Statement of the American Osteopathic Association

to the

Practicing Physicians Advisory Council

February 10, 2003

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The American Osteopathic Association (AOA) appreciates the opportunity to provide its comments and recommendations concerning the development of the 2004 Medicare Physician Fee Schedule. The AOA also thanks the Centers for Medicare and Medicaid Services (CMS) for recognizing the importance of gaining input from the Practicing Physicians Advisory Council early in the development process of the proposed fee schedule.

In addition, we commend CMS and the Department of Health and Human Services for its continued efforts to respond to the health care community's concerns about the regulatory burdens and financial difficulties it faces.

The AOA welcomes CMS Administrator Thomas Scully's determination to resolve the financial devastation caused by the flawed Sustainable Growth Rate (SGR) formula. We support CMS's intentions to work closely with Congress to develop legislation that would permit a positive update.

We are heartened that on January 22nd the United States Senate approved House Joint Resolution 2, which contains provisions that will delay the implementation of the proposed 4.4% reduction in Medicare reimbursements until the end of the FY 2003 budget cycle on September 30, 2003. We hope that an equitable long-term solution is reached before the 2004 Medicare Physician Fee Schedule takes effect. The AOA offers its help to find a fair and balanced resolution to this problem.

Patient Access

Osteopathic physicians represent 18% of all physicians practicing in small towns and rural areas with populations of 10,000 or less, and 22% of all physicians practicing in communities of 2,500 persons or less. The AOA shares Mr. Scully's concerns that the latest round of Medicare payment cuts will have a significant impact on patient access to physicians' services. We are particularly concerned about areas where services are already scarce.

Unless a law is passed to stop the reimbursement cuts, starting March 1, physicians will be forced to absorb a 4.4% decrease in their reimbursements due to the flawed SGR formula, on top of the 5.4% decrease in 2002. A nearly 10% decrease in payments in two years on top of skyrocketing liability insurance costs, as well as complying with regulatory mandates is too much for any physician practice to endure. Without corrective

action by Congress and CMS, the problem will only get worse and patients will suffer the most.

CMS notes that almost 90 percent of physicians accept Medicare assignment today, and as yet CMS has not seen access problems. However, CMS anticipates the possibility of access problems if the reimbursement reduction goes into effect. According to CMS, it is expanding its efforts to monitor beneficiary access to physician services, both nationally and in local healthcare markets.

The AOA is receiving a higher frequency of inquiries about opting out of Medicare. We urge CMS to share with the physician community its methodology for monitoring beneficiary access and determining the causes and changes in beneficiary access to Medicare services. MedPAC's own survey shows early indications of decreased beneficiary access to physician services.

While it is helpful to know the rates of participation changes for physicians, that may not be the best indicator of accessibility. Physicians are participating in Medicare, but they may not be accepting new Medicare patients or they may be giving a lower priority to Medicare patients. It is regrettable that due to financial cutbacks, in addition to regulatory mandates and escalating professional liability costs, physicians are forced to choose between cutting back on patient care and closing their doors completely.

Payment Update Formula

We realize that CMS believes it does not have the legal authority to correct the estimates used to establish the SGR for fiscal years 1998 and 1999. We urge Congress to provide such authority so that this problem can be resolved. Current payment cuts and future decreases in reimbursements will further reduce physician willingness to accept Medicare patients.

CMS must continue to take measures in the 2004 fee schedule to ease physicians' financial burdens under Medicare. For example, we support the move by CMS to change the methodology for adjusting for productivity in the Medicare Economic Index (MEI) used for the CY 2003 physician payment update. As CMS noted, using a 10-year moving average change in economy-wide multifactor productivity produces a stable and predictable adjustment.

However, we are troubled that CMS still finds it necessary to apply a behavioral offset. In the Dec. 31, 2002 final rule, CMS said it is "applying a .49 percent reduction to the practice expense RVUs to account for an anticipated increase in volume and intensity of services in response to payment reductions from the refinement of practice expense RVUs." Payment reductions more likely will lead to volume reductions, not increases. We do not believe a behavioral offset is justified. Will CMS continue to apply a behavioral offset in 2004? CMS must explain its reasons.

Drugs -- In our comments on the proposed 2003 Medicare Physician Fee Schedule, we urged CMS to remove drugs from the SGR. In the final rule, CMS stated it has the

authority to include drugs in the definition of physician services for the purposes of determining allowed expenditures, actual expenditures and the SGR. We maintain that drugs themselves are not physician services.

We urge CMS to review this matter further when developing the 2004 proposed rule. CMS also should address the numerous issues that have been raised such as "the increase in drug spending is due to government policies that encourage the rapid development of new drugs as well as government efforts to urge Americans to be tested and seek early treatment for cancer and other diseases." In addition, drug advertisements encourage patients to request more expensive drugs when a generic drug might be more suitable. Physicians should not be forced to pay for the rising cost of drugs covered by Medicare through reduced fees.

Medical Liability -- According to the July 24, 2002 Health & Human Services report on medical liability (*Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System*), "doctors alone spent $6.3 billion last year [2001] to obtain [malpractice insurance] coverage." Professional liability insurance rate increases are averaging 20%, according to the report. Liability insurance costs are out of control.

Physicians cannot keep up with the escalating costs.

In previous comments to CMS, we cited in Florida, FPIC, the medical liability carrier endorsed by the Florida Osteopathic Medical Association (FOMA), notified the association that they have a moratorium on writing new policies because of net premiums rising 81% last year. With fewer insurance companies writing policies, physicians are forced to pay more for coverage. A multi-specialty practice in Boca Raton was informed that its insurance premiums, currently $80,000 per year, would rise to $2.5 million. A radiologist in Southeast Florida who specializes in reading mammograms was notified that his premiums would increase from $30,000 to $120,000.

CMS must make certain that the costs of professional liability insurance are reflected adequately in the MEI. We appreciate the added information that CMS provided concerning its determination of the 11.3% change in professional liability costs for CY 2003. However, in light of the rapidly rising rates, we urge CMS to provide more detailed information on their data collection and determination.

Regulatory Burden

Physicians also need to be protected from unfunded federal mandates. Medicare payment rates must better reflect the regulatory mandates' costs imposed on physicians and other health care providers. Many physicians limit the number of Medicare patients they see because they cannot handle the increasing regulatory workload. Patients, particularly in rural areas, must travel greater distances to find physicians who accept Medicare.

Unless the impact of compliance requirements, documentation requirements and quality control measures is adequately accounted for, physicians are faced with covering the added costs.

For example, HIPAA's electronic requirements are very expensive for small physician practices. Converting to electronic billing could cost approximately $10,000 or more. Even though practices with fewer than 10 employees would be exempt from electronic billing under Medicare, the reality is physicians need to submit claims electronically to be included in private managed care networks.

CMS has made strides in obtaining feedback and input from the physician community. It is necessary for CMS to work in partnership with the physician community when developing regulations, particularly the fee schedule rule, to avoid confusion, inconsistencies and redundancies.

For example, we are concerned about the growing number of G codes created by CMS. The creation of G codes should be limited as much as possible and be considered a temporary measure. The use of G codes oftentimes creates confusion and disruption, particularly when existing CPT codes describe similar services. We recommend greater consultation between CMS and American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC), CPT editorial panel and the physician community when establishing these codes.

The AOA agrees with the HHS Advisory Committee on Regulatory Reform's guiding principles and we encourage CMS to apply these guidelines when developing the proposed 2004 Medicare Physician Fee Schedule, which state:

- Regulations should be uniform and streamlined to avoid conflict and duplication.

- Regulations should have a clearly articulated purpose that advances an appropriate regulatory function.

- Regulations should be written clearly to promote easy understanding by consumers, employers and health care providers, suppliers and organizations.

- Regulations should be based on evidence from research and peer-reviewed literature, wherever possible, not on anecdotes or interest group politics.

- Regulations should be based on the premise that value is added for consumers (i.e., better service, access, and affordability) and providers or other entities (i.e., improved ability to serve patients without excessive operational costs to comply with regulatory requirements.) Regulations that do not meet such a cost-benefit analysis should not be adopted.

- Regulations should avoid micromanaging the process by which entities operate and instead should focus broadly on improving performance in the areas of quality, solvency, accessibility and affordability.

Conclusion

Overall, the AOA commends CMS for the measures it has taken to address physicians concerns through PRIT, Open Door Forums, and PPAC. In addition, CMS working with the RUC and the Practice Expense Advisory Committee (PEAC) is critical to establishing fair and balanced payment policies under the Medicare Physician Fee Schedule. We appreciate CMS's support of the process.

Strengthening the lines of communication and working with the medical/surgical community to develop future physician fee schedules and other Medicare policies will lead to improved overall quality of health care.