REPORT NUMBER FORTY-FOUR

to the

Secretary

U.S. Department of Health and Human Services

(Re: Physicians Regulatory Issues Team, Volume Performance Measures, Stark II, Health Insurance Portability and Accountability Act Privacy Rule, Access to Physician Services, and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Washington, DC

May 19, 2003

SUMMARY OF THE MAY 19, 2003, MEETING

Agenda Item A — IntroductionThe Practicing Physicians Advisory Council (PPAC) met at the Department of Health and Human Services' Hubert H. Humphrey Building in Washington, DC, on Monday, May 19, 2003 (see Appendix A). The chair, Dr. Michael T. Rapp, welcomed the members of the Council, and the members introduced themselves.

Agenda Item B — Oath of Office and Welcome

Thomas A. Scully, Administrator of the Centers for Medicare and Medicaid Services (CMS), swore in four new physician members to the Council: Dr. Carlos Hamilton, endocrinologist, of Houston, Texas; Dr. Dennis Iglar, family practitioner, of Oconomowoc, Wisconsin; Dr. Laura Powers, neurologist, of Knoxville, Tennessee; and Dr. Robert Urata, family practitioner, of Juneau, Alaska.

In response to a recent PPAC recommendation that the cost of drugs be removed from the calculation of the sustainable growth rate in determining physician fees, Mr. Scully said:

"I think that's a perfect example of what I'm talking about. The obvious thing is just simply take out the drugs. There's a reasonably good argument for pulling drugs out. But if you just pull drugs out of the existing formula, instead of it being a -4.2 over the next 10 years, the formula goes the other way and you get huge updates that are also not justified. So we really should be coming up with a formula that potentially pulls drugs out gradually, or has some limited impact on drugs, because they should be drugs under the physician's control. So I don't know if you decide to pull them out or not, but I think some hybrid approach that pulls them out slowly ... The other problem we get into is, when you look at other parts of the program, that physician services account for (Paul probably knows) $45 billion out of $67 billion roughly, give or take half a billion or so.

"The other parts of the program that are exploding outside of drugs are DME - you know, we had a 97% increase in wheelchairs, for instance, in one of the regions last year - there weren't 97% more seniors that were disabled or disabled non-seniors coming into the program. The only way you can get a mobile wheelchair, for instance, is to write a prescription from a doctor. So, there are a lot of strange things going on in the program that we need to take a whack at. You see these things spike up, and you hit one and another one comes up next to it. Those are in the pot of $67 billion, along with other things like clinical labs.

"So, if you're going to look at it, you should look at overall spending. The real purpose of putting the physician payment update in at all is to control overall spending. Drugs went up 35% last year. It's not going to get any better if you take it out of the SGR. Physicians really have - the only monitoring on the cost of prescription drug volume is from physicians. So there has to be some way behaviorally to modify the system. Just taking - I'm not sure it's fair to penalize the physician fees for 35% drug growth. On the other hand, saying well let's just take it out and forget about it is not the answer either. So I guess my point is I think it's overly simplistic to say let's pull drugs

out of the system and just let it go on – the updates that are underpaying, the updates that are vastly overpaying - that's not the right answer. So, I guess my point is to take a little more digging out. I would love nothing more than to come up with something - Chairman Bill Thomas of Ways and Means and Chairman Grassley of Finance would love nothing more than to come up with a long-term fix for this formula and have physicians behind them. But just pulling drugs out is not the answer. It's got to be a little bit more complicated to fix this than pulling drugs out."

Mr. Scully said CMS is working toward integrating new technology (such as electronic claims processing and medical records) into Medicare to increase efficiency and cut costs; he asked that PPAC consider how physicians could facilitate that integration. Despite claims to the contrary, physician participation in Medicare increased between 2002 and 2003, Mr. Scully said. Finally, he announced that the physician fee schedule for 2004 would likely see another decrease (currently estimated at –4.2%).

Agenda Item C — Opening Remarks

Mr. Tom Grissom, Director of the Center for Medicare Management, presented calculations of assigned vs. unassigned claims and electronic media claims for 2000–2002 and the first quarter of 2003. The results showed a high proportion of doctors (about 90%) accept assigned claims rates and electronic claims now make up about 86% of all claims processed. Mr. Grissom said CMS is attempting to respond to physicians' concerns about access to carrier medical directors (CMDs) and the capacities of carrier call centers. Currently, carriers have 48 toll-free phone numbers available with the capacity to answer more than 25 million provider calls each year. Evaluation and monitoring efforts are in place. At present, 73% of calls are satisfactorily resolved within 60 seconds (a.k.a., call completion). Carriers are required to achieve an 80% call completion rate by 2004.

Old Business

Agenda Item D — Status and Update on PPAC Recommendations from February 10, 2003

Dr. Paul Rudolf, Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the February 10, 2003, meeting (Report Number 43):

43-D-1: PPAC recommends physician communication issues with carrier medical directors (e.g., ease of contact and response time) should be referred to the Physicians Regulatory Issues Team for consideration.

CMS Response: Adopt.

The Physicians Regulatory Issues Team intends to report to PPAC regarding this issue at the June PPAC meeting.

43-E-1: PPAC recommends CMS remove drug expenditures from the definition of physician services in the calculation of the sustainable growth rate.

CMS Response: Adopt with change.

The Center for Medicare Management has advanced this recommendation internally for consideration. The issue will be addressed in the 2004 final rule on the physician fee schedule. (Note comments of Administrator Scully, under Agenda Item B, page 1 paragraph 3.)

43-E-2: PPAC recommends CMS calculate the cost of regulations and sub-regulatory actions by the agency (e.g., quality initiatives) that impact physician practice costs and use the results to increase Medicare payment rates each year to account for these costs.

CMS Response: Not adopted.

CMS already assesses the impact on expenditures due to legislative action as part of our efforts to calculate the medical payment rates each year. CMS carefully reviewed whether to adjust the sustainable growth rate for national coverage decisions in the December 31, 2002, final rule. Nevertheless, we expect to continue examining the effect of national coverage decisions and other sub-regulatory actions on the cost of services included in the sustainable growth rate.

43-E-3: PPAC recommends CMS consult with organizations representing physicians concerning the methodology for calculating regulation impact costs.

CMS Response: Adopt.

CMS currently works with physician groups regarding this issue and will continue to look for new ways to address concerns of outside organizations in the future.

43-E-4: PPAC recommends CMS invite public comment in the proposed rule on changes to the sustainable growth rate formula.

CMS Response: Adopt.

Comments were solicited in the December 31, 2002, final rule. CMS has accomplished this.

43-E-5: PPAC recommends that CMS work with stakeholders to develop new methods of calculating the true costs associated with providing care to Medicare beneficiaries.

CMS Response: Adopt.

CMS welcomes input from physician groups, works with the Practice Expense Advisory Committee, and conducts surveys to obtain this information. CMS presently receives cost data from physician organizations and will continue to obtain input in the future.

43-E-6: PPAC recommends that CMS use accurate estimates of proposed expenditures for national coverage decisions in utilization to adjust the sustainable growth rate targets.

CMS Response: Not adopt.

CMS is currently evaluating this issue further to analyze whether adjusting the sustainable growth rate for the impact of national coverage decisions would have any impact on physician fee schedule rates.

43-F-1: PPAC recommends CMS continue its efforts to transition G codes to CPT (Current Procedural Terminology) codes, as appropriate, at least annually.

CMS Response: Adopt.

CMS does this annually, and this issue was on the agenda for the CPT meeting in May 2003.

43-F-2: PPAC recommends that if new coding and payment decisions are made by CMS, the decisions should be addressed in the proposed rule whenever possible so that interested parties have sufficient opportunity to provide comment on suggested changes.

CMS Response: Adopt with change.

CMS will address decisions and payment in the proposed rule whenever possible but will not delay coding decisions that must be made in response to other programmatic requirements (e.g., changes in statute or national coverage decisions).

43-F-3: PPAC recommends CMS adhere to the Administrative Procedure Act.

CMS Response: Adopt.

CMS is required by law to do so.

43-F-4: PPAC recommends CMS continue efforts to achieve coding standardization, accuracy, and clarity.

CMS Response: Adopt.

CMS attempts to achieve coding standardization, accuracy, and clarity and will continue to do so.

43-F-5: PPAC recommends CMS *not* introduce new G codes without a compelling need. If a new G code is developed to accommodate changes in legislation, regulation, coverage, and payment policy, its transition to a CPT code should occur as soon as possible.

CMS Response: Adopt with change.

CMS will not introduce new G codes without a significant programmatic need.

43-F-6: PPAC recommends that new G codes not duplicate existing CPT codes.

CMS Response: Adopt with change.

CMS will not introduce new G codes that duplicate existing CPT codes without significant programmatic needs. G codes are often created to better define a particular service within a CPT code.

43-F-7: PPAC recommends that CMS modify the G code development process to allow organized medicine to play an integral role.

CMS Response: Adopt with change.

CMS will continue and improve efforts to obtain appropriate provider input when establishing G codes.

43-F-8: PPAC recommends that CMS continue to study the anesthesia conversion factor to determine adequate reimbursement for physician work.

CMS Response: Adopt.

CMS will continue to study the utility and appropriateness of the anesthesia conversion factor in an attempt to determine the proper reimbursement for anesthesia physician work.

43-F-9: PPAC recommends that CMS reevaluate its decision *not* to recognize physician work in the administration of vaccines.

CMS Response: Adopt with change.

CMS understands that this is still an issue before CPT. CMS will wait for CPT to act, then reevaluate as appropriate based on CPT's decision.

43-F-10: PPAC recommends that CMS ensure that the duration of Medicare participation agreements is consistent with the duration of the Medicare fee schedule payment period.

CMS Response: Adopt.

The 2003 enrollment period was an anomaly due to the late publication of the fee schedule and the change in update. CMS extended the enrollment period to April 1, 2003, in response to this unique situation.

43-G-1: PPAC recommends that CMS's proposed rule address the refinement of the professional liability coverage relative value units.

CMS Response: Adopt.

CMS will continue to review, explore, and discuss alternative mechanisms that may allow refinement of the methodology for professional liability coverage relative value units for all physicians, and CMS will publish this information in

either the proposed rule or final rule at such time as different mechanisms are formulated.

43-G-2: PPAC recommends that CMS's proposed rule include a more detailed description of the methodology proposed by the neurosurgeons and the other alternatives CMS is considering for professional liability coverage relative value units.

CMS Response: Adopt with change.

CMS will review and discuss any specific alternative methodologies for professional liability relative value units as part of next year's rulemaking for the physician fee schedule.

43-G-3: PPAC recommends that CMS make available current professional liability premium data at the specialty level immediately.

CMS Response: Not adopt.

CMS is looking into the feasibility of providing such data, but CMS does not own the professional liability premium data. There are issues of confidentiality with the insurance carriers from whom CMS obtains the data.

43-G-4: PPAC recommends that CMS make an explicit request for comments on the appropriateness of refining the professional liability coverage relative value units in 2004 rather than 2005.

CMS Response: Not adopt.

CMS considered this recommendation. Unfortunately, it is not feasible to revisit the professional liability relative value units for 2004. CMS plans to award a contract soon to support revision of the relative value units for 2005. It is not possible to award the contract, analyze the data, and produce revised relative value units in time for the 2004 regulatory cycle.

For 2004 payments, CMS is collecting more current professional liability premium data to be used to update the professional liability Geographic Practice Cost Indices (GPCIs). This revision will be discussed in this year's notice of proposed rulemaking and will be based on our contractor collection of professional liability premium data for 2002–2003. The work and practice expense GPCIs will not be updated until January 1, 2005, because the major source of data for the work and practice expense GPCIs is the 2000 Census, which is not yet available.

43-G-5: PPAC recommends that CMS include a statistically significant sample of all professional liability insurance carriers—rather than only commercial carriers—when collecting liability premium data for the Medicare Economic Index.

CMS Response: Not adopt.

CMS's research indicates this information would not be available in a timely manner, and the format of information needed is not available to be included in the Medicare Economic Index. For example, to include these data in the Medicare Economic Index, CMS would need the percent change in professional liability insurance premiums for a given level of coverage between 2 years, and this information is not available from all carriers. CMS encourages PPAC and other physician groups to help make available the appropriate information on a timely basis.

43-G-6: PPAC recommends that CMS eliminate the 30-day physician visit requirement for outpatient therapy services.

CMS Response: Adopt with change.

Regulatory change is not required; a Program Memorandum addressing this issue is in development. It can be anticipated that this requirement will be eliminated and guidelines put in place that will reduce the administrative burden on physicians yet ensure that outpatient therapy services for Medicare beneficiaries are both timely and appropriate.

43-G-7: PPAC recommends that CMS make available more specific data used to determine the increasing costs of medical liability insurance, as reflected in the Medicare Economic Index.

CMS Response: Not adopt.

CMS collects premium quotes from commercial carriers, which are available directly from them. In addition, this information is available directly from National Association of Insurance Commissioners, although it is not available on a timely basis for the CMS rulemaking process.

43-G-8: PPAC recommends that if CMS proposes changes to the supervision requirements for radiology services, PPAC should be given an opportunity to comment.

CMS Response: Adopt with change.

CMS is not proposing any changes in the supervision requirements for radiology services at this time. However, CMS would welcome comments from PPAC on this issue.

Dr. Rudolf then presented the responses from CMS to PPAC recommendations made at the December 16, 2002, meeting concerning the Doctors' Office Quality (DOQ) project (Report Number 42):

42-F-1: PPAC recommends that the DOQ project take steps to minimize the paperwork and time required by participating physicians in order to avoid creating a financial disincentive to participation.

CMS Response: Adopt with change.

The DOQ project is committed to developing measurement models that minimize or eliminate burden to physicians and their offices. The entire first year of measurement is designed to explore models that correlate well with the gold standard for measures (which is sometimes the medical records, sometimes the administrative data, sometimes patient derived) but minimize or eliminate burden for offices.

42-F-2: PPAC recommends that CMS explore future demonstration projects on the use of financial incentives to achieve quality improvement goals.

CMS Response: Adopt.

Currently, a separate project, the Physician Group Practice Demonstration, will be using financial incentives to achieve quality improvement and efficiency. In the DOQ project, we are exploring incentives with financial implications (e.g., free continuing medical education credit to physicians, linkage to professional liability premium reductions). Other demonstrations linking financial incentives to performance are being discussed.

42-F-3: PPAC recommends that CMS use the American Medical Association (AMA) Physician Consortium for Performance Improvement's evidence-based performance measures and any resulting data for quality improvement purposes only.

CMS Response: Adopt with change.

CMS continues to work with the Consortium on the project's measure selection and project implementation and expects the Consortium will provide insight into all aspects of the DOQ project. The DOQ three-state pilot project is not a public reporting pilot, and the primary use of the measures will be for quality improvement. We do hope to be able to do some exploration and modeling of public recognition as an incentive for improvement, but there will be no public reporting of individual physician results in the DOQ three-state pilot project.

42-F-4: PPAC recommends that CMS continue to work with the AMA and the Consortium to ensure the appropriate development and implementation of evidence-based clinical performance measures that enhance the quality of patient care and advance the science of clinical performance measurement and improvement.

CMS Response: Adopt.

CMS is committed to continuing to work with the AMA and the Consortium to advance our common goals of enhancing the quality of patient care, advancing the science of clinical performance measurement and improvement, and enhancing the practice of medicine.

42-F-5: PPAC recommends that CMS use information gleaned from implementing the measures in the pilot tests of the DOQ project to further refine the measures, if necessary, in collaboration with the Consortium, and the Consortium should be involved in future implementation efforts.

CMS Response: Adopt with change.

Data collected on the DOQ measures will be shared widely, and the Consortium will receive such data. We plan to work closely with the Consortium on an ongoing basis in this endeavor. It is unlikely that the data elements will be useful to CMS or the Consortium.

42-F-6: PPAC recommends that CMS recognize the state of the art of physician performance measurement, which supports the use of measurement to promote continuous quality improvement; existing methodologies do not warrant the use of measures for purposes of individual accountability, comparison, or choice.

CMS Response: Adopt with change.

CMS is working with experts to evaluate all of the issues surrounding the use of clinical, systems, and patient-derived measures for quality improvement and for accountability and is exploring a variety of data sources to understand and advance the science of measurement. We plan to work closely with the Consortium in this endeavor. In the three-state pilot for the DOQ project, there will be no public reporting of individual physician results.

42-F-7: PPAC recommends that CMS acknowledge the serious limitations in using performance measurement to assess physician competence and to work with the AMA and the Consortium to ensure that data from the DOQ project are used to improve the overall quality of patient care and not to assess individual physician performance.

CMS Response: Adopt.

See response to 42-F-6.

42-F-8: PPAC recommends that CMS consider the burden of data collection; consider the use of electronic medical systems to collect and process data; and agree to collect data for the DOQ project prospectively only.

CMS Response: Adopt with change.

Manual data collection can be done retrospectively through med records or prospectively through flow sheets. We are very aware of the issues around burden and are working to minimize them, including exploring projects by involving electronic medical records. We note for PPAC that in a study funded by CMS to determine the accuracy of flow sheet data collection (prospective collection), significant underreporting of care occurred when flow sheets were used. Therefore, we are still exploring whether data collection might be retrospective or prospective.

42-F-9: PPAC recommends that CMS involve the national medical specialty societies and boards in addressing what constitutes the appropriate specialty-specific variance in clinical practice.

CMS Response: Adopt.

This is an excellent idea, and we appreciate the suggestion. Most of the relevant specialty societies are represented on our various work groups and panels.

42-F-10: PPAC recommends that CMS indicate physician participation only as the sole criterion for public recognition by the DOQ project.

CMS Response: Not adopt.

In the DOQ project overall, we will be exploring via focus groups of consumers and practicing physicians and by field testing a variety of options for public recognition of physician participation in quality improvement and for achievement of excellent quality of care. In the three-state pilot of the DOQ project, participating physicians themselves will determine what level of public recognition they would like. We will suggest this to them.

42-F-11: PPAC recommends that the DOQ project measure physician productivity within the context of the current study.

CMS Response: Adopt with change.

The Pacific Business Group on Health, funded by the Agency for Healthcare Research and Quality, is developing and testing measures of efficiency. CMS will consider using those measures or any others that we become aware of after careful review (most likely during the re-measurement year of the DOQ project).

42-F-12: PPAC recommends that specialist physicians be included in the DOQ project.

CMS Response: Adopt with change.

Specialist physicians have been included in the DOQ project as members of the technical expert panel and are certainly key to the development and implementation of measures, as well as other aspects of the project. DOQ is a primary care project and, as such, those practices included in the three-state pilot will be made up of primary care physicians.

At Dr. Rudolf's request, Barbara Paul, MD, Director of the Quality Measurement and Health Assessment Group at CMS, provided some clarification about the DOQ project. She noted that physicians participating in the pilot would decide whether participation should be publicly recognized and, if so, how and to what extent. Dr. Paul emphasized, however, that the recognition would be limited to acknowledging participation in the

quality improvement project. Under no circumstances would performance ratings of doctors be publicly disseminated.

New Business

Agenda Item E — Physicians Regulatory Issues Team (PRIT) Update: CMD Communications

Drs. Ken Simon and Richard Lawlor, medical advisors in the Office of the Administrator, reported the results of a survey of CMDs to determine whether they are sufficiently available to respond to physicians (see Appendix 1). Some areas of improvement were identified: 9% of respondents said it was not possible for customer service representatives to forward calls directly to the CMD when the caller's question could not be answered; 26% said they did not track calls by content; of those who do track calls (35%), only 13% indicated they developed scripts for their customer service representatives on the basis of call content; finally, not all CMDs make their contact information (direct telephone number and e-mail address) easy to locate by publishing it on the carrier web site, in newsletters, in correspondence, etc. Mr. Grissom stated that carriers would be required to address these areas when contracts are renewed. Dr. Simon said many CMDs would like and CMS will encourage more physician outreach efforts by carriers.

> 44-E-1: PPAC recommends PRIT monitor the accuracy of information provided by carriers, develop mechanisms for carriers to improve the accuracy of information they provide, and measure the improvement of carriers in providing accurate information.
>
> 44-E-2: PPAC recommends PRIT work with staff from the CMS Office of Clinical Standards and Quality to identify an indicator sample of physicians and document their ability to obtain accurate information from their carriers.

Agenda Item F — Volume Performance Measures/Volume Intensity Adjustments

John Shatto of the Office of the Actuary explained that CMS is projecting a –4.2% update to the physician fee schedule in 2004 because the Medicare Economic Index and the gross domestic product (GDP) were lower than previously projected while both drugs and other medical costs rose more than previously projected. Council members asked if population demographics, including the severity of conditions, multiple co-morbid conditions, and the high cost of care at the end of life were considered in cost adjustments; Mr. Grissom agreed to provide such information from Congressional Budget Office data at the next meeting.

Council noted the Medicare Economic Index allotted a higher percentage for staff recruitment to hospitals (5.4%) than to physicians' offices (3%), yet offices are in competition with hospitals for the same pool of qualified staff and incur similar recruitment costs.

44-F-1: PPAC recommends that, in calculating the Medicare Economic Index, the salary level for health care workers be equivalent to those established for hospitals rather than to those for the general population.

Mr. Shatto then described a study of the inverse relationship between Medicare physician fees and volume and intensity of services provided (see Appendix 2). Until now, the model for rate setting assumed that 50% of the reduced Medicare revenue to physicians would be offset through increases in volume and intensity. This study, which used data from 1994 to 1996, found the proportion to be closer to 30%. The study also concluded that physician fee increases yielded no appreciable difference in volume and intensity of services provided. Mr. Shatto emphasized these findings are used to estimate volume for future years but actual volume data are used to inform rate setting for the upcoming year.

Dr. John Nelson of the AMA raised concerns about flaws in the formula for setting physician fees, specifically: tying the sustainable growth rate to GDP and allowing volume increases to result in physician fee decreases (see Appendix 3). First, patient needs do not decrease during economic downturns. Second, many of the factors driving volume increases (e.g., new coverage decisions, quality improvement efforts) are beyond physicians' control. Council members further noted that physicians cannot continue to increase patient volume *ad infinitum* to make up for fee decreases. Dr. Nelson said the AMA endorses the recommendation of the Medicare Payment Advisory Committee (MedPAC) to replace the current formula with one that keeps pace with actual costs of medical practice. The American College of Physicians also supports the MedPAC recommendation (see Appendix 4).

44-F-2: PPAC recommends CMS support replacement of the current Medicare physician payment update formula with a system that, beginning in 2004, keeps pace with annual increases in the cost of practicing medicine, starting with a 2.5% increase in 2004.

The Council considered that some increases in volume and intensity of services may result from the fact that many procedures that used to be performed in hospital can now safely be performed in a physician's office. However, the Medicare payment system does not seem to recognize the transition of such services by allotting more funds to physicians to provide such higher-intensity services.

44-F-3: PPAC recommends CMS study the economic impact of physicians providing services in the office that had previously only been available in hospitals; in such cases, CMS should consider transferring the savings realized by Part A providers to Part B providers.

Agenda Item G — Stark II

Paul Olenick, Director of the Division of Technical Payment Policy, described proposed modifications and clarifications to the Stark physician referral provisions that are collectively referred to as Stark II (see Appendix 5). The provisions are meant to discourage unethical referral patterns and conflicts of interest; Mr. Olenick admitted the

final rule is lengthy and very complicated and there are numerous exemptions. Furthermore, the Secretary can recommend additional exemptions as needed. In response to Mr. Olenick's query, Council members indicated that the provisions have had a chilling effect on physicians, in some cases preventing physicians from undertaking actions that would benefit patients out of fear of violating Stark provisions. Mr. Olenick hoped such concerns would be allayed by the availability of exemptions.

Mr. Olenick said the Stark provisions considered lithotripsy a designated health service, although a recent federal court ruling declared the contrary.

> 44-G-1: PPAC recommends the Stark regulation be modified to reflect the federal court decision (American Lithotripsy Society v. Secretary of the Department of Health and Human Services, July 12, 2002, Washington, DC, federal court) that lithotripsy is not a designated health service.

Agenda Item H — Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule/Cell Phone Communications

Linda Sanches of the Office of Civil Rights, which interprets and enforces the HIPAA regulations, gave an overview of how her office approaches questions about HIPAA. She emphasized the overarching concept that patient information can be used and disclosed to carry out essential functions -- e.g., treatment, payment, and health care operations -- without a specific signed release form from the patient. She recommended that providers ask patients to sign an acknowledgment regarding uses of their information, but patients do not have to sign such a form as a condition for obtaining treatment. The Office has no written interpretations regarding the use of cell phones when discussing patient information, but Ms. Sanches recommended discretion and sensitivity to privacy concerns and the possibility of call interception.

Council members asked that the Office of Civil Rights present information at the next PPAC meeting explaining the requirement to provide translation services for beneficiaries with limited English proficiency.

Agenda Item I — Access to Physician Services

Renee Mentnech, Director of the Division of Beneficiary Research, described efforts to monitor beneficiary access to physician services through various sources (claims, environmental scanning, calls to customer service centers, and beneficiary surveys). Her office did not detect any problems on a national scale but did identify some concerns at the state and local level. It is now researching beneficiary access in 11 cities across the country and plans to evaluate 14 more pending funding. Ms. Mentnech hoped the results would be available by the fall.

Kevin Hayes, representing MedPAC, described how MedPAC gathers information used to inform its recommendations, including the results of the *2002 Survey of Physicians About the Medicare Program*. The survey indicated many Medicare physicians are very concerned about the program's billing and paperwork requirements, reimbursement levels, external review procedures, timeliness of payment, and fraud and abuse

investigations. MedPAC also found that the same numbers of physicians were accepting Medicare patients in 1999 as in 2000, but a higher proportion of physicians were accepting only some new patients in 2000. It also found Medicare pays providers about 78–85% of what private insurance plans do in general. MedPAC plans to assess physician payment rates in six market areas around the country.

Agenda Item J — Wrap Up and Recommendations

A recently published proposed rule on new physician enrollment guidelines was raised for discussion. It would codify all the language on enrollment in one place for all providers. Mr. Grissom further explained that CMS is trying to implement a strategy to purge inactive or deceased providers from its enrollment records. The proposed rule would allow CMS to conduct cyclical revalidation by sending enrolled providers every 3 years a form describing the provider's current information on file; providers would be asked to make any needed changes and return the form to CMS. Provider PIN numbers would not be affected, nor would payments. Council members applauded CMS's approach to the situation.

The proposed rule also states that CMS will direct carriers to send out revalidation forms when a provider has not filed any claims for 60 days. Mr. Grissom was not sure whether future payments would be delayed in such a case. Council members felt 60 days was too short a period. A representative from the AMA said the proposed rule would be on the agenda of an upcoming AMA meeting with several specialty societies.

> 44-J-1: PPAC recommends that future PPAC agendas, when published in the *Federal Register*, include a statement that proposed rules published between the time of notice of the PPAC meeting and the actual meeting will be included on the PPAC agenda.

Following a review of all the motions adopted, Dr. Rapp adjourned the meeting.

Report prepared and submitted by
Dana Trevas, Rapporteur

PPAC Members at the May 19, 2003, Meeting

Michael T. Rapp, MD, JD, *Chair*
Emergency Room Physician
Arlington, Virginia

Ronald Castellanos, MD
Urologist
Cape Coral, Florida

Rebecca Gaughan, MD
Otolaryngologist
Olathe, Kansas

Carlos Hamilton, MD
Endocrinologist
Houston, Texas

Joseph Heyman, MD
Obstetrician/Gynecologist
West Newbury, Massachusetts

Dennis Iglar, MD
Family Practitioner
Oconomowoc, Wisconsin

Joe W. Johnson, DC
Doctor of Chiropractic
Paxton, Florida

Christopher Leggett, MD
Cardiologist
Atlanta, Georgia

Barbara L. McAneny, MD
Clinical Oncologist
Albuquerque, New Mexico

Laura Powers, MD
Neurologist
Knoxville, Tennessee

Robert Urata, MD
Family Practitioner
Juneau, Alaska

Douglas Wood, MD
Cardiologist
Rochester, Minnesota

CMS Staff Present:
David C. Clark, RPH, Director
Office of Professional Relations,
Center for Medicare Management

Tom Grissom, Director
Center for Medicare Management, CMS

Terry Kay, Director
Division of Practitioner Services
Center for Medicare Management

Stephen Lawlor, DC, Medical Advisor
Office of the Administrator
CMS

Renee Mentnech, Director
Division of Beneficiary Research
Office of Research Development & Information
CMS

Paul Olenick, Director
Division of Technical Payment Policy
Center for Medicare Management

Barbara Paul, Director
Quality Measurement and Health Assessment Group
CMS

Paul Rudolf, MD, JD
Executive Director, PPAC
Center for Medicare Management

Tom Scully
CMS Administrator

John Shatto, Actuary
Office of the Actuary
CMS

Kenneth Simon, MD, Medical Advisor
Office of the Administrator
CMS

Public Witness:
John Nelson, MD, for the American Medical Association

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Dana Trevas, Rapporteur

APPENDICES

Appendix A: Meeting agenda
Appendix B: Recommendations from the May 2003 meeting

The following documents were presented at the PPAC meeting on May 19, 2003, and are appended here for the record:

Appendix 1: CMD Access Survey (slides): Kenneth Simon, MD, MBA, FACS; Richard Lawlor, DC, MBA; PRIT program
Appendix 2: Volume Performance Measures/Volume Intensity Adjustments: John Shatto, Office of the Actuary, Centers for Medicare and Medicaid Services
Appendix 3: Statement of the American Medical Association to the Practicing Physicians Advisory Council Re: Volume Performance: John Nelson, MD, MPH, American Medical Association
Appendix 4: Statement to the Practicing Physicians Advisory Council: American College of Physicians
Appendix 5: Practicing Physicians Advisory Council: Stark II: Paul Olenick, CMS

Appendix A

Practicing Physicians Advisory Council

Hubert H. Humphrey Building
Room 800
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

May 19, 2003 - Agenda

8:30 –8:35 a.m.	**A. Open Meeting**	**Michael Rapp, M.D.** **Chairman** Practicing Physicians Advisory Council
8:35 – 9:30 a.m.	**B. Oath of Office and Welcome**	**Thomas A. Scully** **Administrator** Centers for Medicare & Medicaid Services
9:30 – 9:45 a.m.	**C. Opening Remarks**	**Tom Grissom** **Director** Center for Medicare Management Centers for Medicare & Medicaid Services
9:45 – 10:15 a.m.	**D. Status and Update**	**Paul Rudolf, M.D.** **Executive Director** Practicing Physicians Advisory Council Centers for Medicare & Medicaid Services
10:15 – 11:00 a.m.	**E. Physicians Regulatory Issues Team (PRIT) Update** **a. CMD Communications**	**Kenneth Simon, M.D.** **Richard Lawlor, D.C., MBA** **Medical Advisors** Office of the Administrator Centers for Medicare & Medicaid Services
11:00 - 12 noon	**F. Volume Performance Measures/Volume Intensity Adjustments**	**John Shatto** **Actuary** Office of the Actuary Centers for Medicare & Medicaid Services
12:00 - 1:00 p.m.	**Lunch**	
1:00 – 2:00 p.m.	**G. Stark II** 1. Do you think that the physician self-referral provisions have had an effect on the patterns of physician referrals? 2. What changes would you want to make to the statute or the regulations?	**Paul Olenick** **Director** Division of Technical Payment Policy Centers for Medicare Management Centers for Medicare & Medicare Services

2:00 – 3:00 p.m.	**H. HIPAA Privacy Rule** **Cell phone communications**	**Linda Sanches** Office of Civil Rights **Jodi Goldstein** Office of General Counsel Health & Human Services
3:00 – 4:00 p.m.	**I. Access to Physician Services**	**Renee Mentnech, RN, MSN** **Director** Division of Beneficiary Research Office of Research Development & Information Centers for Medicare & Medicare Services **Kevin Hayes, PhD** **Medicare Payment Advisory Committee**
4:00 – 5:00 p.m.	**J. Wrap Up & Recommendations**	**Michael Rapp, M.D.** **Chairman** Practicing Physicians Advisory Council **Tom Grissom** **Director** Center for Medicare Management Center for Medicare & Medicaid Services **Paul Rudolf, M.D.** **Executive Director** Practicing Physicians Advisory Council Centers for Medicare & Medicaid Services

Appendix B

PPAC RECOMMENDATIONS
May 19, 2003

Item E: PRIT Update/Carrier Medical Department Communications

44-E-1: PPAC recommends that PRIT monitor the accuracy of information provided by carriers, provide mechanisms for carriers to improve the accuracy of information they provide, and measure the improvement in providing accurate information.

44-E-2: PPAC recommends PRIT work with staff from the CMS office of quality to identify an indicator sample of physicians and document their ability to obtain accurate information from their carriers.

Item F: Volume Performance Measurements/Volume Intensity Adjustments

44-F-1: PPAC recommends that, in calculating the Medicare Economic Index, the salary level for health care workers be equivalent to those established for hospitals rather than to those for the general population.

44-F-2: PPAC recommends CMS support replacement of the current Medicare physician payment update formula with a system that, beginning in 2004, keeps pace with annual increases in the cost of practicing medicine, starting with a 2.5% increase in 2004.

44-F-3: PPAC recommends CMS study the economic impact of physicians providing services in the office that had previously only been available in hospitals; in such cases, CMS should consider transferring the savings realized by Part A providers to Part B providers.

Item G: Stark II/Physician Referral Provisions

44-G-1: PPAC recommends the Stark regulation be modified to reflect the federal court decision (American Lithotripsy Society v. Secretary of the Department of Health and Human Services, July 12,2002, Washington, DC, federal court) that lithotripsy is not a designated health service.

Item J: Wrap-up and Recommendations

44-J-1: PPAC recommends that future PPAC agendas, when published in the *Federal Register*, include a statement that proposed rules published between the time of notice of the PPAC meeting and the actual meeting will be included on the PPAC agenda.

Appendix 3

STATEMENT

of the

American Medical Association

to the

Practicing Physicians Advisory Council

Re: Volume Performance

Presented by: John Nelson, MD, MPH

May 19, 2003

Medicare Payment Update

- **In accordance with the MedPAC recommendations, support replacement of the current Medicare physician payment update formula with a system that, beginning in 2004, keeps pace with annual increases in the cost of practicing medicine, starting with a 2.5 percent increase in 2004;**

- **Analyze thoroughly the full impact of all laws and regulations on physician spending, and calculate these costs as part of the SGR;**

- **Provide the Council with results of any Medicare beneficiary access study, as well as all underlying data and related analysis;**

Physician Enrollment Regulation

- **Include the physician enrollment regulation on the agenda in the near future and delay finalizing the rule until PPAC has had an opportunity to provide input to CMS; and**

Physician Education and Funding

- **Ensure that adequate funding be available for physician education and training.**

The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning volume performance with respect to the Medicare fee schedule for services furnished by physicians and other health care professionals.

MEDICARE PAYMENT UPDATE SYSTEM

At the February PPAC meeting, the AMA discussed that a 4.4 percent cut in Medicare payments to physicians and other health professionals was scheduled to become effective on March 1, 2003. The AMA is very appreciative that the Centers for Medicare and Medicaid Services (CMS) and the Administration worked closely with Congress to restore funding stemming from inadequate spending targets in 1998 and 1999, which resulted in a 1.6 percent payment update for 2003, instead of the 4.4 percent payment cut that was scheduled to take effect. At that time, CMS estimated that there would be "positive updates for 2004 and later years."

Several weeks later, however, in a March 20 letter to the Medicare Payment Advisory Commission (MedPAC), CMS stated that although it had "previously estimated positive updates for 2004 and later years," it now estimates that payments will be cut again in 2004, 2005, 2006 and 2007 because spending for physician services was higher and the GDP lower than previously estimated. Specifically, CMS actuaries are now projecting a

4.2 percent cut in 2004. This cut would mean that payment rates will be 8 percent lower next year than in 2001 and would expand the already substantial gap between payment rates and practice cost inflation. From 1991-2003, payment rates for physicians and health professionals fell 14 percent behind practice cost inflation, as measured by Medicare's own conservative estimates. Additional cuts are only compounded by skyrocketing medical liability insurance costs and increasing administrative burdens.

Congress, CMS and the Administration acted just a few short months ago to avert a 4.4 percent pay cut in 2003 because there were clear indications that doctors could not keep seeing Medicare patients in the face of another cut. CMS Administrator Scully warned of a "meltdown" if Medicare payments to physicians are not increased. This outcome is as true today as it was then.

Further, CMS has announced an expansion of efforts to monitor beneficiary access to physicians services, both nationally and in local healthcare markets. While we are not aware of any results of CMS' efforts, we urge CMS to conduct a thorough analysis of the data, particularly with regard to physician participation in the Medicare program. The AMA is very concerned that CMS has inappropriately focused on the level of physician participation rates as a measure of access. Specifically, CMS has released data indicating that the percentage of par physicians has increased, but has declined to provide the actual numbers of par and non-par physicians with Medicare billing numbers. Data we have seen indicates that the number of physicians (Medicare definition includes MDs, DOs, chiropractors optometrists, oral surgeons and podiatrists) with billing numbers in both categories declined from 2000 to 2001, and again in 2002. However, since the decline was greater among non-pars than pars, the participation percentage rate actually increased.

Further, simply identifying high or increasing rates of physician participation in the Medicare program cannot indicate levels of access to the Medicare program for beneficiaries. Whether a physician continues to participate in the Medicare program does not indicate whether the physician is continuing to see new Medicare patients or whether the physician is implementing any of a number of initiatives that could seriously impact access. In addition, national statistics do not necessarily show the specific situation in local communities, especially in rural areas, and thus it is important to focus on access at the local level as well. **Accordingly, we urge PPAC to request that CMS provide the Council with results of any access study, as well as all underlying data and related analysis.**

MedPAC Recommendations on Physician Update

In March, MedPAC recommended an update for 2004 of 2.5 percent. Further, MedPAC has proposed replacing the SGR with a different update system for physicians' services using the same framework that is currently in place for evaluating payment updates for all other Medicare provider groups. Under that framework, MedPAC would make a recommendation to Congress regarding each year's update based on payment

adequacy, patient access and other factors. Any inappropriate volume growth could be addressed through targeted actions that deal with the source of the increase. This would give Congress more control over the process than exists under the current system. **In accordance with these MedPAC recommendations, the AMA urges PPAC to recommend that CMS support replacement of the current Medicare physician payment update formula with a system that, beginning in 2004, keeps pace with annual increases in the cost of practicing medicine, starting with a 2.5 percent increase in 2004.**

Flaws in the Physician Payment Formula

The current Medicare update formula for physicians and other health care professionals is based on a spending target called the sustainable growth rate (SGR) and is a flawed public policy that results in arbitrary and steep pay cuts never intended by Congress. As discussed above, MedPAC has recommended that the SGR be replaced. We agree.

The use of a spending target does not achieve its goal of reduced volume. As House Ways and Means Chairman Thomas and Health Subcommittee Chairman Johnson observed in a letter, dated March 21, 2002, to CMS Administrator Scully: "An individual physician who reduces volume in response to …the SGR system would not gain a proportionate increase in payments, because payment increases would be shared among *all* physicians who serve Medicare beneficiaries. Contrary to the system-wide goal of restraining volume growth, an individual physician has incentives to increase volume under the SGR system."

The SGR, in particular, is centralized government planning at its worst, and is fatally flawed for two reasons. First, payment updates under the SGR system are tied to the gross domestic product (GDP); the medical needs of patients, however, do not decline during economic downturns. Moreover, the United States' population is aging and new technologies are making it possible to perform more complicated procedures on older and frailer patients than in the past. While the SGR system artificially caps spending on medical services, this type of system inherently cannot cap the amount of medical services that are needed to adequately treat sick patients.

The second flaw under the SGR is that physicians are penalized with lower payments when volume increases exceed the SGR spending target. Yet, the factors driving these increases are often beyond physicians' control. The Congressional Budget Office says that recent Medicare volume increases are due to "increased enrollment, development and diffusion of new medical technology" and "legislative and administrative**"** program expansions.

Indeed, volume increases when the government promotes greater use of physician services through new coverage decisions, quality improvement activities and a host of other administrative decisions that are good for patients, but are not reflected in the SGR spending target. Specifically, Congress has expanded Medicare coverage to include

several new screening tests that frequently trigger additional physicians' services that may or may not be related to the condition being screened. CMS also has added coverage for a variety of new technologies, such as PET scans and cryosurgery; and Medicare's Quality Improvement Organizations achieved a 5 percent increase in the use of mammograms and a 16 percent increase in lipid testing for targeted groups of beneficiaries.
In addition, although the preliminary data available from CMS show that Medicare spending growth in 2002 was about 6.5 percent, this was driven in part, however, by a 3.2 percent increase in the number of beneficiaries enrolled in fee-for-service and above average growth in clinical lab services (10 percent) and drugs (25 percent). In fact, CMS' National Health Statistics Group suggested in a *Health Affairs* article from January/February 2003 that "a wave of new blockbuster drugs...spawned steady growth in prescription drug use and physician visits."

For physician services alone, the AMA estimates that *spending* grew by less than 2 percent a year per beneficiary and that after payment cuts and benefit expansions are factored in, *utilization* per beneficiary rose by about 6 percent to 6.5 percent. Interestingly, this is only slightly higher than in 2001 when the physician update was positive and utilization (after adjustments for enrollment, pay changes, and legislation) increased by 5 percent to 5.5 percent compared to an average of 2.6 percent in 1996 through 2000. In other words, rates of growth were rising independent of what was happening to payments, and, instead appear to be fueled in large part by growth in technology and government expansion and promotion of covered Medicare services, as discussed above.

Further, this pattern of spending increases was repeated across Medicare. According to CMS data cited in the March 26, 2003, *New York Times,* 2002 increases in Medicare spending for durable medical equipment, hospital, home health, skilled nursing facility and hospice services all exceeded the increase in physician spending. Also, as the CMS actuaries wrote in the *Health Affairs* article referenced above, similar trends have been observed across all payers as "national health care spending in 2001 grew at the fastest pace since 1991."

It is neither fair nor feasible to cover the cost of all this additional care by repeated cuts in physician payments. A new payment system that adequately keeps pace with inflation is needed to ensure access to high quality care for our nations' seniors and disabled patients.

Administrative Changes Needed in the SGR Formula

As we have previously discussed with PPAC, there are a number of other problems with implementation of the SGR that inequitably affect payment updates due to factors that are beyond physicians' control, and these problems could be fixed administratively by CMS:

Inclusion Of Drugs In The SGR:

We appreciate that PPAC recommended pursuant to the February meeting that CMS remove prescription drugs from the calculation of the SGR, and the AMA continues to believe that such drugs do not belong in the SGR.

Throughout the duration of the SGR, growth in spending on Medicare-covered drugs has been more than six times that for physician services. From 1996 (the SGR base year) through 2002, drug spending per beneficiary grew by 237 percent (from $55 to $184) compared to 35 percent ($1310 to $1800) for physician services. Drug spending as a share of total SGR spending more than doubled from 3.7 percent in 1996 to 8.7 percent in 2002. Further, early data for 2002 indicates that spending increased by 26.7 percent for drugs compared to 3.9 percent for physicians' services.

Including drugs in the SGR makes it far more likely that actual spending will exceed the SGR target and trigger pay cuts for physicians. Since drugs are not paid for under the physician fee schedule, however, drug payments are not affected by the SGR.

Changes in Medicare Spending on Physicians' Services Due to Laws and Regulations:

Again, we appreciate that PPAC recommended at its February meeting that CMS include increases in physician spending resulting from national coverage decisions for purposes of calculating the SGR, and the AMA continues to believe that these decisions should be included in the SGR. There have been 62 national coverage decisions since CMS formalized its process for making national coverage decisions [in 1999], and this number is growing rapidly, as indicated by the 23 decisions that have already been made in the first three months of this year.

We also believe that the full impact of <u>all</u> laws and regulations on physician spending should be analyzed more thoroughly by CMS and calculated as part of the SGR, and we urge PPAC to make this recommendation to CMS. For example, a number of initiatives undertaken by Congress, CMS and the Department of Health and Human Services (HHS) have increased the use of physicians' services, including new screening benefits and coverage of new technologies. In addition, as discussed above, Medicare Quality Improvement Organizations have increased the use of physician services, and these organizations have been cited as an important factor in improving quality care delivered to Medicare patients in studies conducted during 1998-1999 and 2000-2001. We applaud the QIOs' efforts, but believe any impact on physician spending should be calculated in the SGR.

SECRETARY'S ADVISORY COMMITTEE ON REGULATORY REFORM

The AMA would like to express our appreciation for the efforts of the Secretary's Advisory Committee on Regulatory Reform, which concluded its work about six months ago. The Committee's Chair, Douglas Wood, MD, is a member of this Council. We are

concerned that the hard work of the members of the Secretary's Committee has yet to be acted upon by the Department of Health and Human Services and the Centers for Medicare and Medicaid (CMS). There are a number of recommendations from the Committee which would directly address a number of physician concerns: EMTALA reform, CLIA reform, provision of limited English proficiency (LEP) services, multiple carrier reviews and audits, improving the enrollment process, among others. PPAC and the medical profession deserves to know what the Administration is doing to act on these worthwhile and needed recommendations that would reduce much of the "red tape" and burden associated with these regulatory and program requirements. **Thus, we encourage CMS to update PPAC concerning the status of the important issues addressed by the Committee.**

COUNCIL AGENDA: PROVIDER ENROLLMENT AND EDUCATION AND TRAINING

Although we are pleased that the Council's agenda includes discussion of critical issues relating to the Medicare physician payment update formula, we are disappointed that PPAC will not be updated by the Centers for Medicare and Medicaid Services (CMS) and will not have the opportunity to provide comment concerning the recently published proposed rule on physician enrollment in the Medicare program. This is an extremely lengthy regulation that will have an enormous impact on physicians, both administratively and economically. There are a number of contentious issues in the rule, including, among others: (i) Medicare carriers would be required to revalidate all physician, supplier, and provider enrollment information every three years; although no justification has been provided for the necessity of this massive administrative undertaking, CMS has estimated it will cost $15 million per year; (ii) All physicians who have not previously submitted the 855 enrollment form would be required to do so. Physicians who have received their Medicare identification numbers prior to 1996 have not previously submitted 855 Forms. CMS has not detailed how carriers will carry out this function, the deadlines associated with the process, nor how carriers will use existing resources to process these forms, without jeopardizing the 60-day deadline by which they are supposed to approve Medicare identification numbers. This is of particular concern since carriers often do not currently meet this 60-day deadline; and (iii) CMS would no longer permit physicians and others to provide services to Medicare beneficiaries (for which they would later submit claims) before their Medicare identification number has been issued.

Although CMS is currently seeking public comment on the provisions of the enrollment regulation, it has not included the regulation as an item on today's PPAC agenda. Thus, CMS will not have the opportunity to hear from members of PPAC, who are practicing physicians, with regard to the impact of this regulation. **We urge CMS in the future to ensure that these types of issues are timely included on the agenda.**

Further, we urge PPAC to request that CMS include the physician enrollment issue on the agenda in the near future and delay finalizing the rule until PPAC has had an

opportunity to provide input. CMS has initiated efforts to improve the enrollment process, including improvements to the enrollment form and the procedure for obtaining an enrollment application. Nevertheless, a survey conducted by CMS and presented to PPAC last December indicated that there are still lengthy delays in the enrollment process as well as significant dissatisfaction with the process. These issues should be further analyzed by CMS and we believe PPAC could provide valuable input on this matter.

Finally, we wish to express our strong dismay concerning the Administration's proposed funding request for Medicare operations and provider education and training. The Administration has recommended a funding level of $2.497 billion for FY 2004, an increase of only $29 million over the FY 2003 level for Medicare operations and program integrity functions. We are especially alarmed about the reductions in funding for physician/provider education and training. The President's budget would significantly reduce physician education and training from $41.5 million in 2003 to just $6.5 million requested for 2004 – an 85 percent cut. During the last several years the Administration has opted to cut funding for education and outreach activities whenever carrier budgets have constricted. Physicians are required to understand and comply with over one hundred thousand pages of rules, regulations, requirements and other Medicare directives, as well as a myriad of new laws and related regulations, such as HIPAA, that were enacted over the last several years. Physicians cannot simply digest this magnitude of information without assistance from the carriers**. Thus, we urge PPAC to request that CMS ensure that adequate funding be available for physician education and training.**

The AMA appreciates this opportunity to appear before the Council today and we are happy to work with Council and CMS to achieve timely resolution to the matters discussed above.

Appendix 4

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.

Appendix 5

Physician Self-Referral Provisions – Section 1877 of the Social Security Act

A physician cannot refer a Medicare or Medicaid patient for a designated health service to an entity with which the physician or an immediate family member has a financial relationship unless an exception applies.

The statute is an important and powerful tool in the fraud and abuse arsenal:

- It acts prospectively to prohibit relationships that have been shown to encourage overutilization or increase program costs
- It is especially important for hospital/ physician relationships, since all hospital services are designated health services
- It is a strict liability statute so unnecessary to prove knowledge or intent. Innocent violations trigger denial of payments

Our philosophy in Phase I and Phase II:

- Interpret prohibitions narrowly and exceptions broadly
- Interpret the statute so it will not adversely affect patient care
- Conform regulations to other CMS payment and coverage policies to the extent possible
- Establish bright lines and administrative simplicity where possible

The designated health services:

- Clinical laboratory services
- Physical therapy and speech-language pathology services
- Occupational therapy services
- Radiology services: including MRIs, CT scans, and ultrasound services
- Radiation therapy services and supplies
- Parenteral and enteral nutrients, equipment and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

The Phase I final rule with comment period (January 4, 2001; 66 FR 856) set forth provisions that account for over 75 percent of the comments on the January 9, 1998 proposed rule and the biggest conceptual issues:

- The prohibition
- Almost all definitions

- Exceptions in the law that apply to ownership, investment and compensation relationships
- We used our authority to create exceptions for situations in which there is no risk of program or patient abuse to include exceptions for:

    - A fair market value exception that may apply to almost any direct compensation relationship
    - A special exception for academic medical centers
    - An exception for non-monetary compensation up to $300
    - An exception for medical staff benefits
    - An exception for indirect compensation relationships

The Phase II final rule with comment period:

- **Responds to comments received on the Phase I final rule**

- **Cannot discuss this rule in detail because it has not yet been published**

- **Includes exceptions in the law, among others, that apply to:**

    - **Ownership and investment interests (publicly traded securities and mutual funds; hospitals in Puerto Rico; rural providers; and hospital ownership)**
    - **Compensation relationships (rental of office space and equipment; employment; personal service arrangements [independent contractors]; remuneration unrelated to the provision of designated health services; physician recruitment; isolated transactions; and payments made by a physician for items and services)**

- **Considers the many requests for exceptions for professional courtesy and charitable donations by physicians**
- **Addresses the "set in advance" provision, the effective date of which has been delayed from Phase I**

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Practicing Physicians Advisory Council

Hon. Tommy Thompson
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

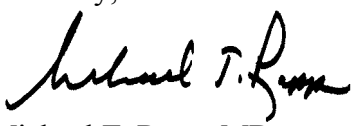
Dear Mr. Secretary:

Enclosed is the Report of the 44th quarterly meeting of the Practicing Physicians Advisory Council. We had the pleasure of welcoming four new members to the Council, including our first practicing physician from Alaska. Both in specialty and geography we are pleased with the breadth of our representation.

Please note that we have in place a revised format for our meetings, which is reflected in our quarterly reports to you. We are much more focused on those Medicare issues upon which we may appropriately and effectively have an influence. I am also pleased to point out that the staff and management of CMS have responded generally positively to our many specific recommendations; we believe that this development of more focused collaboration and cooperation will benefit not only the internal administration of this important Federal program but will also mean improved medical care to the Nation's elderly, a commitment to which we unanimously subscribe.

Finally, I wish to recognize the members of your Department who have worked diligently on the fairness issues our Council has raised with regard to the annual setting of the physician fee schedule. I cannot say that we or our colleagues across the Nation are totally satisfied with the deliberations thus far, but we are greatly encouraged by the seriousness with which this matter is handled by your Department. Again, let me assure you that the Council remains ready to work with you in any appropriate way to insure not only fairness in the physician fee-setting process but also the continued provision of quality medical care to our most vulnerable citizens.

Sincerely,



Michael T. Rapp, MD
Chair, PPAC

Enclosed: 44th Report of the Practicing Physicians Advisory Council

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