STATEMENT

of the

American Medical Association

to the

Practicing Physicians Advisory Council

Re: 2004 Physician Fee Schedule

February 10, 2003

Presented by: Duane M. Cady, MD

The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC) concerning the 2004 physician fee schedule.

We applaud the Centers for Medicare and Medicaid Services (CMS) for reaching out to PPAC and the physician community for input to develop the 2004 physician fee schedule rule. As we have discussed in the past, it is critical for PPAC to have the opportunity to timely consider and make recommendations on Medicare policies and regulations. Discussion of the 2004 fee schedule rule at this meeting is a great step toward achieving this goal.

Further, it is important to have careful consideration (with input from the physician community) of Medicare payment policies, especially since payment policy has such a tremendous impact on Medicare beneficiary access. The 5.4 percent cut in payments for services provided by physicians and numerous other health care professionals has created a serious access problem for Medicare beneficiaries. The 4.4 percent cut that is scheduled to become effective on March 1, 2003, will create an even greater access crisis.

An AMA survey early last year found that although most physicians are still treating Medicare patients, 24 percent had either limited or planned to limit the number of Medicare patients they treated. Preliminary results of a new AMA survey conducted late last December found that 20 percent of the physician respondents had in fact made such restrictions in 2002, and 60 percent reported increasing difficulty in making suitable referrals for their Medicare patients. Moreover, nearly half (48 percent) of all physicians and 61 percent of primary care physicians plan to reduce the number of Medicare patients in their practice if payments are cut again in 2003.

We appreciate that the Administration has signaled that access is a big concern and that appropriate payment must be made to avert a crisis in access to medical care for Medicare beneficiaries. Indeed, CMS Administrator Scully has warned of a "meltdown" if Medicare payments to physicians are not increased. We encourage CMS to continue to make beneficiary access a top priority, and to implement the recommendations we have suggested below as a means for ensuring access.

INCLUSION OF DRUGS IN THE SGR

We urge PPAC to recommend that CMS re-consider its inclusion of drugs in the calculation of the sustainable growth rate (SGR) for purposes of the 2004 fee schedule rule.

In our comments on the 2003 proposed fee schedule rule, the AMA recommended that CMS remove drugs from the calculation of the SGR for several reasons. Indeed, PPAC made this same recommendation to CMS as well. Although we appreciate that CMS acknowledged and discussed these comments in the final rule, we are disappointed that CMS declined to make this change for the 2003 rule. We wish to reiterate the importance of re-considering this issue for purposes of the 2004 fee schedule rule.

CMS acknowledges its authority to take drugs out of the SGR, and the AMA urges CMS to exercise this authority. As we have previously discussed with PPAC and CMS, drugs are not paid under the Medicare physician fee schedule, and thus it is inconsistent to include drugs in the SGR. Indeed, CMS acknowledged in an interim final rule (on the application of inherent reasonableness to Medicare Part B services), which was published just prior to publication of the final fee schedule rule, that the Medicare definition of "physicians' services" excludes drugs.

Further, as we discussed in our comment on the proposed rule, a draft strategic plan by the Department of Health and Human Services (HHS) proposes to "accelerate private sector development of new drugs, biologic therapies and medical technology." To continue including drugs in the SGR is at odds with this goal, and in effect, punishes physicians with lower payments if they provide the very new drugs and therapies that the strategic plan wants manufacturers to produce. In addition, because of these types of policies, along with other factors, drug spending is rising much more rapidly than physician spending. Thus, the inclusion of drugs in the SGR makes it extremely likely that spending on physicians' services will exceed the SGR target.

Finally, the SGR does not provide an incentive to individual physicians to control drug utilization. Since the SGR is based on the collective actions of all physicians and other health care professionals who bill the Medicare program, it is difficult for an individual physician to assess, at any given point in time, the impact of needed prescription drugs on the SGR. We also note that Medicare payment for drugs is not based on the SGR. Since neither prices nor utilization of drugs are affected by the SGR, it is inconsistent and inequitable to argue that the

SGR controls drug spending. We, therefore, respectfully recommend that drugs be removed from the SGR pool.

CHANGES IN MEDICARE SPENDING ON PHYSICIANS' SERVICES DUE TO LAWS and REGULATIONS

We urge PPAC to recommend that CMS reconsider in the 2004 proposed rule its decision not to include an allowance in the SGR target for changes in utilization and spending resulting from all national coverage decisions (NCDs) issued during the last several years.

In the AMA's comments on the 2003 proposed physician fee schedule rule, we recommended that CMS include increases in physician spending resulting from NCDs for purposes of calculating the SGR. Again, we appreciate CMS discussion of these comments in the final rule. Nevertheless, we are disappointed that CMS declined to make this change, and we urge PPAC to reiterate the importance of re-considering this issue for purposes of 2004 rule.

PARTICIPATION AGREEMENTS

We urge PPAC to recommend that CMS ensure that the duration of Medicare participation agreements is consistent with the duration of the Medicare fee schedule payment period.

Medicare law establishes that physicians may voluntarily enter into an agreement with the Secretary of HHS to become a participating physician, and the law defines a "participating physician" to mean a physician who, before the beginning of any year, enters into an agreement with the Secretary which provides that such physician will accept Medicare payment on an assignment-related basis for all items and services furnished to Medicare-enrolled individuals during such year. The law also sets forth some exceptions under which physicians may enter into an agreement (to become a participating physician) after the beginning of a year. Finally, the law permits the Secretary to specify other circumstances under which physicians may enter into an agreement after the beginning of the year.

We appreciate that CMS is extending the participation enrollment period to February 28, 2003 (though the effective date of the participation agreement would be January 1, 2003.) We are concerned, however, that physicians will not be able to make an informed decision about their participation status this year since Medicare rates may fluctuate during the year. For instance, the 4.4 percent cut may or may not go into effect on March 1. In addition, under pending federal legislation, a cut may or may not go into effect on October 1.

Since the law permits the Secretary (of HHS) to specify other circumstances under which physicians may enter into an agreement after the beginning of the year, the AMA recommends that PPAC urge CMS to use this authority to ensure that the duration of the Medicare participation agreement is consistent with duration of the Medicare fee schedule payment period.

MEDICAL LIABILITY

We urge PPAC to recommend that CMS make available more specific data that is used to determine the increasing costs of medical liability insurance, as reflected in the Medicare Economic Index (MEI).

In our comments on the proposed rule, we requested that CMS make available all material information that is the basis for reflecting changes in medical liability costs in the MEI and ensure that the 2003 MEI appropriately reflects the cost increases that physicians are actually experiencing. Although we appreciate CMS' response to this request in the final rule, more data is needed to determine whether the MEI reflects the actual increases physicians across the country are experiencing in their medical liability insurance premiums.

CMS stated in the final rule that it does not collect information about medical liability costs through any standardized form. Rather, it uses an informal process by which CMS requests information from a few national commercial carriers via letter. (CMS, however, did not provide a copy of the letter that was sent to carriers.) Further, CMS discussed that the carriers provide information on a voluntary basis, and generally between 5 and 8 carriers volunteer information.

CMS has indicated an 11.3 percent change in calendar year 2003 liability insurance costs. Various sources in the marketplace, however, indicate that liability costs are increasing by digits much greater than 11.3 percent. For example, the *Medical Liability Monitor* reports that for internists and general surgeons, the average percent of increase in medical liability premiums during the 12-month period 2001-2002 was 145% and 143%, respectively. Other sources report varying percentage increases, all of which are greater than 11.3 percent. Indeed, President Bush has recently made speeches to the public about his great concern regarding the crisis in medical liability costs and the fact that it is a high priority for the Administration to fix our "broken" medical liability system.

Accordingly, it remains unclear whether the medical liability factor of the MEI adequately addresses the significant increases in physicians' liability costs. As we commented in the proposed rule, we still do not know, for example, which insurers were part of the survey. Other questions also remain unanswered: What questions were asked of the insurers surveyed? Are the same insurers surveyed each year? Have any of the insurers surveyed by CMS discontinued provision of medical liability insurance? Are physicians facing liability insurance cost increases that are not reflected in the premiums? What information was provided by the insurers?

As indicated above, more information is needed to determine whether the MEI reflects the actual increases being experienced by physicians, and thus we request that PPAC urge CMS to provide more detailed information concerning the data used to determine increases in medial liability costs.

IMMUNIZATION ADMINISTRATION SERVICES

We appreciate and agree with CMS' decision to modify payment policy for vaccine administration services.

CMS has established separate G-codes to report influenza (flu or influenza) and pneumonia vaccine administration. Instead of linking the relative values for these codes to the relative value for vaccine administration code 90471, CMS had proposed to link the flu and pneumonia vaccine administration codes to the value for code 90782 (a therapeutic injection). In the final fee schedule rule, however, CMS announced that it will instead develop practice expense RVUs for vaccine administration for procedure codes G0008 (influenza), G0009 (pneumonia) and G0010 (hepatitis B). We are pleased with this new policy since it will provide more appropriate payment (nearly double) for these critical services.

We encourage CMS, however, to take additional steps to enhance payment policy for these flu and pneumonia vaccines. Specifically, for example, CMS decided not to assign work values to CPT codes 90471 and 90472 because CMS believes these services typically do not involve a physician. As we commented in the proposed rule, vaccine administration involves unique physician work. The work involved in immunization administration includes discussing with the patient the benefits and risks of the required vaccine, questioning the patient about previous reactions to the vaccine, if any, and providing pertinent informational material to the patient.

Accordingly, we urge PPAC to recommend that CMS reconsider this decision not to recognize the physician work involved in administering vaccines. CMS' decision does not maximize the incentives necessary to ensure, for example, that flu vaccines are administered effectively to as many Medicare patients as possible. It is critical that flu vaccination rates move from the current rate of less than two-thirds being vaccinated to the Healthy People 2010 goal of 90 percent. Indeed, the Secretary of the Department of Health and Human Services recently issued a news release warning that new data show that "influenza may be taking an even larger toll than we have realized" and that nearly one-third of senior citizens still do not get an annual flu vaccination. The Secretary urged that this new data "must strengthen our resolve to develop new strategies for reducing deaths from influenza among all Americans."

We urge PPAC to recommend that CMS assist in the development of new strategies for reducing deaths from influenza by (i) recognizing the physician work involved in vaccination administration, and (ii) withdrawing the immunization G codes and, instead, using CPT codes for these services.

UNFUNDED MANDATES

We urge PPAC to recommend that CMS discuss in the 2004 fee schedule rule the impact of unfunded mandates on spending for physicians' services, and to include these costs in the Medicare Economic Index.

The cost of many burdensome regulatory requirements impose tremendous costs on physicians' medical practices. For example, physicians are required to comply with and fund the cost of extensive requirements under the Health Insurance Portability and Accountability Act (HIPAA). Further, under guidance issued by the Department of Health and Human Services' Office of Civil Rights, physicians who treat Medicaid patients must provide an interpreter to all of their patients with limited English proficiency (LEP), at the physicians' own cost. Often, the cost of the interpreter far exceeds the payment for the patient's office visit. The guidance also requires physicians to comply with a number of other extensive and burdensome regulatory requirements.

The AMA believes that clear, direct communication and understanding is the bedrock of the physician-patient relationship, and thus is a very important concern in providing quality medical care to all patients. Nevertheless, the burden of funding written and oral interpretation services for LEP patients should not fall on physicians, as would occur under OCR's requirements.

Accordingly, we urge PPAC to recommend that CMS calculate in the 2004 rule the costs of all regulations impacting physicians' practice costs and increase Medicare payment rates each year to account for these costs. We also recommend that CMS be required to consult with organizations representing physicians concerning the methodology used in determining such impact.

CREATION OF G CODES

The AMA appreciates CMS' discussion of the status of G codes in the final rule. CMS expressed its view that G codes should be temporary and, working with CPT staff, reviewed all existing G codes and agreed to transition over 20 of them to CPT codes. We agree with CMS that an annual review of G codes is the best way to determine which G codes should be transitioned to CPT codes, and are pleased that CMS plans to continue working with CPT staff on an annual basis to continue transitioning existing G codes to CPT codes.

We also appreciate that CMS has acknowledged the enormous effort and expertise that is required by each specialty in developing coding proposals, vignettes, conducting surveys to determine physician time and work, convening consensus panels, and determining appropriate direct practice expense inputs for each new CPT code that is created. The results of these efforts are then validated through multi-specialty groups of physicians, including CPT Advisors, the CPT Editorial Panel, and the RUC. This process provides stability and credibility to the development of a code.

The AMA is happy to work with CMS to eliminate any duplication of codes and expedite the process of identifying the need for new codes so that any such codes may be developed through the CPT and RUC rather than being assigned a G code by CMS. We encourage this joint effort between CMS and medical community to ensure the stability and credibility of the system, as well as to avoid the creation of unnecessary codes. For example, it appears that

many of the issues surrounding the G codes announced in the final fee schedule rule did not need immediate resolution and could have been processed through the normal channels.

We encourage PPAC to recommend that CMS continue its efforts to work with the CPT and the RUC to ensure that G codes are created only when necessary, and that new codes are developed through the already-established CPT process.

We urge PPAC to recommend that CMS implement a more formal internal process, in consultation with the physician community, to handle the development of G codes, when necessary.

The AMA appreciates the opportunity to provide our views to PPAC and CMS concerning proposals that should be considered for the 2004 physician fee schedule rule, and stand ready to work with PPAC and CMS to ensure proper consideration of these proposals.