

Statement of the American Academy of Family Physicians

House Committee on Energy and Commerce Subcommittee on Health

Hearing on “Keeping the Promise: Site-of-Service Medicare Payment Reforms” 2123 Rayburn House Office Building

May 21, 2014

The American Academy of Family Physicians (AAFP), representing 115,900 family physicians and medical students nationwide, thanks the Subcommittee for holding this hearing and submits the following statement for the record:

Site Neutrality

The AAFP supports Medicare payment neutrality across sites of service. That is, the AAFP believes that Medicare should not pay significantly more for a service in the hospital outpatient or ambulatory surgery center (ASC) setting than in the physician office setting, as long as the service can be provided safely in the physician office.

The AAFP notes several recent proposals in this vein that are before the Committee today:

- The Medicare Payment Advisory Commission’s (MedPAC) March 2012 recommendation that Congress direct the Centers for Medicare and Medicaid Services (CMS) to reduce payment for evaluation and management (E&M) services provided in a hospital outpatient department so that total payment rates for these visits are the same whether the service is provided in an outpatient department or a physician office.
- The *Medicare Patient Access to Cancer Treatment Act of 2013* (HR 2869), introduced by Reps. Mike Rogers (R-MI) and Doris Matsui (D-CA), which would direct CMS to equalize payment between hospital outpatient departments and physician offices for cancer-care services.
- MedPAC’s March 2014 recommendation that Congress direct CMS to reduce or eliminate differences in payment rates between outpatient departments and physician offices for 66 selected ambulatory payment classifications (including E&M services).

The AAFP supports these and other policies that seek to incentivize the delivery of care in the least costly setting—provided that the service can be delivered safely in that setting. Accordingly, the

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AAFP encourages the Committee and Congress to develop incentives for services to be performed in the lower-cost setting. According to MedPAC's analysis, Medicare beneficiaries would also benefit from site-neutrality, through a net reduction in cost sharing of \$100 million per year. See MedPAC Report to the Congress at p. 84 (Mar. 2014).

Transition Care Management Codes

Referring to Section 4 of the *Bundling and Coordinating Post-Acute Care (BACPAC) Act* of 2014, sponsored by Rep. David McKinley (R-WV), and also before the Committee today, the AAFP notes that the Act would require CMS to “establish a new Transitional Care Management (TCM) code to pay for care management by such a [post-acute care] physician or revise and expand the use of existing TCM codes.”

The existing TCM codes (CPT 99495 and 99496) first became reimbursable on January 1, 2013. These codes are designed to compensate a patient's physician or practitioner for the expenses associated with coordinating the patient's care in the 30 days following a hospital or nursing facility stay. Although they were billed minimally in 2013 (after only about 2.3 percent of hospital discharges),¹ the AAFP continues to believe that these codes are promising in terms of their ability to align resources to facilitate the immediate interventions by primary care physicians, with their patients, to avoid preventable hospital readmissions. Several factors may be contributing to the slow uptake of the TCM codes. Anecdotal evidence among AAFP membership indicates that some family medicine practices' management and billing systems are not yet equipped to handle the codes (since the practice must hold the claim until the 30-day period is over); some members may be unwilling to be early adopters of a new code for lack of familiarity; others may simply lack awareness of the codes.

The AAFP continues to promote the use of the TCM codes among its membership, and welcomes the leadership of the Committee in making these codes easier to use for primary-care physicians.

Post-Acute Care

Section 3 of the *Bundling and Coordinating Post-Acute Care (BACPAC) Act* of 2014 adds Section 1866F to the Social Security Act, which among other things eliminates application of the 3-day inpatient hospital stay requirement. The AAFP supports this step as a move away from the arbitrary and outmoded prerequisite that Medicare will not pay for a patient assignment to skilled-nursing care unless the patient has a medical condition that entails at least 3 days of hospital treatment first.

Physicians who, based on their training and experience, use their medical judgment to order a patient into skilled nursing care directly from the community should be encouraged to do so based entirely on patient need, and without worrying whether Medicare will or will not cover the cost of the patient's care.

¹ According to Medicare claims data, code 99495 was reported 143,620 times. Code 99496 was reported 118,961 times. Medicare data also reports 11,180,000 Medicare acute-care hospital discharges in 2012. Assuming that there were at least as many discharges in 2013, physicians billed the TCM codes in conjunction with about 2.3 percent of all hospital discharges.

The AAFP views pending proposals in Congress to count observation days toward the 3-day stay as a positive step forward for patients,² but only a repeal of the 3-day rule will give physicians the ability to admit patients to the most medically appropriate setting without regard to whether Medicare will cover the benefit.

Thank you for the opportunity to provide family medicine's views on the evolving efforts to reform health-care delivery and payment.

² E.g. *The Improving Access to Medicare Coverage Act of 2013* (HR 1179 / S 569).