Nancy Ann Min-DeParle
Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 309-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attn: HCFA-1021-NC
Subject: Medicare Program; Sustainable Growth Rate for Fiscal Year 1999

Dear Ms. DeParle:

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) is pleased to provide comments on the notice regarding the sustainable growth rate (SGR) formula, published in the *Federal Register* on November 2, 1998. This notice announced a fiscal year 1999 SGR target for Medicare expenditures on physicians' services of –0.3%. In the notice, the Health Care Financing Administration (HCFA) also acknowledged two serious problems with the SGR formula: the need to correct errors in projecting the factors on which the SGR is based, and the inherent instability of the formula. HCFA also indicates that it may seek legislative changes in the SGR, so our comments also address the areas where we believe legislative changes are needed.

## SGR Projection Errors

**Because the accuracy of the SGR will have a great impact on physicians and their patients, we are asking HCFA to closely re-examine the data, timeframes, and underlying assumptions which go into to building the SGR.** We feel the SGR is particularly vulnerable to projection errors, and believe there are several reasons why the projections underlying the 1999 SGR will turn out to be inaccurate, thus holding potentially serious repercussions for next year's payment update.

HCFA's own analysis has confirmed that, indeed, there were significant projection errors which distorted the 1998 SGR. This means that the 2.3% payment update for 1999 will be 1% or $430 million below what it should have been. **We would thus urge HCFA to correct the 1998 SGR accordingly, and also assure the 1999 payment update be likewise increased.**

## Correcting Projection Errors

By statute, SGR projections must be extrapolated from data which is incomplete, requiring that actuarial assumptions be applied to fill in the gaps. Naturally, this can never be as accurate as an SGR founded on actual and complete data, eliminating actuarial guesswork. **We would thus urge HCFA to retrospectively adjust physician payment updates using actual rather than projected changes in the SGR's four component factors: GDP growth, changes in payments for physician services before legislative changes (essentially inflation), changes in Medicare Part B enrollment, and legislative/ regulatory changes.**

HCFA has already expressed its support for such retrospective correction of projection errors in the November 2, 1998 notice, indicating its belief that this would be consistent with congressional intent, though questioning whether its interpretation of congressional intent is accurate:

> "We do not believe that the Congress, in enacting the SGR, contemplated such significant variances between estimates made at different points in time. Therefore, we are considering whether we should "adjust" the SGR or the update for a year, to take into account more recent estimates, when the subsequent year's update is determined. Such an adjustment for estimate differences would assure that the update is related to actual performance. However, we have concerns about how this could best be accomplished, if at all, under current law."

If the SGR system is to work at all, these projection errors must be corrected. The SGR is meant to be based on GDP, not projected GDP. The uncertainty expressed in this year's SGR notice with respect to congressional intent is also inconsistent with previous HCFA regulations. The final rule for the 1998 Medicare Payment Schedule specifically states, "Differences between projected and actual real gross domestic product per capita growth will be adjusted for in subsequent years."

Clearly, HCFA officials recognize the obvious and practical importance of correcting projection errors in the SGR and we agree. Real per capita GDP growth for fiscal year 1998 was projected at only 1.1% in setting the 1998 SGR target. This was a serious underestimate. Economists project that growth will be roughly double HCFA's projected rate. HCFA could have made use of actual data on GDP growth for most of fiscal year 1998 in setting the 1999 conversion factor update. Failure to do so would unfairly reduce physician payments in 1999 by approximately 1%, or $430 million, below what they should be under current law.

We also find HCFA's basis for projecting changes in fee-for-service enrollment problematic. HCFA has projected a 4.3% decline in fee-for-service enrollment for fiscal year 1999 and a 29% increase in Medicare+Choice enrollment for the year. Recent, well-publicized accounts of health plan withdrawals in many areas suggest that this projected increase is likely to be too high. It is significantly higher than average annual growth in risk HMO enrollment for 1995-1997, and a September 1998 report from HHS Office of the Inspector General concludes, based on recent survey findings, that "beneficiary interest in joining an HMO decreased." If the decline in fee-for-service enrollment is less than the rate projected by HCFA, then physician payments will be permanently reduced by the amount of the error unless any such projection error is corrected.

Furthermore, HCFA has underestimated the potential effect of imprecise and inaccurate enrollment projections on the SGR. In the November 2, 1998 notice, HCFA states that "...the differences between the initial estimate and a later estimate [of changes in enrollment] could be large and as a result could affect the SGR by as much as 1 percentage point." To illustrate, if actual growth were 15% instead of 29%, then the actual decline in fee-for-service enrollment would be only1.8%, instead of the 4.3% reduction in FFS enrollment estimated by HCFA. In this example, HCFA may have underestimated the SGR by as much as 2.5 percentage points by assuming an unrealistic rate of increase in Medicare+Choice enrollment. If this were compounded by another underestimate of GDP growth, the 1999 SGR could be underestimated by 3-4 percentage points, resulting in a $1.2-$1.6 billion cut in physician payments in 2000.

The 1996 Physician Payment Review Commission (PPRC) report to Congress states: "This limitation [projection errors] could be readily addressed by incorporating an adjustment into the sustainable growth rate that corrects for previous errors in the projection." Given that Congress essentially adopted the recommended form of the SGR from PPRC, it is clear that HCFA does have the latitude to update the SGR targets with the most recent data available.

HCFA has the authority to use the most recent data available in setting the conversion factor update for a particular year. August 1st of each year, HCFA should issue a revised SGR target for the current fiscal year, as well as a projected SGR target for the coming fiscal year. The revised SGR will still be an estimate as it will be based on actual data for most, but not all, of the current fiscal year. For example, the 1999 conversion factor update should be based on revised figures for enrollment changes, GDP growth, and inflation that were used to develop the fiscal year 1998 SGR target.

**Instability of the SGR System**

HCFA also states in the November 2, 1998 notice that, "In the long term, [conversion factor] updates could oscillate between the maximum increase and decrease adjustments..." This means, in essence, that conversion factor updates could alternate between periods of inflation plus 3% and inflation minus 7%. Such dramatic swings would be highly disruptive to the predictability of physician reimbursement, and be a particular hardship when the conversion factor is set at inflation minus 7%. **This inherent instability in the SGR system is a serious problem which must be addressed by HCFA, Congress, and the Medicare Payment Advisory Commission (MedPAC)**. Hopefully, it should be corrected before a large payment cut occurs.

**Changes Requiring Legislation**

The SGR formula has several other shortcomings that will require legislative correction. **First and foremost, there should be an add-on to the SGR formula to allow for technological changes in medicine that increase the demand for physician services and allow for shifts in site of service to ambulatory settings.** As first envisioned by the PPRC, the idea of a target tied to GDP included a 1 to 2 percentage point add-on for changes in medical technology. Ever-improving diagnostic tools and surgical techniques have undoubtedly contributed to growth in utilization of physician services, and to the well-being of Medicare beneficiaries. Technological change in medicine shows no sign of abating, and the SGR should include a technology add-on to assure Medicare beneficiaries' continued access to mainstream medical care.

**Second, the cost of ambulatory care practice rises with the shift in care from hospital inpatient settings to outpatient sites**. As MedPAC has pointed out, hospitals have reduced the cost of inpatient care by reducing length of stay and scaling back on staff. Some inpatient staff and service reductions are offset by increased costs and services in physician offices and other outpatient sites**. An add-on to the SGR target is needed to allow for this trend.**

**Third, the SGR should also be adjusted for changes over time in the characteristics of patients enrolling in Medicare+Choice plans compared to those remaining in the fee-for-service program.** HCFA has stated that Medicare beneficiaries who enroll in managed care plans may be healthier than those who stay in the fee-for-service program. If the trend is for people who

are older and/or sicker to remain in the fee-for-service program, there should be an adjustment to the SGR to account for such differences in the beneficiary population. Absent such corrections, if fee-for-service payments are slashed relative to Medicare+Choice payments, the Medicare fee-for-service program may effectively dissolve, leaving beneficiaries without a viable alternative to managed care.

**Finally, we believe that the lower limit on payment updates under the SGR is unacceptably low.** Assuming a Medicare Economic Index of 2%, the lower limit of inflation minus 7% would imply a 5% actual cut in the conversion factor in a single year. The Medicare update formulae for other (non-physician) providers does not expose them to the degree of payment reductions that physicians are likely to experience under the SGR. Medicare+Choice payments are guaranteed annual increases of 2%. For the hospital update for a year to be analogous to the lowest potential physician update, it would have to be set at market basket minus 7% – an unlikely scenario at best**. The lower limit on SGR updates must be raised to provide a more acceptable floor on payment updates.**

We appreciate your consideration of the foregoing comments and urge HCFA to work towards a final SGR methodology which is more current, precise, and equitable and fair to all physicians who provide care to Medicare Part B enrollees. If you have any questions about these comments, please contact ACP-ASIM's Senior Vice President of Government Affairs and Public Policy, Robert Doherty, at (202) 261-4530.

Sincerely,

Harold C. Sox, MD, FACP
President

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