December 21, 2016

Andrew M. Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1656–IFC
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Dear Acting Administrator Slavitt:

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,900 family physicians and medical students across the country, I write in response to the hospital outpatient prospective payment and ambulatory surgical center payment systems final rule with comment period as published in the November 14, 2016 *Federal Register*.

A. Implementation of Section 603

As noted in the AAFP's August 24, 2016 comment letter to the corresponding proposed rule, in general, the AAFP supports CMS efforts to align payment policies for physicians in independent practice with those owned by hospitals, and we believe the finalized policies in this rule will lead to a more level economic playing field for independent practices while also being more equitable for Medicare beneficiaries. The AAFP continues to encourage CMS also to consider site-of-service payment parity polices from a broader perspective. Namely, CMS should not pay more for the same services in the inpatient, outpatient, or ambulatory surgical center setting than in the physician office setting. From a global cost perspective, and as further discussed in the AAFP's August 29, 2012 letter to CMS sent in response to the solicitation of comments regarding outpatient status, the AAFP encourages CMS to create incentives for services to be performed in the most cost-effective location, such as a physician's office. The AAFP considers the artificial distinction between "inpatient," "outpatient," and other sites of service as a product of the equally artificial distinction between Part A and Part B. The AAFP calls for policies that progress beyond this silo mentality and instead pay for healthcare services in a more consistent and equitable manner.

With respect to the present rule, we believe that the agency has done a reasonable job of defining applicable items and services and an off-campus outpatient department of a provider consistent with the statute. We also believe that CMS's policies regarding exceptions to the policy are also consistent with the statute.

We support CMS's decision to void the excepted status of off-campus provider-based departments (PBDs) that move or relocate. Like CMS, we believe that the intent of section 603 of the *Bipartisan Budget Act of 2015* (the BBA) is to curb the practice of hospital acquisition of physician practices

that then result in receiving additional Medicare payment for similar services. Failure to void the excepted status of off-campus PBDs that move or relocate would have allowed hospitals to circumvent the law's intent, as CMS notes. In this context, we appreciate that CMS has provided a reasonable defined, limited relocation exception process, which will permit excepted off-campus PBDs to relocate temporarily or permanently, without loss of excepted status, for extraordinary circumstances outside of the hospital's control, such as natural disasters, significant seismic building code requirements, or significant public health and public safety issues.

We understand CMS's decision not to finalize a policy that would limit service line expansion in excepted off-campus PBDs. We are hopeful that CMS's other policies will effectively prevent circumvention of the statute's intent without such a limit, and we appreciate CMS's intent to monitor service line and volume growth and, if appropriate, propose to adopt limits on the expansion of services or service lines in future rulemaking.

Finally, we thank CMS for better explaining the rationale behind its proposal and subsequent decision that excepted status for an off-campus PBD would transfer to new ownership only if ownership of the main provider is also transferred and the new owner accepts the Medicare provider agreement. Under the final policy, if the provider agreement is terminated, all excepted off-campus PBDs will no longer be excepted, and an individual excepted off-campus PBDs cannot be transferred from one hospital to another and maintain excepted status. We support this policy.

B. Interim Final Rule with Comment Period: Establishment of Payment Rates under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by Non-excepted Off-Campus Provider-Based Departments of a Hospital

The AAFP supported CMS's original proposal to pay non-excepted, off-campus PBDs or excepted off-campus PBDs that provide non-excepted items and services under the Medicare physician fee schedule at the non-facility rate for 2017. We continue to believe that this was a reasonable response consistent with section 603 of the BBA.

Accordingly, we are disappointed that, for 2017 and 2018, CMS will continue to pay non-excepted, off-campus PBDs or excepted off-campus PBDs that provide non-excepted items and services under what, in essence, remains the OPPS, albeit at a discounted rate. Nominally, the payment rates are under the MPFS, but as CMS notes in the interim final rule with comment, these rates are "specific to and can only be reported by hospitals reporting nonexcepted items and services on the institution claim form," which acknowledges explicitly that payments to all hospital outpatient departments—excepted or non-excepted—will maintain an enhanced status.

As CMS also notes, its planned payment methodology for 2017 and 2018 will not assure equal payments for the same service regardless of site of service. That means hospitals may still be incentivized to buy physician practices based on the mix of services they provide and bill for them as PBDs at Medicare rates higher than would have been paid had the practice not been bought by the hospital, which is contrary to the intent of section 603. Equalizing payments "in the aggregate" still encourages hospitals to make business decisions that run counter to the public interest and the goals of the Medicare program.

Thus, for calendar year 2019, if not sooner, we support CMS's intent to adopt an approach similar to the approach that it initially proposed for CY 2017. As noted, under this approach, CMS would pay non-excepted off-campus PBDs for their non-excepted items and services at a true MPFS-based rate that would reflect the relative resources involved in furnishing the services. For most

services, this MPFS-based rate would equal the non-facility payment rate under the MPFS minus the facility payment rate under the MPFS for the service in question. For other services for which CMS does not provide separate payment under the MPFS, if payment is made under OPPS, this MPFS-based rate would equal the MPFS non-facility rate. For still other services, the technical component rate under the MPFS would serve as the MPFS-based rate. Such an approach would, in fact, equalize payment rates between physician offices and non-excepted off-campus PBDs on a procedure-by-procedure basis which is consistent with the AAFP's vision for how Medicare payment should be designed.

We appreciate the opportunity to comment and make ourselves available for your questions. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Wanda D. Filer, MD, MBA, FAAFP
Board Chair