ACP American College of Physicians
INTERNAL MEDICINE | *Doctors for Adults*

STATEMENT TO THE

PRACTICING PHYSICIANS ADVISORY COUNCIL

May 19, 2003

The American College of Physicians (ACP), the nation's largest medical specialty society, representing over 115,000 internists and medical students, is pleased to provide testimony to the Practicing Physicians Advisory Council (PPAC) regarding: Physicians Regulatory Issues Team (PRIT) Initiative; Office of the Actuary—Volume Performance Measures/Volume Intensity Adjustments; and Access to Physician Services.

1. Physicians Regulatory Issues Team Initiative

ACP commends the Centers for Medicare and Medicaid Services (CMS) for its PRIT initiative and for working with physician organizations to reduce the Medicare regulatory burden. ACP is pleased that CMS has implemented improvements in numerous areas, including revising the documentation requirements pertaining to teaching physician evaluation and management (E/M) services that involve a resident. ACP looks forward to working with the agency to implement solutions to the issues on the current PRIT list, as well as new issues that arise.

A. Correct Coding Initiative

ACP requests that CMS add "Correct Coding Initiative (CCI) Access" to its list of issues on which the PRIT will take action. Physicians have inadequate access to the Medicare CCI process. Physicians have a difficult time monitoring the CCI because the updates are frequent and costly to obtain. Further, a number of CCI edits have been retracted after implementation—causing confusion and placing the burden on physicians to resubmit inappropriately denied claims.

CMS should help physicians to comply with the unwieldy CCI process. The June 6, 2002 CMS Program Memorandum, Transmittal AB-02-079 (Change Request 213), instructing carrier customer service personnel to tell physicians that they are unable to provide information on specific CCI edits/modifiers highlights the need for CMS action. While ACP understands the rationale that carrier personnel cannot be expected to maintain familiarity with the thousands of CCI edits that involve thousands of procedure codes, **CMS should make CCI edits available through its website, in a form that is searchable by Current Procedural Terminology (CPT) code (the code edits should be listed without violating the American Medical Association CPT copyright). The CCI edits should be available electronically at no cost to physicians. Further, ACP urges the PRIT to work to improve the process by which proposed CCI edits are reviewed by the American Medical Association and specialty societies.**

B. Department of Health and Human Services Regulatory Reform Committee Recommendations

The PRIT should review the November 21, 2002 Department of Health and Human Services (HHS) Regulatory Reform Committee final report that contains 268 recommendations for reducing the regulatory burden imposed by HHS programs. The Committee issued recommendations—intended to reduce the burden and cost associated with regulations while maintaining or enhancing effectiveness—pertaining to issues on which the PRIT has worked, such as E/M service documentation guidelines and the Emergency Medical Treatment and Active Labor Act (EMTALA). **The PRIT should lead CMS in taking a proactive role in acting on relevant HHS Regulatory Reform Committee recommendations and should report to the public the action the agency is taking on each recommendation.**

2. Office of the Actuary—Volume Performance Measures/Volume Intensity Adjustments

ACP is troubled that higher than expected 2002 Part B spending and lower Gross Domestic Product (GDP) growth prompted the agency to forecast negative physician payment updates for 2004 and the subsequent years through 2007. ACP challenges the CMS perception that 2002 spending was higher than the agency projected because physicians increased the volume of their services to offset the 2002 5.4% payment cut. The agency's notion that the spending increase can simply be attributed to deliberate action by physician to offset the 2002 payment cut is too simplistic and ignores several important facts.

Data from the CMS 2004 payment update preview indicate that growth in beneficiary use of physician services began to accelerate in 2001, a year before the payment cut. According to the CMS data, a substantial portion of the 6.5% 2002 Part B spending increase was due to a rise in drug and clinical laboratory service costs as well as a 3.2% increase in the number of beneficiaries enrolled in fee-for-service. Further, published data compiled by CMS actuaries indicate that increased health care spending is not limited to physicians. A March 26, 2003 *New York Times* article, citing CMS data, stated that the percentage increase in Medicare 2002 spending for durable medical equipment, hospital, home health, skilled nursing facility and hospice services exceeded the percentage increase in physician spending. Clearly, there is something more pervasive behind this across-the-board growth than physicians recouping losses from a Medicare pay cut. **ACP urges CMS to analyze 2002 spending and all other relevant data to determine alternate or contributing causes for unexpected increases in Part B spending.**

Specifically, ACP has reviewed data that compare 2002 Medicare Part B charges to 2001 charges. These data depict changes in charges by type of service (e.g. physician, laboratory, drugs); by place of service; by specialty; and by procedure code. **The ACP-identified potential explanations for growth in 2002 Part B charges are below.**

A. Some of the changes can be attributed to the increased number of Part B beneficiaries and to the continued aging of the Medicare population (and corresponding need for more services).
B. The data generally show an increased trend away from the hospital setting and towards more treatment in the office setting. As patients are discharged from the hospital sooner an increase in volume and intensity of office services will result. The net effect should be an overall savings of cost for Medicare, not an increase as office-based services are typically much less costly than hospital services. One of causes for the decrease in the hospital services is Medicare's use of the McKesson's Interqual criteria to justify Medicare admissions to the hospital. This is having an increasing impact as more hospitals use these criteria, which become effective October 2000.
C. Several years ago, the Medicare Payment Advisory Commission expressed concern that Office of Inspector General and CMS statements on fraud and abuse were encouraging physicians to undercode their visits. Now that the rhetoric has cooled somewhat, perhaps physicians are more likely to be coding correctly and less likely to be undercoding.
D. Increased Medicare spending for internal medicine subspecialties is the proliferation of new improved infusion therapy drugs, such as Remicade. Generally, spending will increase as technology improves and patients can be treated for previously untreatable problems.
E. Practice guidelines promoting the use of certain services (e.g. colorectal cancer screening) are increasing the volume of certain services appropriately. Other examples are as follows:
    a. The increase in use of Epoeitin injections in non End Stage Renal Disease (ESRD) patients is partially due to the increased awareness of Chronic Kidney Disease fostered by new clinical practice guidelines for detection and treatment of patients (with "non-dialysis requiring" kidney disease).
    b. The Agency for Healthcare Research and Quality (AHRQ) recently reported that increased use of myocardial perfusion imaging leads to fewer unnecessary admissions for acute myocardial infarctions. Accordingly, this test is done increasingly in the outpatient setting even though the number done in hospitals is not changing significantly.
F. Increased patient demand. There is increased use of drugs due to direct-to-consumer advertising (television, magazines, etc); for example: epoeitin injections in non ESRD patients with cancer and other chronic diseases.
G. CMS should account for charges associated with new procedures and/or new Medicare benefits separately. This will allow for straightforward analysis of whether CMS expenditure estimates track with actual spending associated with new procedures.
H. CMS payment policies may have encouraged physicians to schedule/beneficiaries to seek more office visits. Possible payment policies include:
    a. Correct Coding Initiative edits, which prohibit payment for multiple services/procedures on the same date, can provide an incentive/necessity for physicians to furnish services/procedures on separate visits; and
    b. Medicare rules that bundle payment for telephone calls and other interactions with beneficiaries in between visits into the payment for a face-to-face encounter (calls and interactions the reason for which may or may not correspond to the

face-to-face encounter) could be a contributing factor if physicians decided to have these beneficiaries make an office visit instead of providing under-compensated (or uncompensated) care via the telephone. This is supported by the increase in spending for 99211s.

3. Access to Physician Services

ACP commends PPAC for its March 2002 and September 2002 recommendations to CMS to improve the agency's ability to measure Medicare beneficiaries' access to physician services, including assessing how long beneficiaries wait to get an appointment. We also thank CMS for its effort to compile better beneficiary access data. **ACP urges PPAC to recommend that CMS continue to provide periodic updates on efforts to better measure beneficiary access.**

Further, ACP thanks PPAC and CMS for their instrumental role in averting a payment cut in 2003. While we are grateful for the modest 2003 payment increase, especially in light of the scheduled 4.4% payment reduction, the projected payment cut for 2004 and future years dictates that beneficiary access issues remain a high priority.

Physicians have a strong sense of commitment to their Medicare patients. However, the 2002 Medicare payment reduction and the 2004 and subsequent projected cuts jeopardize the ability of physicians to care for Medicare beneficiaries. Physicians are being forced to/are considering whether to restructure their practices' patient and service mix to reduce their reliance on Medicare revenue to ensure economic survival. The financial strain is even forcing some physicians to go out of business, by closing their practices entirely.

While ACP encourages CMS to continue to expand its efforts to study the beneficiary access issues, existing studies demonstrate the acuity of the problem and the need for immediate action. These studies provide compelling evidence that these Medicare payment cuts are threatening access to care, and if continued as planned, will further harm beneficiaries. Highlights/excerpts from these are reports are noted below.

A. Medicare Payment Advisory Committee March 2003 Report to Congress

The March 2003 Medicare Payment Advisory Committee (MedPAC) report to Congress cited the following findings from the MedPAC 2002 survey of physicians.

Although 96% of physicians accepting some new patients reported that they were accepting at least some new Medicare patients, other results indicate potential diminished beneficiary access:

- The percentage of physicians accepting new Medicare fee-for-service patients dropped from 76% in 1999 to 70% in 2002;
- The percentage of physicians accepting only some new Medicare fee-for-service patients rose from 20% in 1999 to 26% in 2002;
- Physicians reported that it was more difficult to find appropriate referrals for their Medicare fee-for-service patients; and

- Approximately 77% of physicians stated that they were concerned about reimbursement levels for their Medicare fee-for-service patients;

While only 15% of the physicians indicating concern about Medicare fee-for-service reimbursement limited their acceptance of new Medicare patients, ACP believes it is logical that future Medicare payment cuts would likely cause physicians to convert their concern into action and reduce or stop accepting new Medicare patients.

Although MedPAC states that the relationship between changes in physician practice and Medicare payments is unclear, the 2002 MedPAC physician survey demonstrated that physicians are reducing their practice costs as two-thirds of physicians said that their practices had delayed or reduced capital expenditures. ACP believes that payment cuts inhibit physicians' ability to improve or even maintain the infrastructure of their practices.

B. American College of Physicians 2002 Policy Paper "Reimbursement Problems Undermine Medicare"

Our 2002 policy paper demonstrating that adequate reimbursement is necessary to sustain a viable Medicare program identifies the following access problems:

- 30% of family physicians did not accept new Medicare patients in 2001;
- A 2000 Association of American Physicians and Surgeons survey found that almost 25% of physicians were refusing to treat new Medicare patients; and
- A 2001 Denver Medical Society survey found that 40% of primary care respondents were not accepting new Medicare patients.

C. Center for Studying Health System Change September 2002 Issue Brief "Growing Physician Access Problems Complicate Medicare Payment Debate"

A September 2002 Center for Studying Health System Change Issue Brief "Growing Physician Access Problems Complicate Medicare Payment Debate" states that:

- In 2001, over a third of Medicare beneficiaries waited more than three weeks for a checkup. A similar percentage waited a week or more for an appointment concerning a specific illness;
- 23.6% of Medicare seniors who put off or delayed care did so because they could not get an appointment soon enough, up from only 13.9% in 1997; and
- Although the increases in the amount of time required to get an appointment and delays in getting needed care were evident even before the 5.4% cut in 2002 payment levels, "additional Medicare cuts of the magnitude expected over the next few years are likely to increase beneficiaries' access problems, especially in markets where private insurers pay significantly more than Medicare for physician services."

D. American Medical Association 2002 Physician Survey

Physician responses to survey questions specific to the scheduled 4.4% 2003 payment cut that was averted likely provide a preview of physician behavior in response to projected future payment cuts. A 2002 AMA physician survey found that:

- The number of physicians indicating that they plan on continuing to participate in the Medicare program in 2003 (83%) is down from the previous year (92%);
- 24% of physicians have either decreased the number or type of Medicare patients they treat, or plan to do so in the next six months; and
- If Medicare payments were cut an additional 5-6% in 2003, 42% of physicians stated that they would not continue to participate in the Medicare program. When asked why, the number one response was, "can't afford to."

D. Recommendation to Address Access Problems

ACP urges PPAC to recommend that CMS support the MedPAC recommendation that Congress should update payments for physician services by the projected change in input prices, less an adjustment for productivity growth of 0.9% for 2004, a formula resulting in a 2.5% positive update. In its March 2003 report to Congress, MedPAC states that "increasing payments for physicians services would help preserve beneficiary access to care" and "increasing payments to physicians would help to maintain the adequacy of those payments and allow physicians to furnish high-quality services."

Further, ACP urges CMS to work with the Congress to permanently revise the flawed Sustainable Growth Rate (SGR) formula so that subsequent annual updates ensure that Medicare payments are more closely linked to the actual medical practice costs.

ACP thanks PPAC for the opportunity to comment on: Physicians Regulatory Issues Team Initiative; Office of the Actuary—Volume Performance Measures/Volume Intensity Adjustments; and Access to Physician Services.