AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

February 19, 2016

Fred Upton
Chairman
House of Representatives Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Joseph R. Pitts
Chairman, Subcommittee on Health
House of Representatives Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Subcommittee Chairman Pitts,

Thank you for the opportunity to provide input to the House of Representatives Energy and Commerce Committee and its Health Subcommittee on the impact, and potential expansion, of section 603 of the Bipartisan Budget Act (BBA) of 2015. This section of the BBA established policies addressing the issue of disparate payments for different health care delivery sites (e.g., inpatient, outpatient, Ambulatory Surgical Center, emergency department, physician office). Representing more than 18,000 board-certified orthopaedic surgeons, the American Association of Orthopaedic Surgeons (AAOS) is very concerned about the issue of so-called "site neutrality" in payments and thanks the committee for addressing this important issue.

Having payments that vary by facility site derives from the idea of payment based on total resources used in provision of healthcare services, something that has long been a part of Medicare and Medicaid payments, and remains the central part of payment systems like the Physician Fee Schedule. Even for prospective payment systems like the Outpatient Prospective Payment System and the Ambulatory Surgical Center payment system, varying payment by site is part of the overall calculations.

However, health care policymakers have long been aware of the economic inefficiencies created when these natural variations become inflated, such as the case of payment rates in the outpatient setting for basic patient visits (evaluation and management visits) varying by more than 20 percent compared to payments for the same exact service in the physician office. This degree of variation is all too common in the Medicare payment system and has resulted in inefficient care, increased consolidation of physician practices into hospital systems (because the office for an employed physician can be deemed as an outpatient setting when the physician is paid staff for a hospital system), and increased costs to Medicare patients who face higher co-pays for outpatient services compared to services provided in an office setting.

For all these reasons and more, Congress enacted section 603 of the BBA prohibiting the use of the outpatient setting for a physician office or ambulatory surgical center (ASC) purchased by a hospital after January 1, 2017 for payment purposes unless the office is located on the main

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campus of a hospital. According to a letter dated February 5, 2016, the committee and subcommittee have received a substantial amount of feedback, with some stakeholders supportive of expanding section 603 of the BBA and others supportive of mitigating its impact.

The AAOS is generally supportive of efforts to reduce payment differentials by site for the same services and have consistently commented to the Centers of Medicare and Medicaid Services (CMS) and Congress that we believe significant differences in payments by site creates economic inefficiencies that result in unnecessary expenditures by payers like Medicare and Medicaid. We have been supportive of making payments for services furnished in the physician office or the ASC equal to payments in the outpatient setting. However, we have consistently recommended seeking this equilibrium not by bluntly reducing the outpatient payments to equal ASC or office payments but by also increasing payments in those settings toward a more middle ground. We urge the committee to consider this as a method to equalize payments and provide incentives for physicians to be rewarded for providing care in the setting most safe and convenient for their patients, not just the one with the higher payment settings. Hence, we recommend that any payment to facilities come from Medicare Part A, such that Part B funds are freed up to pay for physician services. We believe that capping Part B payments is financially not viable for physicians and presents a great burden on them.

We also do not believe the committee should enact significant changes to section 603 of the BBA until the policies under section 603 have been in effect for a significant amount of time so as to measure and track the impact of the changes. It would be premature to preemptively expand or contract section 603 at this time. We also urge the committee to conduct analyses, possibly through the Medicare Payment Advisory Committee (MedPAC) or the General Accountability Office (GAO), to determine what the true cost differentials are for outpatient facilities, which do incur real additional costs for things like graduate medical education (GME) and increased compliance and regulatory costs compared to physician offices or ASCs. However, these differences should not be more than a small percentage on average and anything above those differences risks unintended consequences like excessive spending for the system, decreased competition, decreased innovation.

We recommend the committee consider the following for the future, but only after section 603 has taken effect and the impact been tracked and measured.

- Pay any facility reimbursements from Part A funds while keeping Part B payments untouched.
- Equalize (or nearly equalize) rates for office visits and in office procedures.
- Equalize (or nearly equalize) rates for ASC procedures.
- In addition, create positive payment adjustments for ASC facilities that are operated inside a hospital and include an emergency room.
- Create a positive payment adjustment for facilities incurring GME expenses.

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- Making all adjustments budget neutral so that savings incurred through the policies are returned into the system

We commend Congress and the Energy and Commerce Committee for addressing this healthcare inefficiency and encourage the committee to continue to address systematic inefficiencies that result in excess costs to the system and inefficient quality of care for Medicare and Medicaid patients.

Thank you for your time and for considering the concerns, comments, and recommendations of the AAOS on this important proposed rule which primarily addresses revisions to payment policies under the Medicare Physician Fee Schedule. Should you have questions on any of the above comments, please do not hesitate to contact AAOS' Medical Director, William O. Shaffer, MD, at 202-548-4430 or via email at shaffer@aaos.org.

Sincerely,

David D. Teuscher, MD
President, American Association of Orthopaedic Surgeons

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