



Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Physician Fee Schedule Final Rule
Stark Physician Self-Referral Regulations
Ambulatory Surgical Centers Final Rule
National Provider Identifier

December 3, 2007

Presented by: William A. Dolan, MD

Division of Legislative Counsel
202 789-7426

Statement
of the
American Medical Association
to the
Practicing Physicians Advisory Council

Re: Physician Fee Schedule Final Rule
Stark Physician Self-Referral Regulations
Ambulatory Surgical Centers Final Rule
National Provider Identifier

December 3, 2007

The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning the: (i) physician fee schedule final rule; (ii) Stark physician self-referral regulations; (iii) ambulatory surgical centers final rule; and (iv) national provider identifier.

PHYSICIAN FEE SCHEDULE FINAL RULE

On November 1, 2007, the Centers for Medicare and Medicaid Services (CMS) issued the physician fee schedule final rule for calendar year 2008. There are a number of provisions in the rule that are of great concern to the AMA, as discussed further below.

Immediate Action Needed to Avert Steep Medicare Physician Payment Rate Cuts in 2008

CMS confirmed in the final rule that Medicare payment rates for physicians and other health care professionals will be cut by 10.1%, effective January 1, 2008. These cuts are due to the flawed sustainable growth rate (SGR) physician payment formula. Because of the fundamental defects of the SGR, Congress has had to scramble at the 11th hour in each of the last five years to forestall steep Medicare physician payment cuts. Despite these efforts, however, Medicare payments to physicians in 2007 are essentially the same as they were in 2001. Further, cuts of 15% are projected over 2008 and 2009, and drastic cuts totaling almost 40% are projected from 2008 through 2016, while physician practice costs will increase nearly 20% during this time period.

Only physicians and other health professionals face steep Medicare cuts. Other providers, such as nursing homes and hospitals, have payment updates that reflect the cost of inflation. Further, the 10.1% cut in payment rates facing physicians is in stark contrast to Medicare Advantage (MA) plans, which are paid on average 112%t above the cost of traditional Medicare, with a significant number of MA plans paid from 120% to more than 150% of traditional Medicare. These overpayments are shortening the life of the Medicare trust fund.

There is no rational basis for this significant disparity in the positive payment update for MA plans, in which only about 20% of Medicare patients are enrolled, while steep negative updates are scheduled for the Medicare fee-for-service program, in which 80% of our nation's Medicare patients are enrolled. In fact, the Medicare Payment Advisory Commission (MedPAC) has pointed out that Medicare spends far more per beneficiary for seniors enrolled in MA than it does for those in original Medicare and has called for these subsidies to be eliminated.

It is not just the government that is subsidizing the extra payments to MA plans, but beneficiaries too are contributing to this lopsided playing field through their Part B premiums. In order for the health care system to effectively promote patient choice and meaningful competition, the options available to Medicare beneficiaries should be on equal footing. By favoring MA plans over Medicare fee-for-service in its budget proposals and regulatory decisions, the government has created a two-tiered system for seniors in which payment updates for managed care health plans cover more than their cost increases, whereas fee-for-service physician services face substantial funding shortfalls.

Physicians are the foundation for our nation's health care system, and thus a stable payment environment for their services is critical. Although physicians want to continue providing care to all their patients, continued Medicare payment cuts make it difficult to do so. A 2007 AMA survey confirmed that patient access will suffer as a result of these draconian cuts. A majority of physicians, 60%, say that next year's 10% cut will force them to limit the number of new Medicare patients they can treat, and this number increases to 77% of physicians if Medicare rates are cut 40% by 2015.

Time is running out. The Medicare physician payment formula must be addressed now to preserve care for our seniors and disabled patients, especially as the program prepares to enroll the huge influx of baby-boomers that will begin entering the Medicare program in 2010, with enrollment growing from 43 million in 2010 to 50 million by 2016. We urge PPAC to recommend that CMS work with Congress to ensure immediate action to provide at least two-years of positive updates and avert the 15% cut over 2008 and 2009; repeal the SGR altogether; and replace the SGR with a system that produces positive physician payment updates that accurately reflect increases in medical practice costs, as indicated by the Medicare Economic Index (MEI).

Budget Neutrality Adjustment

CMS is proposing increases to work relative value units (RVUs) for certain codes pursuant to the five-year review of RVUs, and these changes are required by law to be implemented on a budget neutral basis. Against the urging of the AMA and 75 specialty societies, CMS will adjust the physician work RVUs to achieve budget neutrality instead of applying budget neutrality across-the-board through the conversion factor. The work adjustment will increase from 10% in 2007 to 12% in 2008 and this will have differential effects on payment rates for different services and specialties.

Applying the budget-neutrality adjuster to the work RVUs is contrary to long-held CMS policy. Further, adjusting the conversion factor is preferable because it does not affect the relativity of services reflected in the recommended RVUs. In contrast, adjusting the work RVUs only to achieve budget neutrality has more potential to inappropriately affect relativity. Moreover, adjusting only the work RVUs will diminish the valuation improvements for the services for which the work RVUs increased due to the five-year review and the full benefit of these improvements would not be achieved. Finally, an adjustment to the conversion factor is also preferable because it would: (i) have less impact on other payers who use the Medicare RBRVS, along with their own conversion factor; (ii) be consistent with the notion that budget neutrality is mandated for monetary reasons, and since the conversion factor is the monetary multiplier in the Medicare payment formula, this is the most appropriate place to adjust for budget neutrality; and (iii) be consistent with CMS' goal of transparency in the Medicare payment system. **Accordingly, the AMA urges PPAC to recommend that CMS apply the budget neutrality adjuster to the conversion factor for 2008 and subsequent years.**

Productivity Adjustment to the Medicare Economic Index

Medicare physician payment updates also are based in part on changes in the Medicare Economic Index (MEI,) which measures physician practice cost increases. In establishing the MEI each year, CMS adjusts it downward to account for assumed physician productivity increases. CMS has announced that the MEI for calendar year 2008 is 1.8%, which includes a 1.4% productivity offset. **We have urged CMS to reevaluate and reduce this 1.4% productivity adjustment to the MEI, but it has declined to do so in the final rule.**

The President's budget proposal for 2008 recommends that the payment update for inpatient and outpatient hospital services, hospices, and ambulance services be reduced by 0.65% each year to offset productivity increases. Unlike updates for these other providers, in measuring increases in practice costs, the MEI includes an automatic reduction for presumed increases in productivity. The 1.4% productivity adjustment for physicians is more than twice as much as the proposed reduction for these other services. Surely physicians' and other health professionals' productivity is not increasing at twice the rate of other health care providers. In fact, there was general agreement among economists who participated in a meeting hosted by CMS actuaries last fall that the current productivity adjustment is too large. Indeed, it would be nearly impossible for physicians to increase their productivity in treating patients in light of various Medicare initiatives that impose numerous time and

paperwork burdens, thereby slowing productivity, not increasing it, and increasing practice costs.

Use of a 1.4% productivity adjustment adds up to a substantial amount of dollars and a reduction in the productivity adjustment could have significant implications for physician payment rates. Over a ten-year period, the 0.75 percentage point difference between the productivity adjustment being made to the MEI and the productivity adjustment recommended for other provider groups in the President's budget is equivalent to 7.5%, which is close to the size of the rate cut physicians face in 2008.

The AMA continues to recommend that CMS reduce or eliminate the productivity adjustment to the MEI so that it better reflects physicians' increasing costs. This would improve the accuracy of payment update calculations and reduce the cost of legislation to provide a long-term replacement for the SGR.

Revised Physician Self-Referral Regulations

Phase III Physician Self-Referral Regulations

On September 5, 2007, CMS published Phase III of the final "Stark Law" physician self-referral regulations, which will become effective December 4, 2007. Phase III slightly changes, and in some cases substantially revises, various concepts, definitions, and exceptions to the Stark Law. Many of the individual Phase III changes are themselves troubling, and the revisions as a whole add several more layers of confusion to an already stunningly complex statute. Specifically, Phase III makes the following significant changes: changes to the rules on physician recruitment, revisions to the definition of "indirect compensation arrangements," elimination of the safe harbor definition for fair market value of physician compensation, modification of the exception for personal services arrangements, and narrowing of the ability of independent contractors to qualify as a "physicians in the group practice."

Physician Self-Referral Changes in the 2008 Physician Fee Schedule Final Rule

In the 2008 Medicare physician fee schedule proposed rule, CMS offered proposed changes and requests for comment on potential changes to the Stark law, which the AMA urged CMS to withdraw and reevaluate. While CMS declined to finalize many of these issues in the final rule, the agency made it clear that these issues will be revisited in the near future.

A future rule will likely address burden of proof standards, liability insurance subsidies for obstetricians, the period of disallowance for noncompliant financial relationships, ownership or investment interest in retirement plans, certain compensation arrangements, alternative criteria for satisfying certain exceptions, services furnished "under arrangements," per-click payments, "set in advance" and percentage-based compensation arrangements, "stand in the shoes" provisions, among others. While we are pleased that CMS declined to address these proposed changes in the physician fee schedule final rule and recognized that to do so "would not be prudent," we are disappointed that a final rule on those issues is likely

forthcoming. We believe that such changes would represent an unfortunate retreat away from earlier phases of the Stark regulations that sought to strike a balance between eradicating fraud and abuse and protecting arrangements that promote efficiency and protect patient access. There is little doubt that should a final rule on these issues be promulgated, it would negatively effect innovation, efficiency, and access to care. **Thus, the AMA will continue to advocate for withdrawal of the onerous new proposed regulations and against the imposition of new self-referral rules. Further, in general, we ask PPAC to urge CMS not to issue additional rules that further complicate the Stark self-referral laws by adding more layers of confusion and regulation that serve only to further confound physicians, shift more money to the attorneys that are required to interpret them, and discourage efficient, innovative, quality health care.**

The only suggestion in the proposed physician fee schedule rule that was part of the final rule made changes to the “anti-markup” provision of the self-referral law. Under the final rule, if a physician or other supplier orders and bills for a diagnostic test purchased from an outside supplier or performed at a site other than “the office of the billing physician or supplier,” the anti-markup restrictions will apply. This revision expands the anti-markup rule to apply to the professional component and the technical component of services provided by the physician, or group, when they are performed outside of the office of the billing physician. Notably, when the billing physician or other supplier is a “physician organization” (as defined in § 411.351 (of the Stark Phase III rules)), the “‘office of the billing physician or other supplier’ must be space in which the physician organization provides *substantially the full range of patient care services* that the physician organization provides generally.”

This new site of service test is stricter than the Stark “in-office ancillary services” exception. Physician groups that legitimately provide diagnostic services inside the group but in the “wrong” location will be reimbursed for those services in the same way they would be reimbursed for services purchased from outside suppliers. Thus, a group facility that qualifies as a “centralized building” for Stark purposes, even if immediately adjacent to the group’s other clinical facilities would be impacted; as would a group facility (e.g., a departmental building or satellite office) that qualifies as a “same building” for Stark purposes but fails the new “full range of services” test; and potentially, even a floor in a building where the building meets the new test, but the floor on which certain diagnostic tests are done does not.

Where the anti-markup rule is deemed to apply, physicians and groups will be required to provide CMS with a per procedure charge for the cost of providing each service, as if they were purchasing the service, even though they are providing it themselves. While there is no definite guidance on how to calculate a “per procedure” cost for services performed by an employee technician or physician, commentary in the rule indicates that the employee’s salary should be the sole factor used in determining cost. In other words, physicians and medical groups will not be reimbursed for equipment, overhead, or any additional expenses for providing services in their own offices.

There is little doubt that providers will struggle to understand the impact of this rule and to comply with it by the January 1, 2008 effective date. This confusion and compliance issue is further compounded because the change was not included in the proposed rule. As a result, many physicians will incur needless expenses associated with moving equipment and modifying facilities. Others will simply be unable to comply with the new site of service test, and will have to develop a new system for calculating a “per procedure” cost and deliver the services to Medicare patients at a loss, or simply forgo the provision of those tests for their Medicare patients. **Thus, we believe that CMS should delay implementation of this provision in order to evaluate the substantial impact these changes will have on health care providers.**

The self-referral rules are complex, exceptionally lengthy, at times unclear, and often beyond the scope of the average physician to fully comprehend and thus comply with. As it is, the law threatens to punish even unintended violations and any deviation of a physician's relationship with an entity, however minor or unintended, yields dramatic consequences. Moreover, all of these continued modifications and alterations endeavor to regulate every aspect of a physician's practice. And they continually force physicians and health care entities to re-structure longstanding relationships previously thought to be acceptable, driving up the cost of health care at the very time we should be looking for ways to make it more affordable. As is, the regulations pose significant obstacles to physicians, group practices, and integrated health systems attempting to coordinate patient care, despite the fact that referrals between the components of integrated systems are often times in the best interest of patients. This latest round of proposed changes, requests for comment on potential changes to the rules, and the final promulgation of Phase III of Stark II, simply creates additional ambiguity, complexity, and barriers to the delivery of care.

Rather than adding restrictions and complexities, CMS should focus on refining the regulations to simplify compliance, reduce the risk of making illegal many non-abusive physician relationships that have nothing to do with self-referral, and protect certain physician arrangements that create efficiencies and better quality patient care. Focusing efforts on these laudable goals, rather than further complicating already complex regulations in an attempt to anticipate and restrict every potential physician action for which there might be unsubstantiated anecdotal evidence of abuse, or the potential for abuse, would be of much greater benefit to the health care system as a whole.

Physician Assistance and Quality Initiative Fund

The *Tax Relief and Health Care Act of 2007* (TRHCA) required the Secretary of the Department of Health and Human Services to establish a Physician Assistance and Quality Initiative Fund (Fund) in the amount of \$1.35 billion. TRHCA authorized the Secretary to use these funds for physician payment and quality improvement initiatives, including application of the Fund to adjust the physician conversion factor. Although physicians are facing a 10.1% payment rate cut on January 1, 2008, CMS proposed to use the Fund for quality reporting only rather than apply it to the conversion factor. **The AMA strongly urged CMS to use the Fund to help offset the pending steep Medicare physician cuts in**

2008. CMS states in the final rule that “almost all comments on this issue” requested that the Fund be used in this manner as well. Yet, but CMS declined to do so.

Application of the entire \$1.35 billion to the 2008 update would be a critical first step towards lessening the 10.1% reduction in the conversion factor for 2008. By stating its plans to use the Fund in this manner, CMS and the Administration could help demonstrate to senior citizens that it does not wish to see their access to medical care curtailed, as well as demonstrate to Congress that it is committed to facilitating physicians’ and other health professionals’ investments in information technology and quality measurement. Because physicians face a 10.1% payment rate cut, many physicians will not have the financial resources to make the significant financial investments needed to participate in the Medicare quality reporting program, and thus would not even be eligible to participate in the reporting program, despite a potential bonus payment of about 1.5% (and likely not more than 2%) under the Fund.

CMS’ rationale for not using the Fund for the physician conversion factor is as follows: If CMS were to use the Fund to reduce the negative update for 2008, it would have to estimate an amount by which to reduce the update that is low enough to ensure that the \$1.35 billion funding cap is not exceeded. If this amount is too low, however, the agency could leave money in the Fund and CMS would face the problem of spending the remaining funds in the future.

The AMA does not believe that this rationale justifies CMS’ decision not to use the Fund to reduce the physician update. In fact, the Congressional Budget Office (CBO), in providing Congress with a cost estimate for this provision of the TRHCA, anticipated that CMS could develop a plan by which 90% of the Fund could be used in calendar year 2008 and the remaining funds in 2009. CBO also noted that “the funds will remain available until spent.” CBO clearly was anticipating that CMS would apply the Fund to the negative update since it discussed use of 90% of the Fund in 2008, and, as discussed by CMS in the proposed rule, use of the Fund for the update would involve using a percentage in 2008 and the remainder in 2009. If CBO anticipated that the Fund would only be used for quality purposes, as is proposed by CMS, it would have stated that CMS could use 100% of the Fund for quality reporting payments for services furnished in 2008.

Further, CMS stated that if its estimate is too low for use of the Fund in 2008, it could leave money in the Fund and CMS would face the problem of spending the remaining funds in the future. This is not problematic since Congress stated in section 101(d) that the Fund should be used “to the maximum extent feasible” for physicians’ services during 2008. Clearly, Congress anticipated that not all of the Fund would be used and the remainder could be used in 2009. CBO underscored Congress’ intent by stating that “the funds will remain available until spent.”

Like CBO, Congress also anticipated that CMS could use the Fund to help avert the negative payment update. Indeed, under section 101(d) of TRHCA, Congress indicated its intent by specifically providing that the Fund “may include application of an adjustment to the update of the conversion factor.” Congress further underscored its intent by directing, under section

101(d), how the conversion factor should be calculated in a subsequent year if the Fund is applied to the update: “[I]n the case that expenditures from the Fund are applied to, or otherwise affect, a conversion factor . . . the conversion factor under such subsection shall be computed for a subsequent year as if such application or effect had never occurred.” We urge CMS to consider that Congress and CBO anticipated application of the Fund to help avert the negative update.

Finally, CMS stated in the proposed rule that implementing the Fund through an extension of the PQRI program is the best way to ensure physicians get the greatest benefit from the Fund’s resources. The AMA is committed to continuing our efforts to improve quality, but we do not believe that using the Fund solely for the PQRI provides the “greatest benefit” to physicians. As stated above, the PQRI does not provide all physicians with an opportunity to participate. Physicians within certain subspecialties treat patients with conditions for which PQRI measures do not apply and therefore these physicians cannot participate in the quality reporting program. Physicians who treat certain patient populations for which PQRI quality measures do not apply should not be disadvantaged by CMS’ proposed use of the Fund. Clearly, use of the fund to “spend down” approximately 2% of the negative update for 2008 would benefit all physicians across the Board.

The Fund was intended to provide some relief and stability to the physician payment system during 2008. Yet, if CMS uses the Fund for quality improvement purposes only, relief would not be available until well after 2008 since CMS cannot begin to calculate the PQRI bonus payment until after the close of the 2008 reporting period. Further, because CMS is required to meet a \$1.35 billion aggregate cap, this means that CMS cannot let physicians know the amount of the reporting bonus until well after the close of the 2008 reporting period.

Accordingly, for the reasons stated above, we urge PPAC to recommend that CMS use the Fund to partially offset the negative update and allow all physicians to benefit equally from the Fund.

Physician Quality Reporting Initiative

The final rule includes the list of quality measures for the 2008 Physician Quality Reporting Initiative (PQRI). We are pleased that ninety-one of 119 measures in the rule are those that were developed and approved through the AMA-convened Physician Consortium for Performance Improvement process. We are disappointed, however, that the rule does not include a number of new measures developed in 2007. The AMA and more than 40 medical specialty societies sent a sign-on letter urging CMS to provide the utmost flexibility for the inclusion of quality measures in the 2008 program in order to allow for broad, yet voluntary, physician participation in the PQRI.

Section 101 of TRHCA requires that PQRI quality measures “shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such

measures.” A number of quality measures met this criteria, but were not included in the final rule. **We are concerned that CMS’ overly rigid interpretation of the rulemaking process unnecessarily precluded a number of robust quality measures from being included in the final rule, and the AMA along with the medical specialty societies will continue to strongly urge CMS to include these measures in the 2008 PQRI.**

Removal of the Fax Exception for E-Prescribing

Section 101 of the MMA mandates the use of uniform e-prescribing standards for prescribers who voluntarily elect to electronically transmit prescriptions for drugs covered by the Medicare prescription drug benefit (Part D). In November 2005, the U.S. Department of Health & Human Services (HHS) adopted a final rule establishing three prescribing standards known as the “foundation standards.” Use of these standards became effective January 1, 2006. One of these standards is the National Council for Prescription Drug Programs SCRIPT Standard (SCRIPT standard). However, the November 2005 final rule also created an exception to this requirement that allowed electronic prescribers to continue using computer-generated facsimiles in lieu of e-prescribing consistent with the SCRIPT standard (the “fax exception”). This allows prescribers to key in information into their existing electronic programs and then utilize a function that enables them to send an electronically generated facsimile with the prescription and certain prescription-related information to the dispenser. Effective January 1, 2009, the final rule removes the fax exception for electronic prescribing.

The AMA supports the use of electronic prescribing. We believe, however, that removing the fax exception will inhibit physician adoption of e-prescribing. Specifically, it will cause many prescribers who currently elect to use electronic technology to forgo utilizing it to avoid costly upgrades in existing products/programs. Prescribers will instead use paper. According to CMS, software is available to physicians through “automatic version upgrades built into annual software vendor maintenance fees.” Physicians whose e-prescribing software cannot be upgraded to meet Medicare standards, however, would need to either purchase new software or return to paper prescriptions. This will slow down the adoption of health information technology in general and e-prescribing in particular. In addition, mandating that all e-prescribers use this standard is premature given that all the e-prescribing standards have not been adopted.

Accordingly, we urge PPAC to recommend that CMS reinstate the fax exception and work with Congress to provide financial incentives to physicians to facilitate wider adoption of e-prescribing.

PROPOSED CHANGES TO THE AMBULATORY SURGICAL CENTER PAYMENT SYSTEM AND CY 2008 PAYMENT RATES

The AMA is pleased with CMS’ efforts to implement a new ambulatory surgical center (ASC) payment system, as mandated by the MMA. We appreciate CMS’ attempts to encourage quality and efficient care in the most appropriate outpatient setting and more

logically align payment rates across payment systems to eliminate incentives favoring one care setting over another.

Covered Surgical Procedures

We are glad that the final rule adds about 790 procedures to the ASC list for services provided on or after January 1, 2008. Adopting a methodology that excludes procedures with certain characteristics rather than maintaining a specific list of all available procedures, as is done currently, will provide many beneficiaries with an economically viable alternative to costly inpatient services. We are disappointed, however, that the final rule did not eliminate the use of specific ASC list criteria. We believe that rather than defining safety using a set of predetermined, static criteria, CMS should have established a process to consult with national medical specialty societies and the ambulatory surgical community to develop and adopt a systematic and adaptable means of reimbursing ASCs for all safe and appropriate services, allowing for changes in technology and current-day practices.

ASC Payment Methodology

We are pleased that CMS established a methodology for ASC rates based upon the corresponding hospital outpatient department (HOPD) rate for the same procedure. The rule sets the methodology so the exact percentage can only be determined when final 2008 HOPD rates are available. Based upon the proposed 2008 HOPD rates, however, ASC rates would be 65% of HOPD rates. While this percentage will provide higher payments to ASCs over the next several years than would have resulted from the 62% that CMS originally proposed, in many cases these low rates will likely force physicians to move cases to the more expensive hospital setting, resulting in increasing costs to patients and the Medicare program.

The AMA is also glad that CMS adopted the same policies for ancillary services, such as radiology, brachytherapy sources, new technology pass-throughs, and drug and biologics, for ASCs as are applied to HOPDs. However, we are concerned that as CMS continues to bundle payments for certain ancillary services into procedures, the discounted rate for ASCs will become inadequate to cover the costs of the actual procedure. In addition, we are concerned that payment for some implants, especially during the transition, will be inadequate. Toward the beginning of the four-year transition, payment for procedures may not adequately cover the costs of both the procedure and the implants. As an example, the fastest growing glaucoma filtering code, 66180-aqueous shunt to extraocular reservoir-is performed both in an ASC (40%) and the HOPD (60%). It requires the use of a filtering device (L8612) and a biologic covering (V2790) which are currently paid as a pass through in the ASC. The current ASC payment for 66180 is \$717 plus \$575 for L8612 and \$255 for V2790, totaling \$1,547. The new payment rate for 66180 in 2008 totals \$940.40. It has an payment indicator (N1) which requires that V2790 and L8612 be bundled. Due to this bundling, these glaucoma procedures will not be performed in the ASC in 2008 because the payment would not cover the costs of the procedures and bundled devices. When fully implemented in 2011, the payment rate will be \$1,612. CMS should consider either 1) not bundling implants that are currently paid separately in ASCs until the transition period is

complete or 2) accelerating the full payment for the bundled services to the beginning of the transition period.

We are disappointed that the rule caps payments to ASCs for procedures that are performed more than 50% of the time in physician offices at the lower physician practice expense portion of the annual physician fee schedule. This cap will result in reimbursement levels that make it economically infeasible for many ASCs to continue offering certain procedures—forcing patients who could be treated safely and more cost effectively in an ASC into a hospital outpatient department. Although physicians may safely perform many procedures on Medicare beneficiaries in the office setting, certain beneficiaries will require additional infrastructure and safeguards. Eliminating ASCs as an option for such patients, by reducing ASC payments to such a level as to make their use infeasible, imposes unnecessary costs on both individual beneficiaries and the Medicare program.

Annual Rate Updates

Under the final rule, ASC payments will be adjusted annually in two ways, to account for inflation and to account for changes in technology or the way procedures are performed. With regard to the first adjustment, the annual inflation update for ASCs beginning in 2010 will be equal to the change in the consumer price index for urban consumers (CPI-U). We are disappointed with CMS' decision to use the CPI-U for ASCs inflation update. We believe that with the implementation of a new payment system tying ASC rates to HOPD rates, CMS could and should tie both the HOPD and ASC updates to changes in the hospital market basket. CMS does not appear to dispute this position but argues that it is more reasonable to retain the prior systems update which tied ASC updates to the CPI-U. ASCs are affected by the same inflationary costs related to personnel and supplies that affect hospitals, which are not related to general consumer price increases. Moreover, without a more appropriate update the gap between ASC and hospital payments will continue to widen, creating incentives for procedures to migrate from ASCs to hospitals.

With regard to the second adjustment, to account for changes in technology or the way a procedure is performed, CMS updates the HOPD relative weight assigned to each ambulatory payment classification (APC) every year using hospital cost data. To make this adjustment in ASC payments, CMS will begin by recalculating the relative weights for HOPDs. These relative weights will be adjusted again to insure that changes are budget neutral in the ASC setting. As a result, the relative weights within the ASC will differ from relative weights within the HOPD even though there is no evidence that the relative costs of these procedures differs across the two settings.

We believe that applying a secondary recalibration to ASC payments, absent evidence that the services performed in an ASC became relatively less expensive than those performed in a HOPD, will create unfounded variation in the payment rates between ASCs and HOPDs. **Thus, we urge PPAC to recommend that CMS develop a better alternative such as paying ASCs a defined flat percentage of what is paid to hospitals for each procedure that would not vary every year.** This approach would further the long-term goals of consumer-directed health care and transparency by providing Medicare beneficiaries with

information that would allow them to understand and compare the cost of care in alternative settings versus the cost of care in the hospital setting.

Transition

The payment rates in the final rule will be published as part of the 2008 OPPS/ASC final rule later this year. We are pleased that the final rule will create a four-year transition period for implementing the revised rates. Four years, as opposed to the initially proposed two-year transition period, will provide ASCs with more adequate time to adjust to the new program.

NATIONAL PROVIDER IDENTIFICATION

The Health Information Portability and Accountability Act (HIPAA) required the implementation of the national provider identifier (NPI) as a unique national identifier for physicians and other health care providers starting May 23, 2007. However, due to lack of industry readiness, CMS issued an NPI contingency plan that allows physicians and others to continue using “legacy” numbers on claims and other healthcare transactions while they prepare for use of the NPI. CMS has said that all NPI contingency plans must end by no later than May 23, 2008, and Medicare recently announced it will terminate its contingency plan at this time.

Given the significant problems that persist more than five months into Medicare's NPI implementation, the AMA has several serious concerns, including Medicare's ability to appropriately “match” a physician's NPI number(s) to the appropriate legacy number(s); the requirements being placed on many practitioners to re-enroll; significant claims rejections practitioners are experiencing when there is a mismatch; and an overall lack of early and consistent information. With very little time left until the May 22, 2008, NPI contingency plan deadline arrives, immediate outreach to physician practices is needed in order to avert further claims processing interruptions.

Until recently, when an appropriate match could not be made between a physician or group NPI to the appropriate legacy number(s) in the internal Medicare “crosswalk file,” Medicare would pay the claim. Beginning September 3rd, the Medicare carriers began making NPI systems edits effective, thereby resulting in the rejection of mismatched claims. We appreciate that Medicare, rather than electing to implement the new system immediately, chose to phase in these edits. Nonetheless, this has caused a significant number of claims to be rejected when a match cannot be made. Claims rejections spiked in some cases to more than 10% following the carriers' initial activation of the NPI edits. Although the matching problems in many cases were able to be resolved, a significant number of claims rejections are still occurring and we continue to receive numerous complaints. There can be significant financial implications for a single practitioner or small group practice who experience matching problems and the resultant claims rejections.

We are also concerned that reasonable notice was not provided to physicians about the decision to begin implementing the edits. While some practitioners received informational

error codes on their remittance advice this summer, they were poorly explained, and insufficient outreach was completed. As a result, many recipients of this information did not fully understand their significance. We have been alerted to numerous situations in which practitioners received no error codes on their remittance advice but, nonetheless, are experiencing significant claims rejections resulting from matching problems.

In addition, Medicare contractors were directed to provide at least seven days advance notice of the bypass edits being lifted along with pertinent information to assist physicians and providers. One week notice, or even two, was simply not enough time to prepare practitioners, especially given the widespread misunderstanding of the significance of the informational edits. Furthermore, this did not give the AMA an adequate amount of time to utilize our own internal communication channels before the edits went live.

Furthermore, single, incorporated practitioners continue to see significant matching problems and claims rejections. Efforts aimed at informing these practitioners early on that they needed an NPI, both for themselves and their corporation, was slow coming and inconsistently communicated. Frequently, these practitioners learned they needed two NPIs only after submitting an enrollment or change to enrollment application. Moreover, due to the way carriers enrolled single, incorporated practitioners in the past, an untold number of these practitioners were only assigned an individual PIN. It was not until after Medicare activated the NPI edits earlier this fall that single, incorporated practitioners with one PIN were instructed by Medicare to re-enroll to obtain a group PIN if they plan on billing Medicare with their Type II (corporate) NPI. We are unaware of any widespread outreach done on this prior to this time. We are also concerned that Medicare chose to wait to address these issues with practitioners until after the NPI compliance deadline – a decision which has complicated an already difficult transition. The Medicare matching problems have been exacerbated by significant confusion surrounding what is expected of practitioners. In many cases, when practitioners have called their carriers for assistance with matching problems or for information on why their claims rejected, many are either unable to get through or the information regarding necessary enrollment steps they must take has not been readily forthcoming and often inconsistent. While some carriers have begun conducting outreach when matching problems have been identified, much of this has happened only very recently. This type of targeted outreach was needed months ago, and Medicare should have instructed carriers to initiate direct contact with practitioners on these issues sooner.

We also believe that significant matching problems have ensued as a result of earlier carrier PIN enumeration policies. Medicare's solution to this is for practitioners to re-enroll, a highly burdensome process that adds to already stressful situation when claims are not processing. Despite the advance notice concerning Medicare's recent decision to require NPI or NPI/legacy pairs on claims beginning March 1, 2008, we are concerned that this may not be a sufficient amount of time for practitioners who have been asked to re-enroll.

With respect to our concerns described above, the AMA strongly urges PPAC to make certain recommendations to CMS, and these recommendations are further explained in detail in the attached sign-on letter sent to CMS by the AMA and the Medical Group Management Association (MGMA). In short, we recommend that CMS—

- **Work quickly to implement a rapid and direct outreach plan with a special emphasis on small and rural practitioners.**
- **Allow its carriers flexibility to ensure enrollment applications do not stall or result in unnecessary rejections, especially given the fact that an untold number of practitioners are being asked to reenroll.**
- **Reconsider the revalidation process that began in October until the enrollment problems associated with Medicare NPI matching problems are thoroughly resolved, as this will place further burden on an already strained enrollment process.**
- **Carefully monitor the industry's overall ability to use only NPI numbers by May 23, 2008, particularly the readiness of Medicare and those billing Medicare.**

The AMA appreciates the opportunity to comment on the foregoing, and we look forward to continuing to work with PPAC and CMS in addressing these important matters.