December 10, 1998

Nancy-Ann Min DeParle, Administrator

Health Care Financing Administration
Department of Health and Human Services
Attention: HCFA–1005–P
P.O. Box 26688
Baltimore, Maryland 21207

Attn: HCFA-1005-P RIN 0938-A156

Subject: Medicare Program; Prospective Payment System for Hospital Outpatient Services

Dear Ms. DeParle:

The American College of Physicians–American Society of Internal Medicine (ACP–ASIM) is pleased to provide comments on the proposed rule concerning the Prospective Payment System (PPS) for Hospital Outpatient Services published in the *Federal Register* on September 8, 1998. ACP–ASIM supports a policy of establishing an incentive-neutral, level playing field across all sites of services, including hospital outpatient departments (HOPD), ambulatory surgery centers (ASC), and physicians' offices. To achieve this aim, payment rates for HOPD services should be based on individual services received, and not on groups of services as specified in the proposed rule.

The system the Health Care Financing Administration (HCFA) is proposing, to bundle services into groups, contributes to an uneven playing field because it does not eliminate wide disparities in payment rates among the various ambulatory settings. In fact, by making it easier to compare reimbursement rates for a procedure furnished in an ASC versus in an HOPD, the proposal may increase incentives to use a particular site-of-service without regard to the patient's best interest.

Further, bundling services into ambulatory patient classification (APC) groups creates incentives for providers to limit or eliminate certain ancillary services, especially if the weighting of the service bundles is inequitable or if the services are inappropriately bundled. This would disrupt continuity of care and unduly jeopardize the physician-patient relationship.

The proposed APC payment groupings are not homogenous with other services in that same group. This is contrary to HCFA's statutory mandate, which requires that any groups contain services that are similar clinically or in terms of resource cost. Since HCFA does not have sufficient clinical or resource cost data to develop appropriate groups of services, it should base payment rates on individual services. If the agency proceeds to implement APCs, however, it should carefully evaluate and re-assign services to more appropriate groups, after considerable consultation with appropriate industry representatives knowledgeable of the real costs of providing a service.

Additionally, HCFA should implement a procedure where services can easily be transferred from one APC Group to another more homogenous group. For instance, HCFA could (a) institute an initial period of refinement of APC Groups; (b) conduct a cost survey at least every 5 years, and update APC rates accordingly; and/or (c) establish a petition process under which a service may be reviewed, and, if appropriate, assigned to a different APC Group.

Specific to chemotherapeutic therapy, oncologists have identified a number of errors in the data used to assign chemotherapy drugs to particular APCs. Many drugs appear to be assigned to the wrong group and the groups contain drugs with significantly different costs, providing a possible incentive for hospitals to choose lower cost drugs in a group even when a higher cost drug is clearly more appropriate. In addition, the current proposal assigns all new drugs to the lowest cost group, which is clearly inappropriate. The latter may also result in discouraging the development of new drugs, denying the patients of today and those of future generations access to more effective treatments.

For these reasons, the ACP−ASIM recommends that, rather than including Medicare-covered drugs in the APCs, HCFA should continue to make separate payments for these items. If drugs are included in the APCs, however, then the high-cost chemotherapeutic agents should be pulled out of the system and separately reimbursed. APC payments rates should continue to cover the limited pharmaceutical drugs that are currently covered by Medicare, and the payment rate for these drugs should be consistent with the rate paid for such drugs when furnished in a physician's office.

ACP−ASIM is also very concerned that the proposed rule excludes certain cardiac services from outpatient PPS reimbursement, which can and have been safely performed (and reimbursed by HCFA) in a much more cost-effective outpatient setting in the past. Among those excluded by HCFA are two cardiac procedures which could be easily be performed in an outpatient setting: (1) the removal of pacemakers, and; (2) the removal of defibrillator pulse generators.

ACP−ASIM is also opposed to lumping all echocardiography services into one APC, as these vary widely in terms of type of imaging, accompanying sedation medication and contrast agents, and, hence, cost. We thus recommend that HCFA establish more APCs for echocardiography services to account for the varying nature and expense of this diagnostic service.

ACP−ASIM is also concerned that HCFA's proposed requirements to ensure that hospital-owned physician practices are financially and clinically integrated with hospitals may not be appropriate.

HCFA's requirement that the physician practice be a "provider based entity" to be eligible for outpatient PPS reimbursement is much too restrictive, forcing physicians into an all-or-nothing decision concerning where they practice. Physicians may be reluctant to enter agreements with hospitals for delivering outpatient services if doing so means sacrificing their independence and ability to form other practice arrangements. ACP−ASIM therefore recommends that HCFA relax or remove its requirement for provider based entities, affording physicians and hospitals the flexibility to adapt to local market conditions, and to use any number of practice arrangements to

provide cost-effective, quality care. Specifically, rather than requiring the hospital (or "main provider") to own 100% of the outpatient facility, HCFA should state that the main provider should hold "at least 51% ownership interest" in the ambulatory center. This change would give physicians more incentive to enter joint practice arrangements with hospitals while maintaining overall governance by the main provider.

Anticipating that the shift to an outpatient PPS could produce unnecessary increases in the volume of covered hospital outpatient services, the Balanced Budget Act of 1997 directs HCFA to "develop a method for controlling" such increases. Although HCFA does not propose a volume expenditure target for years beyond 2000, it is considering extending to outpatient services (and possibly to ASCs as well) the sustainable growth rate ("SGR") formula used for physician services. HCFA contends that this extension would give physicians an incentive to control growth within the system.

ACP−ASIM opposes use of a volume expenditure target as a means of controlling costs, since it fails to distinguish between necessary and unnecessary care. Further, we do not believe HCFA has the statutory authority to impose such a target. It is imperative that any method for controlling unnecessary services allow for technological growth, shifts in sites-of-service and the continued provision of necessary services.

ACP−ASIM also opposes any extension of the sustainable growth rate targets used for physician services to HOPDs or ASCs. We question HCFA's authority to implement such a proposal, and. do not agree with HCFA's assumption that a single target for physicians and outpatient services is needed to discourage physicians from ordering unnecessary HOPD services. Merging HOPD and physician spending targets would simply extend possible distortions from HCFA's inability to predict outpatient utilization to other providers.

ACP−ASIM also disagrees with HCFA's proposal to disallow any outlier payments on the basis that (1) APC Groups have minimal packaging and (2) if a patient is furnished multiple services, Medicare will pay multiple payments (but discounted for additional surgical services.) Under this policy, the APC system may not properly take into account costs for higher-end services, such as those provided in cancer centers, and thus these providers may experience serious economic losses. ACP−ASIM supports outlier payment adjustments, and urges HCFA to establish an outlier adjustments as a supplement to the outpatient PPS.

We appreciate your consideration of the foregoing comments and urge HCFA to work towards a final outpatient PPS, which supports rather than discourages providing the best care possible to our Medicare beneficiaries. If you have any questions about these comments, please contact ACP−ASIM's Director of Managed Care and Regulatory Affairs, John DuMoulin at (202) 261-4535.

Sincerely,

Alan R. Nelson, MD, FACP
Associate Executive Vice President

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