



Statement

of the

American Medical Association

to the

Practicing Physicians Advisory Council

RE: Physician Fee Schedule Final Rule
Voluntary Reporting
Ambulatory Surgery Center Proposed Rule

Presented by: Stephen R. Permut, MD, JD

December 4, 2006

**Division of Legislative Counsel
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The American Medical Association (AMA) appreciates the opportunity to submit this statement to the Practicing Physicians Advisory Council (PPAC or the Council) concerning: (i) the physician fee schedule final rule; (ii) pay for voluntary reporting; and (iii) the ambulatory surgery center final rule.

PHYSICIAN FEE SCHEDULE FINAL RULE

Imminent Medicare Physician Payment Cuts for 2007

The Centers for Medicare and Medicaid Services (CMS) recently issued its physician fee schedule final rule for calendar year 2007. In the rule, CMS confirmed that Medicare payment rates for physicians and other health care professionals will be cut by 5%, effective January 1, 2007. To compound matters even more:

- The 2007 cuts will be the first in a series of cuts that the Medicare Trustees have projected will total almost 40% over nine years;
- Physician cuts projected over nine years will occur as medical practice costs rise by about 20% over this same time period, according to the government's own conservative estimate;

- From 2007 through 2015, almost \$200 billion will be cut from payments to physicians for care provided to seniors – just as baby boomers are aging into Medicare by the millions; and
- The 2007 cuts follow five years of congressional intervention to prevent cuts and establish modest updates (including a freeze) – none of which have kept up with practice cost increase – and payment rates in 2006 remain about the same as in 2001.

Only physicians and other health professionals face steep cuts under a flawed Medicare payment formula. Physicians are the foundation for our nation's health care system, and thus a stable payment environment for their services is critical.

A 2006 AMA survey, as presented to PPAC at its May meeting, confirmed that patient access will suffer as a result of these draconian cuts. Further, a recent national poll conducted by the AMA shows that the vast majority of Americans (86%) are concerned that seniors' access to health care will be hurt if impending cuts in Medicare physician payment take effect on January 1, 2007. In addition, 82% of current Medicare patients are concerned about the cuts impact on their access to health care. A staggering 93% of baby boomers age 45-54 are concerned about the cuts impact on access to care. In just five years, the first wave of baby boomers will reach age 65, and will turn to Medicare for their health care.

To avoid this looming crisis, the AMA urges PPAC to recommend that CMS work with Congress to avert Medicare physician payment cuts for 2007 and beyond, and implement a positive payment update that covers increases in physicians' practice costs. Further, CMS should work with Congress to repeal the SGR and replace it with a system that adequately keeps pace with annual increases in medical practice costs. The AMA will continue to work with the Administration, CMS, and Congress to achieve these goals. In doing so, we emphasize that although the Administration and many policymakers envision transforming the physician payment system to emphasize use of health information technology and quality improvement efforts, that vision will never be realized as long as the SGR and the pay cuts that result from this formula continue.

Administrative Actions to Help Reform the Medicare Physician Payment Formula

In comments on the final physician fee schedule rule, the AMA reiterated our request that CMS assist Congress in solving the SGR problem by taking administrative actions that would significantly reduce the cost of repealing the SGR. These actions include: (i) removing drugs retroactively from the SGR; (ii) accurately reflecting in calculations of the SGR government-induced increases in spending on physicians' services; (iii) reflecting in the SGR Medicare physician spending due to national coverage decisions (NCDs); and (iv) rebasing the Medicare Economic Index. CMS, however, has declined to take any of these actions. (A more detailed discussion of each of these issues is included as Attachment A.)

Five-Year Review

In the final physician fee schedule rule, CMS announced its decisions to accept the increases in work relative value units (RVUs) recommended by the AMA/Specialty Society RVS Update Committee (RUC) for Evaluation and Management services and to fully apply these increases to global surgical procedures. CMS also reconsidered its initial decision to not accept the RUC recommendations for certain orthopaedic, cardiothoracic surgery, and other procedures, and has now accepted many of these recommendations. **The AMA appreciates that CMS accepted 95% of the RUC recommendations for the five-year review.**

Five-Year Review Budget Neutrality

When CMS issued the “Five-Year Review” proposed rule earlier this year, the agency proposed to revise physician work RVUs that will increase Medicare expenditures for physicians’ services by \$4 billion. By law, however, CMS must implement these work RVU adjustments on a budget neutral basis. To meet the budget-neutrality requirement, CMS proposed to reduce all work RVUs by an estimated 10%.

In the AMA’s comments on the “Five-Year Review” proposed rule, we strongly urged CMS to apply the budget neutrality adjuster to the physician fee schedule conversion factor, rather than the work RVUs. In our comments, we provided CMS with various reasons for doing so, including that applying budget neutrality to the conversion factor rather than the work adjuster is critical in light of the imaging cuts mandated by the Deficit Reduction Act of 2005 (DRA).

Specifically, under the DRA, effective January 1, 2007, payment rates for the technical component of imaging services furnished in physicians’ offices cannot exceed the payment rate for the same service furnished in a hospital outpatient department. If the budget neutrality adjuster is applied to the work RVUs, payments for all physician services with work RVUs will be reduced. On the other hand, payments for the technical component of imaging services that are slated to be cut under the DRA will not be affected because these services have practice expense RVUs only, not work RVUs. Because the differential in payment between imaging services furnished in physicians’ offices versus a hospital outpatient department will not be narrowed, the DRA cuts will ultimately remove more dollars from the physician payment pool.

If, however, the budget neutrality adjuster is applied to the conversion factor, this would reduce payments for all physicians’ services equally, including the technical component services, and would narrow the payment differential between imaging services furnished in physicians’ offices versus a hospital outpatient department before the DRA provision is applied. Thus, when the DRA cuts are implemented, fewer dollars would be removed from the total Medicare funding for physician services.

Despite compelling arguments, CMS has rejected a nearly unanimous call from the AMA, RUC, and federation of medical specialty and state medical societies for the budget neutrality adjustment to be applied to the conversion factor. **Rather, CMS will apply the**

budget neutrality adjustment factor to the work RVUs. This will reduce payments for most services by about 5.5%, on top of the 5% pay cut due to the SGR. For some specialties, the visit code increases exceed the budget neutrality adjustment, but for others the adjustment exacerbates the impact of the SGR cut. Further, the AMA estimates that about \$200 million dollars in 2007 will be permanently removed from physician services funding due to application of the budget neutrality adjuster to the work RVUs instead of the conversion factor.

Practice Expense

CMS also announced in the physician fee schedule final rule its decision to begin the first year of a 4-year transition to revise practice expense RVUs, including a revised methodology and adoption of supplemental survey data for several specialties. The rule expresses CMS' support for the AMA's efforts to field a multi-specialty survey of practice expenses and other physician practice information. Nearly 50 physician and nonphysician specialties have agreed to participate in the Physician Practice Information Survey to be launched in 2007.

CMS had agreed to use the unadjusted work RVUs in allocating indirect practice expenses. CMS, however, has not implemented this final decision. The AMA is working with CMS to ensure that the practice expense relative values are computed correctly. **We urge PPAC to recommend that CMS publish a technical correction prior to implementation of the 2007 Medicare physician fee schedule.**

Geographic Adjustments

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated an increase of the physician work geographic index to 1.00 with respect to any locality for which such geographic index is less than 1.00. This provision will expire in 2007. **The final rule outlines the geographic adjustment factors for 2007, indicating that physicians in a large number of localities face additional payment reductions, in addition to the 5% cut.**

Imaging Services

We appreciate that the final rule also announced CMS' decision to implement the payment reduction for multiple imaging procedures performed on contiguous body areas at 25%, instead of imposing a steeper reduction in 2007 of 50% as originally planned. As required by the DRA, the final rule decreases payments for the technical component of imaging services performed in physician offices if the office payment rate is higher than when the same service is done in a hospital outpatient department. **Implementation of this provision will remove \$1 billion from payments to physicians.**

Payment Impacts

The combined impacts of the various Medicare physician payment changes for 2007 are attached in Attachment B. Because the negative update due to the SGR reduces payments for all physician services, only four specialties, infectious disease (+4%), emergency medicine (+2%), pulmonary disease (+1%) and endocrinology (+1%), will see net positive impacts in 2007. Most specialties will see cuts, including internal medicine which faces a 1% cut and five specialties that face double-digit cuts of 10-14%. Family physicians will see no net change in payment. When the elimination of the work GPCI floor is combined with the specialty impacts, cuts will exceed 15% in a number of localities.

The AMA is extremely concerned about the pending pay cuts. When the negative update is combined with the other payment changes that are outlined in the final rule, nearly half of physicians nationwide will be facing cuts of from 6% to 20%.

In light of the foregoing various factors that will exacerbate the impact of the Medicare physician payment cut in 2007, immediate action by CMS and Congress to remedy this situation is critical. Physicians are united in their view that the most important problem that Congress needs to address is the 5% pay cut scheduled to take effect January 1, 2007. This cut will reduce payments for all specialties and all payment localities, and action by CMS and Congress to replace this 5% cut in 2007 with a positive update that adequately reflects increases in practice costs will help physicians in every state and specialty.

Self-Referral Rules

CMS had proposed a number of changes in the physician fee schedule proposed rule governing physician referrals for diagnostic tests. In response to concerns about the potential for serious unintended consequences for patient access to care due to this complex proposal, CMS decided to defer finalizing the new regulations until it has further studied these issues. **The AMA appreciates CMS' recognition of the complexity and potential consequences of this proposal, and we look forward to continuing to work with CMS in addressing this matter.**

VOLUNTARY REPORTING

The AMA has concerns about CMS' current proposals for implementing the Physician Voluntary Reporting Program (PVRP), including those relating to: (i) CMS' recent proposed quality measures for 2007; and (ii) efforts by CMS to direct Quality Improvement Organizations to independently develop and/or facilitate physician performance measure development for the PRVP.

Proposed Quality Measures for 2007

In October, CMS posted a document to its website proposing new quality measures for which physicians could voluntarily report data in 2007 under the PVRP. We commend

CMS for working with the AMA, national medical specialty societies, state medical societies, the Council of Medical Specialty Societies, and American Board of Medical Specialties this year to collaboratively develop physician performance measures through the Physician Consortium for Performance Improvement (Consortium). This work has allowed CMS to significantly expand the measures available to the PVRP program by involving practicing physicians representing 100+ medical organizations that make up the Consortium.

The AMA hopes to continue this partnership as we believe PVRP measures should be developed collaboratively across physician specialties through the Consortium process and maintained by the Consortium and appropriate professional organizations. This allows measures to be periodically reviewed and updated with current evidence-based information in an open and transparent multi-specialty forum that includes the foremost experts in the country.

This is particularly important in light of the fact that, in evaluating the October document and proposed measures for 2007, many of the measures lacked specificity while others had incomplete measure descriptions. Inconsistencies in the document, coupled with lack of specificity, made it impossible to provide meaningful comment to determine if measures are appropriate for the specialties to which they are assigned by CMS.

It was also unclear whether CMS plans to use any of the current sixteen 2006 PVRP “Core Starter Set Measures.” Some of the 2006 measures were included (see nephrology, critical care) in the 2007 measure list along with incorrect information regarding pending National Quality Forum (NQF) and AQA review. If so, this is problematic because the majority of 2006 measures were created by CMS using facility level measures not designed for individual physician attribution. Efforts of the physician community should help resolve these problems as its work through the Consortium this year has focused on helping CMS create measures appropriate for physician level measurement for the same clinical topics. Thus, CMS should take advantage of these newly created measures and replace the inappropriate 2006 measures.

Finally, early last year CMS altered the wording of several Consortium-developed, AQA-adopted, NQF endorsed measures, thereby changing their clinical meaning. CMS has continued to use these measures in the 2006 PVRP. Without further details regarding the measures outlined in the October document, it is not clear if CMS plans to again alter measures intended for 2007. **The AMA urges PPAC to recommend that CMS ensure that all Consortium-developed, NQF-endorsed, and AQA-selected measures used in the PVRP reflect the wording and specifications as developed and endorsed by stakeholder organizations, without modification by CMS.** Accurate and detailed measure documentation is critical to successful implementation of the PVRP, and we look forward to working with CMS to further improve the PVRP.

Quality Improvement Organizations

The AMA and a number of medical organizations recently sent a letter to CMS expressing strong concern about recent actions by CMS to direct Medicare Quality Improvement

Organizations (QIOs) to independently develop and/or facilitate physician performance measure development for the PVRP. As discussed above, the current process of measure development by the Consortium, with endorsement by the NQF and consensus approval by the AQA ensures that all stakeholders are involved. We are concerned that CMS is seeking to exert greater control over physician measure development by diminishing the role of the Consortium through this shift to the QIOs working independent of the existing process.

The Consortium has worked over the past six years to develop physician performance measures through a rigorous and transparent process that, to date, has resulted in the development of 151 measures, and work on new measures will continue at a rapid pace through 2007 and beyond.

The cross-specialty nature of the Consortium is critical to creating valid physician performance measures with broad-based support in the physician community because it allows input from the multiple physician specialties that treat different aspects of care often associated with a single disease. It allows physicians to come together to focus on what is best for patients as opposed to creating competing and potentially conflicting performance measures under 100+ independent specialty and sub-specialty silos. In no way can the Consortium be replicated through a development process created from scratch by CMS and the QIOs.

In the QIO 8th Statement of Work for 2005-2008, QIOs are specifically tasked with providing technical support to physicians, communicating with and educating physicians about CMS quality initiatives such as the PVRP, and assisting physicians with adoption of electronic health records. The AMA supports these QIO activities. **The AMA urges PPAC to recommend that instead of attempting to replicate an established measure development process that includes virtually all physician specialties, CMS should further direct its resources to allow QIOs to pursue these important complementary responsibilities. This will allow Medicare and the QIOs to work together in a collaborative fashion to help Medicare implement useful programs to assist physicians in providing the highest quality care to their patients.**

AMBULATORY SURGICAL CENTER PROPOSED RULE

CMS recently issued a proposed rule to revise the ambulatory surgical center (ASC) payment system, for implementation January 1, 2008, and the AMA has several important concerns that we submitted to CMS regarding the proposed rule.

The AMA commends CMS on its efforts to implement a new ASC payment system, as mandated by the MMA. We are confident that a new payment system can help to ensure that Medicare beneficiaries have access to the highest quality surgical care while lowering their cost-sharing obligations and assisting the Medicare program in containing health expenditures. We are hopeful that implementation of a new payment system will help to create a level playing field between ASCs and hospital outpatient departments so that facility determinations are based primarily upon what is best for the patient.

ASC Payable Procedures

The proposed rule adopts the recommendation of the Medicare Payment Advisory Commission (MedPAC), that the ASC procedures list be modified such that ASCs can receive Medicare facility payments for any surgical service, except those that the Secretary of Health and Human Services (HHS) designates as posing a significant risk to beneficiary safety when furnished in an ASC or that would require an overnight stay. CMS deviates from the MedPAC recommendation, however, and lists criteria that it will use as proxies for safety. Specifically, CMS proposes to exclude those procedures involving major blood vessels, major or prolonged invasion of body cavities, significant loss of blood, or procedures defined as inpatient-only services in the outpatient prospective payment system.

Thus, the proposal defines safety using a set of criteria, rather than engaging in a meaningful dialogue with physicians, including those practicing in ASCs, about which procedures are safe in the ASC setting. Physicians are best equipped to determine the safest place to perform a procedure. They are most familiar with assessing anesthetic risk, expected duration and complexity of a procedure, the anticipated degree and duration of postoperative pain and discomfort, and the probability of peri- and post-operative complications. While an ASC may not always be the proper surgical setting, it may indeed be safe and appropriate for many patients undergoing procedures not typically performed in an ASC. And we believe that this determination should be made based on the expertise of the physician community.

We strongly believe that physicians, in consultation with their patients, are in the best position to determine the most appropriate site of service for a surgical procedure. **For this reason, we urge PPAC to recommend that CMS establish a process to consult with national medical specialty societies and the ambulatory surgical community to develop and adopt a systematic and adaptable means of fairly reimbursing ASCs for all safe and appropriate services, allowing for changes in technology and current-day practices.**

ASC Payment for Office-Based Procedures

CMS proposes to further expand the list of procedures by discontinuing the restriction on payment for procedures performed in an ASC that “are commonly performed, or that may be safely performed, in physicians’ offices.” However, CMS proposes to cap payments for these services at the lesser of the non-facility practice expense payment under Medicare’s physician fee schedule, or the ASC payment rate. This cap would 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 the Medicare program and individual beneficiaries.

For example, in the hospital outpatient department (HOPD) setting, payment for CPT® 64555, Percutaneous implantation of neurostimulator electrodes, would be \$3025.80, whereas payment for performing the procedure in an ASC, under the proposed rule, would be only \$96.40. Similarly, the payment for performing CPT® 65210, Removal foreign body of the eye, in an ASC would amount to only \$26.81; CPT® 53025, Incision of urethra, would be capped at \$14.09; CPT® 56606, Biopsy of vulva, would amount to \$33.54; and payment for CPT® 62368, Analyze spine infusion pump, would be only \$21.90. As is clear from these examples, payment amounts for many services would be so low under the proposed rule that utilization of an ASC for these and other procedures would be impractical and unworkable.

CMS indicates that it is concerned that allowing payment for office-based procedures under the ASC benefit may create an incentive for physicians inappropriately to convert their offices into ASCs or move all of their office surgery to an ASC. However, we do not think that capping payments at a level that in many cases will not cover the cost of performing the procedure is a viable solution. **Thus, we urge PPAC to recommend that CMS review carefully the costs related to these lower intensity services and develop a payment system that adequately covers such costs if performing the procedure in an ASC is indeed appropriate. Finally, in the interest of promoting a system whereby facility decisions are made based upon a patient's best interests rather than reimbursement rates, we urge PPAC to recommend that CMS apply any payment policies uniformly to both ASCs and hospital outpatient departments.** CMS should recognize that if a payment would be unreasonably low for a service provided in a hospital outpatient department, then it is equally unreasonable in the ASC setting.

ASC Conversion Factor

The AMA is pleased that CMS is proposing to link ASC payments to the rates paid to HOPDs. We believe it is essential to revise payments for surgical procedures provided in ASCs so that they are aligned with surgical procedures provided in hospital outpatient departments. Such alignments would make payments more accurate and promote higher quality and value in outpatient care. We are concerned, however, with CMS' proposal that ASCs be paid based upon a methodology that results in ASCs being paid no more than 62 percent of the HOPD rates in 2008 and even less in 2009.

While we understand that this low percentage is driven by CMS's interpretation of the MMA's requirement that the new system be implemented in a budget neutral manner, we believe that CMS' interpretation is based upon unproven assumptions and is unduly narrow. There are a number of assumptions behind CMS' calculation that budget neutrality requires the new ASC rates to be set at 62 percent of the outpatient prospective payment system (OPPS) rate for the same service. Although the 62 percent payment rate, as well as the expanded ASC coverage policy, will make it possible to provide some services in ASCs that are now commonly provided in hospital outpatient departments, this payment rate also

represents a sharp reduction for a number of services that are already being frequently provided in ASCs.

In particular, many single-specialty ASCs that specialize in gastrointestinal, pain management, and ophthalmic procedures that provide critical care to Medicare beneficiaries may not be feasible at these rates. Patients could then be forced to obtain treatment in hospitals, which will increase costs to the program and limit physicians' ability to determine the most appropriate setting for their patients. To take procedures that are currently provided frequently in ASCs and revert back to providing them in a hospital setting would represent a major reversal of medical progress.

We urge PPAC to recommend that CMS reconsider its assumptions about utilization rates under the new payment system and work to achieve the highest possible level of comparability between the ASC and OPPS rates in order to minimize the adverse impact on gastroenterology, pain management, and ophthalmic services facing steep reductions under the current proposal. For example, CMS should not assume migration of procedures that currently are provided in physician offices into ASCs. Many services defined as surgery, such as dermatological procedures, are highly unlikely to migrate from physician offices to ASCs. The services that are most likely to be done more frequently in ASCs under the new payment system are those that are primarily done in hospitals currently due to significant underpayment in ASCs.

We also urge PPAC to recommend that CMS interpret broadly the budget neutrality requirement. Providing Medicare beneficiaries with access to ASCs offers them more choices and enhances their access to services in a timely manner. In addition, it provides significant economic savings to the Medicare program and its beneficiaries. Maintaining ASC access, however, requires reasonable payment rates, and since current ASC rates are based upon 20-year old data and a 6-year freeze, a broad interpretation of budget neutrality is necessary to establish such rates and allow Medicare and its beneficiaries to take advantage of the myriad benefits of ASCs.

Furthermore, like hospitals, ASCs should be updated based upon the hospital market basket rather than the Consumer Price Index for all urban Consumers (CPI-U). The hospital market basket more appropriately reflects inflation in providing surgical services. Moreover, alignment with hospital updates would achieve parity and transparency in the market and assure that facility decisions are made based upon what is best for the patient, rather than the economic strength of the facility.

Finally, under the proposed rule, the new payment rates would be phased in over a two-year period. For 2008, CMS would pay a blended amount equal to 50 percent of the rate under the existing payment system and 50 percent of the rate under the new system. Starting in 2009, payment rates would be tied entirely to the new methodology. The AMA is concerned that such a short transition period could threaten the viability of many centers and recommends that CMS provide more time for phasing in the new methodology.

We are pleased that CMS is moving forward with adoption of a new ASC payment system and support CMS in this effort. We look forward to working closely with CMS to refine a program that works well for physicians, patient, and CMS.

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.