparing to recommend that the physician update for 2010 be based on the increase in the costs physicians face instead of being cut by 21 percent, as would be required by the Sustainable Growth Rate (SGR) formula. At the same time, however, we remain concerned that the Medicare Economic Index (MEI) which serves as the foundation for MedPAC's recommendation includes a very substantial productivity adjustment which reduces the MEI by half, or even more. We strongly urge the Commission to consider recommending a 2010 update for physician services that reflects the full increase in medical practice input prices without any productivity adjustment.

The current estimate of the increase in input prices is 2.4 percent. Subtracting 1.3 percent for nonfarm multifactor productivity would reduce the update recommendation to just 1.1 percent. It took the Medicare conversion factor until 2008 to finally get back to where it was before the 2002 cut, and even now average physician payment rates are only slightly higher than in 2001, while the MEI has risen by 22 percent. A 1.1 percent increase in 2010 will not begin to make up for that gap. Besides not making up the gap, a 1.1 percent update is unlikely to even cover practice cost increases for 2010 because the MEI formula routinely understates the true cost of care.

There are two primary reasons that the MEI lags so far behind actual practice cost increases: one is that the MEI is a price index only, so the data used to calculate the physician update is based on what a medical practice looked like when the "market basket" used in the MEI was developed in 1973 and does not reflect all the costs involved in providing medical care in 2008. No adjustments are made for new costs, such as computers, copiers and additional staff, which were not present in physician offices in 1973. For example, data presented to MedPAC in October on Health Care Sector Growth indicates that just between 1999 and 2008, physician office employment increased by 27 percent. In fact, there is little about a medical practice of 2009, whether in the medical technology that is available, the office environment, the medical records processes, or the skilled clinical staff, that bears much resemblance to the medical practice of 1973, but that is the year that the inputs used in the MEI were determined. Prices have changed and weights have changed, but not the underlying inputs.

This problem is then exacerbated by an assumption that is built into the MEI and, to date, included in each year's MedPAC recommended update, that physicians, unlike any other

provider group, can increase productivity year after year to the same degree as the nonfarm economy. This assumption is unrealistic. There are some ways in which physicians can and have increased productivity and efficiency but there are limits on how many minutes can be shaved off of a given service and how many services a physician can do in a day. In addition, there are often costs associated with increased efficiencies that are recognized to some extent in the relative value reviews for particular services, but there is no mechanism for increasing overall physician service funding to account for new resource inputs.

More importantly, any time that physicians may have saved by streamlining practices has been more than consumed by the time required for compliance with all the new regulatory burdens imposed on physicians over the last decade. For example, conversion to new provider identification numbers required by the Health Insurance Portability and Accountability Act (HIPAA) has led to lengthy enrollment and re-enrollment backlogs for physicians that delay payments for months, and sometimes years. During this time, physicians and their staff spend hours and hours trying to find out the status of their applications, revising and resubmitting them, and lining up loans in an increasingly tight credit market to pay their staff and other expenses. Once their enrollment is finally processed, they have to spend time making sure they get paid for all the services they provided during the months or years that the application was awaiting approval. Other tasks that have decreased physician productivity are:

- The constantly expanding list of services or durable medical equipment subject to physician certification and recertification;
- Ever-changing Part D formularies and preauthorization requirements;
- Compliance with HIPAA privacy and other administrative standards;
- Pulling medical record information for the ever-expanding number of audits that physicians are subject to, such as Recovery Audit Contractors;
- Transition to the new Medicare Administrative Contractors; and
- Upcoming imaging accreditation requirements.

In the last six years, MedPAC has routinely waived or cut in half the productivity adjustment when recommending updates for inpatient and outpatient hospital services. Only once, in its recommendation for the 2004 outpatient hospital update, did MedPAC include a full productivity adjustment. The undersigned organizations urge the commission to recommend that no productivity adjustment be applied to next year's physician update. Thank you for your consideration.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Home Care Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology Professional Association

American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Geriatrics Society
American Medical Association
American Medical Directors Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Psychiatric Association
American Rhinologic Society
American Society for Gastrointestinal Endoscopy
American Society for Therapeutic Radiology and Oncology
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
American Society of Plastic Surgeons
American Society of Transplant Surgeons
American Thoracic Society
American Urogynecologic Society
American Urological Association
Association of American Medical Colleges
Child Neurology Society
College of American Pathologists

Congress of Neurological Surgeons
Heart Rhythm Society
Infectious Diseases Society of America
Joint Council of Allergy, Asthma and Immunology
Medical Group Management Association
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Maternal-Fetal Medicine
Society for Vascular Surgery
Society of Critical Care Medicine
Society of Gynecologic Oncologists
Society of Hospital Medicine
Society of Interventional Radiology
Society of Thoracic Surgeons
The Endocrine Society