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Practice Management Section

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“Physicians stare at federal and state legislation, insurance company rules and payments, and political demography as if they were handed down from an almighty being, absolute and with no recourse. American Physicians holding within its power all the knowledge of medical science, the support of the patients for which they care, and the authority of all their societies have chosen to relinquish decision making to persons whose knowledge and motive are suspicious at best.”

Senator Edward Kennedy
Speaking before Senate , Spring 2007

SUMMER OF 2007 STATEWIDE ISSUES

The most historic legislation that will affect the practice of gastroenterology in the State of New York passed the State Assembly this summer. Signed into law by Elliot Spitzer, the law requires the Department of Health to “regulate office endoscopy”. Within 18 months, all offices in the state of New York will need to be “accredited” by an external agency. The most likely agencies that the State of New York will approve include: 1) Joint Commission (formerly JCAHO); (2) Accreditation Association for Ambulatory Health Care (AAAHC); and (3) American Association of Accreditation of Ambulatory Surgery Facilities (AAAASF).

Historical Background

Although a Federal Government commissioned study from Medicare and Medicaid Services (CMS) found office based endoscopy in New York to be safe and effective, several complaints from hospitals in NY led Antonio Novello (former Health Commissioner of the State of New York) to convene a “Committee of Public Safety” to specifically draft legislation to regulate office based endoscopy. The “Committee”, which included two gastroenterologists, including the Chair of the Committee, met at the Department of Health during 2004 and 2005. During this time, legislation was drafted. The NYSGE, ACG, ASGE, AGA were not invited to attend any of the meetings. At the last session, with special thanks to Maurice Cerulli who discovered that these meetings were occurring, I was able to attend. This last full committee meeting merely finalized a document that had been developed by dozens of physicians, nurses, healthcare specialists and public health officials that had met during the year in 2004. Despite public comment from hospitals, nursing associations, anesthesiologists, accrediting organizations, the gastroenterology community was left completely in the dark. The draft legislation was

packaged and sent to Albany for vote. The delay until now only occurred because of the elections that led to a change in leadership from the Pataki Administration to the Spitzer Administration.

Legislation Effects

Whether you are practicing endoscopy in the office, hospital, or Ambulatory Surgical Center in the State of New York, you will be affected by this legislation. We estimate almost 500 offices in New York State perform Endoscopy with a volume approaching 300,000 cases per year (actual data is being collected). The process to accreditation is not easy (see below) and many gastroenterologists will choose not to become accredited. Thus many patients will be moved from the offices into hospitals and/or the few ASCs that exist in NY. Hospitals and ASCs will need to find new methods of accommodating the physicians and patients that will need to be moved. Offices that do choose to become accredited will find the task costly, time consuming, but rewarding (discussed below). Insurance carriers who likely supported the legislation as a quick way of increasing corporate profit by decreasing volume (many procedures will simply not be performed due to the complexity of accreditation or movement of patients to hospitals), will in the end pay more either in hospitals, ASCs and, as I will discuss below, facility fees for office based endoscopy (OBE).

Accreditation

After attending the final meeting at the Department of Health and being told by Dr. Bernard Rusoff, Chair of the Committee (and a Gastroenterologist) that the State Assembly would “quickly pass the draft legislation”, several offices began the process of accreditation with the Joint Commission. We sought assistance from an independent consulting company that worked with other specialties for office based surgery, Validare (Validare.com). With an impressive web-based program, this company could assist an office in becoming accredited in 4-6 months through the Joint Commission. Also, they would assist your new “accredited facility” in billing for a facility fee. Billing?! How could we bill without an Article 28, certificate of need (CON) from the State of New York? Well, it is true that you would not be able to bill patients covered by Medicare and Medicaid. However, Article 28 does not apply to private insurers. This company had worked with the Medical Society of the State of New York, and several law firms, including Einiger and Associates which met with the Department of Health to clarify this issue.

Accreditation required approximately 10,000 dollars in fees, 10,000 dollars in physical plant changes, hundreds of hours of work on my part, and at least an additional 10 hours weekly (total) from my staff. And even now, to maintain accreditation, the work continues to occupy 5-10 hours a week of work from me and my staff (total). I must stress that the vast majority of work will fall upon a physician in the practice. Although I tried to delegate the work to consultants and even staff, in the end, especially during the inspections, you must maintain complete knowledge of the process. This knowledge is only obtained by doing the work for accreditation yourself.

There are clear advantages to accreditation (aside from the current state requirement). My office is by far a more safe, effective and accountable office for practicing endoscopy than it had been without accreditation. My staff are more enthusiastic, wiser and able to assist in the delivery of care to a far greater level of excellence. We are no longer an isolated island of health care delivery but a facility in a network of accredited offices working for patient care on a higher level. Every day, based on the standards and requirements of the Joint Commission, our office works to improve the delivery of health care to our patients and community.

Office Based Endoscopy: Facility Payments

Why have physicians accepted that their office based facility, which has equipment, stretchers, etc, should not receive a payment? Article 28's purpose was to protect state and federal dollars and focus the payment to facilities that demonstrated to the state a need to exist (Certificate of Need – CON). In truth, it was a political maneuver of the hospitals to maintain control of the “financial pot”. This relationship does not apply to private insurers. With payments dropping for endoscopy, and the national acceptance of a facility payment to cover the equipment, only an appropriate facility payment for the services that should always have received a facility payment in a gastroenterologist office will allow Office Based Endoscopy to survive. I traveled to Albany twice last year with Donald Moy, Esq, Medical Society of the State of New York and Scott Eineger, Esq to specifically understand the legality of billing. We met with officials from the Department of Health, including their lead attorney, Donald Berens, Esq and members of the office of professional misconduct (OPM). After it became apparent that the state had no problem with the practice of billing a facility fee, I instructed Validare, which had assisted in my Joint Commission Accreditation, to bill for the facility I provided private carriers for their patients. Within the first year, facility payments resulted in almost 1 million dollars of additional revenue for our practice. This payment has allowed my accredited office to acquire new equipment, stretchers, staff and match, I dare say, surpass the hospital in quality.

Many carriers have refused to pay a facility payment. Some of these carriers are negotiating with Validare and our Society, such as GHI and HIP. Some carriers have called it fraud and asked for their money back. But seriously, who is perpetuating this purported fraud, the office facility or the insurance carrier that refuses to recognize its existence? In general, the insurance industry wants office based endoscopy, but does not want to pay appropriately. Accreditation is the first step in demanding office based facility payments!

Ambulatory Surgical Centers in NY State

While New York has been trying to obtain a facility payment for office based endoscopy, the remainder of the country has been concerned with the survival of an entity that does receive facility payments: ASCs. ASCs are the NY Article 28 sites that allow all insurances and medicare as well as Medicaid pay for a facility payment. For example, the ASC facility payment for Medicare or Medicaid gets paid an additional 400-450 dollars per procedure. Yes, that's how procedures get done in ASCs for such abysmal payments to the physician!

Maryland has almost 500 State Approved ASCs, New York has only 88. Huh? We have 10 times the population, 40 times the number of endoscopic procedures being performed. How could the State of New York have only a sixth of the ASCs. To be blunt, it is pure politics. ASCs mean private profit and success of individual physicians and physician groups as opposed to hospital profit. The fewer the ASCs, the more likely procedures will need to be performed in the hospitals. In addition, few ASCs help keep costs for the insurance industry lower. The general feeling appears to be, why pay for a facility when they (the insurance carriers) get it for free. Some carriers, such as Aetna, and in the past, Oxford, offer a poor 200 -300 dollar “incentive” to physicians to perform procedures in the office. This is sad given the fact that several studies, commissioned by the ACG and ASGE show that the cost of performing a procedure in the office is between 350 and 450 dollars.

The Public Health Council of the State of New York, which must approve ASCs, is controlled by a strong group of hospitalists and insurers that do not want to see the creation of ASCs (for endoscopy, surgery or any method of health care delivery). I have spent the past year going through the application process and attending meeting after meeting. I have almost reached the final vote with the help of a brilliant advisor, Frank Cicero Jr., whose father Dr. Frank Cicero helped develop the ASC law for the State of New York when he served on the Department of Health Council. The process has been one of pure politics, lack of honesty. The lack of integrity from the hospitals trying to stop me has been unimaginable. I have an office that for a decade has performed procedures only in the office. I pose no threat to hospitals in my area that have lack of vision in Endoscopy and largely maintained antiquated facilities. It is not my fault that patients have chosen to come to my site where I provide a higher level of care, including short wait times, nourishment after procedures, dieticians, etc. Although my own hospital, Maimonides Medical Center, a hospital gleaming with vision in the future of endoscopy, supported my application, other area hospitals, merely jealous of the relationship, demanded that the Public Health Council not approve the application. They claimed that my existence was a “threat”. They wrote and argued that I should shut my office down and move all the patients to their antiquated facilities. Almost 50% of my patients were covered by Medicare and Medicaid. The government would only provide me a facility payment with State Approval, an Article 28 CON. So, what was the problem. As of this writing, I have spent over \$200,000 on legal and consulting fees, final vote is pending. Despite the fact that the officials from the Department of Health have supported this application against the Public Committees, these external “forces” continue to try and stop my ability to obtain fair payment for providing fair services as described by the federal government.

SUMMER OF 2007 NATIONAL ISSUES

Physicians Due For 10% Across The Board Cut From CMS

In order to curb the rising costs of healthcare in the United States, the government decided to punish physicians. The hospitals, insurers and pharmaceutical industry have strong lobbys. In general, physicians are split, confused, demoralized, working too hard on patient care and academics to concentrate on issues that affect their ability to practice. Anyway, years distant, congress developed a simple formula, Sustainable Growth Rate.

If the volume of any service increased, physician payments would be cut! Yes, even if more patients are aging into the system, and even if we prevent more disease such as colon cancer with colonoscopy, we would be punished. Similar to past years, due to this Sustainable Growth Rate Formula used by CMS to determine payments to physicians, we are due to receive a 10% cut in payments this year from CMS. By the way, almost all insurance carriers use CMS's payment schedule for calculating our payments.

There may be a glimmer of hope on the horizon. With the help of Congressman Charles Rangel, Chair of the House Ways and Means Committee, both sides of Congress, House and Senate, have approved an authorization for a 0.5% increase in our payments rather than a cut. Although we have received this slight break over the last several years, increasing payments by 0.5% per year into a system whose inflation is 4-5% per year, effectively cuts our payments annually regardless. Well, 0.5% increase is better than a 10% cut. Maybe we should just be happy with that?!? This 0.5% proposed increase in payment is an attachment to a larger bill which reauthorizes, and expands, the State Children's Health Insurance Program (SCHIP). In order to maintain budget neutrality, the bill authorizes an increase in the Cigarette tax to pay for the cost of the bill. Although the bill would help Children obtain health insurance if they were financially disadvantaged, and the bill would help avert a 10% decrease in payments to physicians, and even has wording to clear up an issue on colorectal cancer screening (the deductible issue for screening colonoscopies if a polyp is found), the bill is in jeopardy. Expanding health care at the cost to the tobacco industry is not a favored topic for the President. He has threatened to Veto the Bill. It is possible to overturn the expected Veto. Congress is mostly Democratic supporting the Bill and Republicans, especially after the last election, may want to join with the Democrats on a bill popular among the "citizenry". You can also make a difference:

You can communicate to congress and make a difference:

To write your Representative, go to: http://ga4.org/campaign/ASC_House_2007

To write your Senators go to: http://ga4.org/campaign/ASC_Senate_2007

CMS Announces Massive Cut (27%) to Gastroenterologists Who Perform Endoscopy in ASCs

While NY Gastroenterologists must focus on obtaining a facility payment, the remainder of the country is facing a drop in that payment. I should point out that tying up New York Gastroenterologists with local issues (such as myself), limits our ability to participate on National Issues. (Sounds like a conspiracy eh?). Part of the Medicare Modernization Act that led to prescription coverage required CMS to develop a new method of paying Ambulatory Surgical Centers. The final rules will crush gastroenterologists who have Ambulatory Surgical Centers. By decreasing payment to 65% of the hospital outpatient rate (HOPD), few endoscopy specific (which are the majority) ambulatory surgical centers will survive. The ACG commissioned a study which shows when fully implemented, the cost of procedures will be greater than the revenue.

Although this information does not apply to the vast majority of New York Gastroenterologists, the pattern is real. Payments for hospitals increase and those to cover the costs of private, perhaps higher quality ASCs, drops. Worse, unlike hospitals, ASCs are not reimbursed for disposable items and do not increase in payment at the rate HOPD increase.

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Our experience shows that Congress responds to contacts from constituents. Therefore, in addition to sending letters yourself, consider informing your patients about the cuts and the effect that it may have on your practice.