Statement
of the
Medical Society of the State of New York
to the
Practicing Physicians Advisory Council
Re: 2004 Physician Fee Schedule, and the
Physicians Regulatory Issues Team Update

On behalf of the 30,000 physician and medical student members of the Medical Society of the State of New York (MSSNY), We are pleased to provide this statement for the record to the Practicing Physicians Advisory Council (PPAC). As requested, our statement focuses on the 2004 Physician Fee Schedule and the Physicians Regulatory Issues Team Update. Since, by the very name of this Council, we are all practicing physicians, we feel we are *Preaching to the Choir*. Many of the issues that follow are issues that concern us all.

Initially, we must point out that MSSNY strongly supports the PPAC with your earlier recommendations to the Centers for Medicare and Medicaid Services (CMS), namely, your the earlier recommendations regarding:

MEDICARE PAYMENT CUTS
MEDICAID
CARRIER MEDICAL DIRECTORS
MEDICAL REVIEW POLICIES
SELF-ADMINISTERED DRUG POLICY
PREVENTIVE CARE / GPCI

While we will address the 2004 Physician Fee Schedule and the Physicians Regulatory Issues Team Update, we find it important to mention the following matters with regard to the 2003 Medicare Physician Fee schedule and the NYS Medicaid Program.

With regard to the 2003 Medicare Physician Fee schedule, we have recently informed the NYS county medical and specialty societies that the 2003 Medicare Physician Fee Schedule does not take effect until March 1, 2003. We advised our constituency that claims for services rendered in January and February 2003 that can be processed by the carrier(s) before March 1, 2003 will be processed based on the 2002 fee schedule. Claims for services rendered in January or February 2003 that are processed on or after March 1, 2003 will be paid at the 2003 payment rate. In addition, we informed our membership of the introduction by Representative Bill Thomas (R-CA) of House Joint

Resolution 3 on January 7th which calls for a freeze of Medicare rates at 2002 levels through the end of 2003. We have urged our members to contact their elected officials to support H.J. Resolution 3 that would buy time for Congress to undertake the needed "fix" of the Medicare formula. The resolution, however, will not be addressed until after the House of Representatives returns from a scheduled recess on January 28th.

In addition, we informed our members that the time limit for any modifications to the Medicare physician participation status has also been extended. Any changes to current (2002) Medicare physician participation status has to be received by the Medicare carrier(s) no later than February 28, 2003 for the 2003 fee screen year.

A Medicare carrier in our jurisdiction asked us for our assistance in getting this word out to the physicians since their budgetary constraints precluded them from "hardcopy/bulletins/mail" notification until it is **too** late (i.e. mid-February) to inform the physician community.

We are aware that the Medicare Carriers printed the 2003 Physician Fee Schedule data for mailing to physicians back in October 2002, not knowing that the government was going to delay the publication of the *Federal Register* until December 31, 2002. As soon as the *Federal Register* was published, the Carriers mailed the data with the incorrect effective dates. Again, due to the carriers' fiscal constraints, they could only advise physicians of the incorrect dates, contained in the mailing, via their websites. As you may know, not every physician has the time or the opportunity to verify the accuracy of their local Medicare carriers' mailing by searching the Web.

NYS MEDICAID

Again, we agree with your previous recommendation, on this matter, to CMS. However, we find it necessary to iterate that the NYS Medicaid Physician Fee-for-Service Fee Schedule is one of the lowest in the nation. Also, we have been making all attempts to work with our NYS Department of Health (DOH) in an effort to amend this most egregious situation.

As you may or may not know, up until October 2000, a NYS physician was able to receive approximately $7.00 for an office visit for a Medicaid recipient. MSSNY was successful in getting a Medicaid fee increase for selected Evaluation and Management (E/M) services. The codes affected are: 99201-99205, 99211-99215, 99381-99385, and 99391-99395. Effective October 1, 2000, these codes are now payable, by NYS Medicaid, at $30.00. Emergency room visits were also increased from the old $6.50 to the current $17.00 fee.

MSSNY agreed to this increase as a first step in an effort to have all fees in the NYS Medicaid Physician Fee-for-Service Fee Schedule increased. In researching our fee schedule plight, we looked at the State's Medicaid fee expenditures for 1997 or 1998. We noticed that physicians fee-for service expenditures accounted for less than 2% of the State's payment schedule for Medicaid recipients. Of a 32 billion dollar budget, only

344 million was paid to physicians on a fee-for-service basis. The physicians' portion accounted for a very tiny piece of the pie.

What MSSNY proposed to our State was that within the same budget neutral budget, if there was a shift of recipients away from the hospitals, ERs, OPDs and clinics into the physicians offices, the State could potentially see a significant cost savings. In order to take that initial step - the initial fight, we actually said to the NYS Legislature, let us see what we can do. The intent when MSSNY started this discussion, with the State, was to try to get patients to a physician's private office. As a starting point, we asked for a $30.00 fee. Our thought was that a $30.00 in the office would be an increase from the $7.00 fee and that there was potential for moving more patients out of ER, OPDs, clinics and hospitals. It was perceived that by providing a medical home, the State would be able to reduce the hospital, ER, OPD, and clinic expenditures.

By making that cost savings, the State could eventually explore expansion of monetary benefits to other services, such as EKGs, chest x-rays, etc. If by shifting recipients to a medical home of a physician's private practice, the State should see a significant monetary savings that could be rolled over for the exploration of an overall Medicaid fee increase.

However, we now find ourselves in a "Catch 22". The NYS DOH has modified their take on the initial intent by assuming that, based on a $30.00 office visit, there would be a significant increase in physician participation in the NYS Medicaid Program. The NYS Medicaid Program has ludicrous fee schedule, which continues to have an adverse effect on patient access and physician participation. Therefore, we applaud your ongoing efforts to have CMS work with the states to measure access and participation rates and to the extent possible to encourage equal access to Medicaid across the states.

2004 PHYSICIAN FEE SCHEDULE

It is rather difficult to talk about a "*wish list"* for the 2004 Physician Fee Schedule when 2002 and 2003 have faced such significant payment cuts (5.4% in 2002 and 4.4% in 2003). Is there any other profession that is expected to provide the highest quality while accepting pay cuts? We are speaking of life and death when practicing medicine – especially when it is for the treatment of the elderly and disabled population in this country. In order to provide the anticipated quality of care, we must employ staff just to monitor and keep abreast of all the rules and regulations that must be adhered to with regard to the Medicare Program.

Something is terribly wrong here. Why must all these rules be written and then re-written, changed, adjusted and modified? And at what cost to the government and the Trust Fund? Although the administration of the Program has always been touted to be a very low percentage, it translates into high office overhead costs for physicians and others who treat beneficiaries. Maybe if the government could stop changing or

amending the rules, both the administration and Medicare providers could save some money.

Physicians went to medical school to practice medicine – not business school. Physicians treat the sick and the infirmed, understand the need to file claims and expect to be paid for the care and treatment provided. The government, on the other hand, tries to regulate and re-regulate either the practice or business of medicine. Why must it be so difficult?

As the pay cuts continue, fees will be reduced to that of payments made before the Resource Based Relative Value System (RBRVS) was implemented in 1992. This cannot be what Congress intended. What about the cost of living? Also, the cost associated with practice expenses has continued to rise. Based on government regulation, physicians are expected to and must pay for the expenses involved with and compliance for:

Limited English Proficiency (LEP)
Health Insurance Portability and Accountability Act (HIPAA) electronic billing mandates;
HIPAA privacy standards;
HIPAA security standards; etc.

Since we can assume that HIPAA will not go away anytime soon, shouldn't there be some funds appropriated by the government for the rules and mandates that physicians are expected to follow. In addition, physicians must consider the costs associated with modifying all their record keeping systems and staff training requirements if the government chooses to change from the existing ICD-9 Diagnosis Coding System to the ICD-10 Diagnosis Coding System.

Physicians are expected to comply with all these regulations that do cost the physician all the while as the rates for malpractice insurance continue to skyrocket out of control. Where is the *quid pro quo*? Have the practice expense and the malpractice expense RVUs kept up with the government's wish lists that do nothing but **over**-regulate the practice of medicine???

By equating healthcare expenditures to the Gross National Product (GNP) in the name of a Sustainable Growth Rate (SGR), some accountant/*bean counter* must have missed the boat. It has long been the Medicare theory that the working generation, through contributions to FICA and other forms of taxation, has supported the Medicare funds for the retired generation.

Has anyone looked forward to where the "baby boomer" population – who were not as prolific/propagating as their parents – will need the Medicare program? The generation following the baby boomers will, no doubt, have significant difficulty in supporting the baby boomers entering the Medicare Program. Just fixing the SGR or the physician fee schedule is not enough. There needs to be a significant reconsideration of the Program

for the people who will become Medicare eligible upto and including the year 2029. [The baby boomers were born during the years following World War II starting in 1946 and continuing through 1964.]

The following chart shows the number of U.S. births from 1940 to 1994 in thousands. For example, in 1940, there were 2,559 thousand (or 2,559,000 - that's 2.6 million) births. This data comes from the U.S. Department of Commerce, Bureau of the Census. These numbers refer to U.S. births only. The births for the so-called "baby boomers" are shown in bold.

1940	2,559	**1955**	**4,097**	1970	3,731	1985	3,761
1941	2,703	**1956**	**4,218**	1971	3,556	1986	3,757
1942	2,989	**1957**	**4,300**	1972	3,258	1987	3,809
1943	3,104	**1958**	**4,255**	1973	3,137	1988	3,910
1944	2,939	**1959**	**4,245**	1974	3,160	1989	4,041
1945	2,858	**1960**	**4,258**	1975	3,144	1990	4,158
1946	**3,411**	**1961**	**4,268**	1976	3,168	1991	4,111
1947	**3,817**	**1962**	**4,167**	1977	3,327	1992	4,065
1948	**3,637**	**1963**	**4,098**	1978	3,333	1993	4,000
1949	**3,649**	**1964**	**4,027**	1979	3,494	1994	3,979
1950	**3,632**	1965	3,760	1980	3,612		
1951	**3,823**	1966	3,606	1981	3,629		
1952	**3,913**	1967	3,521	1982	3,681		
1953	**3,965**	1968	3,502	1983	3,639		
1954	**4,078**	1969	3,606	1984	3,669		

If the government's plan is to expand Medicare benefits to respond to the needs of the elderly and disabled populations to pay for prescription drugs and additional preventive services, money for funding the Program has got to come from somewhere. This must be reevaluated. The funding of additional services should not fall under the Physician Fee Schedule component of the program.

Physicians Regulatory Issues Team

As was mentioned in the preface of this statement, physician organizations were needed to get the word out regarding misinformation concerning the 2003 Physician Fee Schedule and the 2003 Medicare physician participation program. How could a government program not have budgeted sufficient funding for their carriers to either make corrections or generate a notice along with the 2003 mailing so that the physician community would have had correct information with respect to effective dates????

This is just another example of over-regulation and mismanagement. It may be a case where the issue has gotten too big to handle. Something should be re-thought. Medicare does not need to be this complicated.

In the attempts to make the Program more open and *"user friendly"*, the Centers for Medicare and Medicaid Services should consider a broader base of commentary for its

Correct Coding Initiative (CCI). Bundling and downcoding by Medicare carriers should not be allowed without the medical/surgical chart review conducted by a physician of same or similar specialty. Additionally, there should be a RVU and an associated fee for every AMA-CPT code identifying a physician's service, care and/or treatment. This is especially true in the realm of telephone calls and telephone consultations, which are common place in today's medical practice standards for various conditions and treatment regimens. As healthcare professionals, we cannot practice in a vacuum. We must be able to interact with colleagues in order to provide the highest quality care without being accused of upcoding an Evaluation and Management E&M visit.

Further, there must be a coordinated effort to ensure that some local medical review policies that are aberrations and are in conflict with standard medical practice be evaluated and eliminated.

For example, Trailblazer is a carrier that has jurisdiction for processing Medicare Part B claims in the areas of Maryland, Virginia, Washington, DC, and Texas, etc. This carrier has recently put forth a draft local medical review policy that includes the following assertion: "Medicare expects that these modalities will constitute no more than 25 percent of the services by time rendered on any given day". Does the government's program have expectations of what a patient may or may not need of any given day?? Whatever happened to medical necessity?

We appreciate the opportunity to be heard [or read] to the PPAC Council and hope to continue a longstanding relationship that will serve to benefit the elderly and disabled who are in need of the benefits offered by the Medicare Program. We also hope that the Program continues so that we will have access to it when our time comes.

January 23, 2003