August 29, 2013

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS Proposal to Cap Payment in Physician Offices at Facility Rates
CMS-1600-P; RIN 0938-AR56

Dear Administrator Tavenner:

On behalf of the undersigned medical organizations, we are writing to oppose the 2014 Medicare Physician Fee Schedule (PFS) proposal to cap payment rates for 211 physician services at outpatient prospective payment system (OPPS) or ambulatory surgery center (ASC) rates. The proposal will reduce payments for some services by 50 percent or more, potentially driving them out of physician offices altogether and requiring patients to obtain these services in a more costly, less convenient facility setting. We urge the Centers for Medicare & Medicaid Services (CMS) to withdraw this proposal.

Services provided less than 5 percent of the time to hospital outpatients are supposedly exempt from the cap. However, as the cap was actually applied in the proposed policy, any of the 211 listed codes meeting that utilization threshold would have its PFS payment capped at the ASC rate, whether or not it exceeded the OPPS payment cap and whether or not it was provided at least 5 percent of the time in an ASC. As a result, the proposal would expand codes affected by the policy by more than a third and reduce payment rates for these services to 40 percent below the OPPS level, since ASC payments are just 60 percent of the OPPS rate for the same service.

An AMA analysis found that, for 82 percent of the codes with proposed reductions, the direct expenses alone (i.e., clinical labor, supplies, and equipment employed in the service as adopted and implemented by CMS) exceed the proposed payment rate. Also, only eight of the 112 codes that are being tied to the ASC payment rate are actually provided in an ASC at least 5 percent of the time, and only 34 of these codes would have hit the OPPS payment cap. In other words, 78 of the 211 services for which CMS proposes to reduce payments to the ASC level are already paid less under the PFS than the OPPS rate, meaning that Medicare and patients will actually pay more, not less, if these services are driven out of physician offices and into hospital outpatient departments.

This proposal's underlying premise is irreparably flawed. CMS has ignored fundamental differences in Medicare payment methodologies between the statutorily-required resource-based relative value scale (RBRVS) that is the basis for the PFS and the ambulatory payment classifications (APCs) used for OPPS and ASC rates. These differences render service-by-service comparisons inappropriate and inaccurate. APCs are a bundled payment system that averages low- and high-margin hospital services within a single APC. In contrast, the RBRVS captures the relative resource costs of each individual service. While hospitals can make up for losses on one service with profits on another, physicians will have no opportunity to make up their losses because CMS does not propose to increase payments for the hundreds of codes where the PFS rate is lower than the APC rate.

In addition, as many services targeted by the CMS proposal are rarely even provided in hospitals, it is easier for a hospital to absorb the lower rate than it would be for a physician practice that provides the

services more frequently. This also means that the services' costs may not be accurately reported by hospitals and not adequately reflected in the APC calculations. For individual services within an APC, guidelines allow for up to a two-fold difference in costs, although for low-volume services the actual gap can be much wider. If the frequency with which they are provided in a hospital is low enough, even very high cost services do not show up in APC rates because higher frequency, lower cost services bring down the average payment for the entire APC bundle.

An example helps to illustrate the problem. In the PFS, the practice expense for *peritoneal chemotherapy infusion through an indwelling catheter* (96446) is valued at $185 while the practice expense associated with *pleural cavity chemotherapy infusion, including thoracentesis* (96440) is pegged at $806. Both services are grouped together in APC 439 and will be subject to a payment cap of $146.21 according to the proposed rule. The pleural cavity code requires a disposable catheter with an invoice cost of $329, so the catheter cost alone is nearly double the CMS proposed payment rate for the service. The payment rate for APC 439 is actually driven by a non-chemotherapy infusion code that is paid at $75 under the PFS and is responsible for 90 percent of the OPPS volume for this APC. Clearly, the $146 payment rate for the APC bears no relationship to the costs of performing either the high or low end of the APC services in physician offices.

As required by law, the proposal must be implemented in a budget neutral manner for the PFS overall, yet the impacts on the affected codes and about 20 specialties that provide them are far from neutral. CMS has not provided an estimate of the total dollars involved, but it appears that more than $500 million per year would be redistributed among specialties. In pathology, for example, which CMS projects would see total Medicare revenues fall by 6 percent as a result of this proposal, the direct practice expenses for nearly 40 codes exceed the APC payment by amounts ranging from just over $3 to more than $400. Dermatologists, physicians who provide angiography, and several other specialties report that their procedures are being capped at the ASC rate even though they are virtually never done in the ASC. Radiation oncologists, despite three recent reviews of their services, have 16 codes on the list. Under the proposed cap, practice expense payments for planning a course of intensity modulated radiation therapy would cover only 65 percent of the currently listed direct costs and payments for breast and lung cancer radiation oncology treatment episodes would fall by 16 percent. Neurology faces a 25 to 75 percent reduction for 16 neurology diagnostic testing services while otolaryngology faces a 14-60 percent reduction for 13 head and neck procedures.

While the AMA and affected specialties agree that, if properly structured, a comparison of OPPS and PFS rates might be an appropriate screen to identify services for review as potentially misvalued, we are confident that the PFS data are the most accurate data available, not the APC data. For starters, the APCs are based on hospital charge data that, as detailed in recent press reports, can be highly inconsistent and, as laid out in the recently proposed OPPS/ASC rule, subject to a variety of methodological manipulations. We note that elsewhere in the proposed PFS rule, CMS states that it has "considered asking hospitals to break out the costs and charges for their provider-based departments as outpatient service cost centers on the Medicare hospital cost report" because currently "this practice is not consistent or standardized."

In addition, APC data is much more volatile than the information used in the PFS, creating the potential for significant yearly payment shifts that will exacerbate the instability in PFS rates due to the SGR. There are numerous examples of codes that have experienced payment swings of 10 to 20 percent or more in a given year for reasons that appear to be related to the particular vagaries of hospital charging practices and the mix of hospitals in the data rather than any actual change in service inputs. The

proposed rule indicates concern that physician specialties do not always submit sufficient verification of the costs of equipment and other supplies. Yet each list of the resources needed to provide services in the physician office is collected using standardized processes, carefully examined by a cross-specialty panel, and is typically submitted with invoices for expensive equipment and supplies. CMS participates in all deliberations and makes final decisions on the practice expense values.

Another major flaw in the proposal is that the cap that would apply to 2014 PFS rates is based on a comparison to 2013 OPPS and ASC rates. This means that the policy will ignore anticipated payment updates of 1.8 percent for the OPPS and 0.9 percent for the ASC payment rates as well as any APC weight changes that CMS has proposed, which in some cases will result in significant disparities between the OPPS/ASC cap and the actual rate that is being paid in these settings in 2014. For example, for code 96446 that, as described above, would be paid $146.21 under the PFS in 2014, the 2014 APC rate is actually increasing to $201.73. Similarly, the physician fee schedule payment for the technical component of CPT code 95928 *Central motor evoked potential study,* which currently is set at $218, would be capped at $79.83 even though the APC rate affecting this code is being increased by over 50 percent ($121.86) in 2014.

As noted above, for 82 percent, or 172 of the 211 codes subject to the proposed cap, the new payment rate would not even cover the direct practice expense component of the current PFS payment. Besides the cost of the disposable catheter used in code 96446, we offer the following examples of services which are rarely provided to hospital outpatients and for which the capped rate would not even cover a single high cost supply that is needed each time the service is provided, as shown by current paid invoices:

- CPT code 88367 *Insitu Hybridization Auto* is commonly performed in the non-facility setting (65 percent). This service requires CMS supply code SL196 HER-2/neu DNA probe kit costing $157. The total payment for this code in the non-facility setting is currently $258.23. The proposed cap would allow a total payment of $103, which is a 60 percent cut and is $54 below the cost of the DNA probe kit alone.

- CPT code 91120 *Rectal sensation test* is performed almost entirely in the physician's office (99.77 percent). This service requires a custom barostat catheter (CMS supply code SD216) with a price point of $217. The current total payment in the non-facility setting is $427. The proposed cap would lower the total payment to $138, a decrease of 68 percent and $79 below the cost of the barostat catheter.

- The code descriptor for CPT code 65778 *Placement of amniotic membrane on the ocular surface for wound healing; self-retaining* clearly includes the amniotic membrane itself. In 2011, however, only 39 percent of OPPS claims for the APC for this service included the V2790 code for amniotic membrane products. The supply code for amniotic membrane (SD248) is quite expensive, $895. The fact that 61 percent of hospital claims did not include the device means that CMS was missing a considerable amount of cost information when it set the 2013 payment rate for this service and used it to propose a 14 percent cut in the PFS payment rate.

With payments that often do not cover the direct costs of care, the only alternative for physicians in many cases will be to send patients to hospitals, where care may be more fragmented, further away, less convenient, and more costly. Patients will face disruption in longstanding relationships with their physicians and may be forced to seek care outside their local community, creating significant obstacles for those whose condition or treatment makes driving risky or impossible. Moreover, for the 78 services where OPPS payments exceed PFS payments, both the Medicare program and patients may actually pay more, not less, for their care than they do currently.

It is clear that the proposal to cap PFS payment rates at the OPPS and ASC rates is erroneous and misconceived, and we strongly urge that it be withdrawn. We appreciate the opportunity to express our views and look forward to additional opportunities for further dialogue on this important issue.

Sincerely,

American Medical Association
American Academy of Dermatology Association
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American Association of Oral and Maxillofacial Surgeons
American Clinical Neurophysiology Society
American College of Cardiology
American College of Chest Physicians
American College of Gastroenterology
American College of Mohs Surgery
American College of Physicians
American College of Radiation Oncology
American College of Radiology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Gastroenterological Association
American Society for Blood and Marrow Transplantation
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Hematology
American Thoracic Society
American Urogynecologic Society
American Urological Association
Association of Freestanding Radiation Oncology Centers
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
Joint Council of Allergy, Asthma, and Immunology
Medical Group Management Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Gynecologic Oncology
Society of Interventional Radiology
The Endocrine Society