



September 24, 2004

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Hubert Humphrey Building, Room 445-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Attention: CMS-1429-P

Dear Dr. McClellan:

The Association of American Medical Colleges represents approximately 400 of the nation's major teaching hospitals and health systems, all 125 accredited allopathic medical schools, 96 professional and academic societies, nearly 105,000 academic physicians and the nation's medical students and residents. The AAMC appreciates this opportunity to submit comments on the *Revisions to Payment Policies Under The Physician Fee Schedule Rule for Calendar Year 2005*.

Published Changes to the Fee Schedule

The proposed rule indicates that a conversion factor (CF) update of -3.7% would occur under the Sustainable Growth Rate (SGR) if the SGR methodology were to be in place for CY 2005. Instead, a positive update of 1.5% will occur because of provisions in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Although the physician community welcomes the positive updates of 1.5% for CYs 2004 and 2005, the gap between the CF updates and the Medicare Economic Index (MEI), projected at 2.8% for CY 2005, continues to widen. Thus, payment rate increases and medical practice cost increases are not keeping pace and the differential continues to place financial strains on physicians participating in the Medicare program.

The Medicare Trustees project that between 2006 and 2012, when the physician payment update methodology returns to the SGR, the CF will be updated by approximately -5% annually. The MEI is expected to continue to rise and to increase by an additional 19% by 2012. If action is not taken, the result of the cumulative decreases in payment, in light of the steadily increasing practice costs, will erode further the ability of physicians to maintain economic viability while serving Medicare beneficiaries.

Section 303—Covered Outpatient Drugs and Biologicals

Fundamental changes to the SGR system will require additional action from Congress. However, the Administration has the ability to take specific action in the 2005 payment rule to help address issues created by the payment methodology. Specifically, as previously requested by the physician community, CMS can remove expenditures on drugs, biologicals and changes due to law and regulations from the SGR target.

The Centers for Medicare and Medicaid Services (CMS) includes the costs of physician-administered drugs in its determinations of whether or not spending under Part B has exceeded the SGR target. Between the SGRs base year of 1996 and 2002 spending for physician administered drugs rose from \$1.8 billion to \$6.2 billion, an increase of 244% per beneficiary, compared to an increase of 38% per beneficiary for physician services. Thus, drugs have represented an increasing share of SGR dollars, rising from 3.8% of the total to 10.2%.

It has been argued that including drugs in the SGR was necessary to curtail over-utilization under the drug reimbursement system. However, most of the drug-related increases, in terms of both numbers of drugs and dollar expenditures, arise from use of chemotherapy and other cancer-related drugs. Due to the nature of these drugs, physicians have little discretion regarding their utilization.

Further, the MMA has eliminated such incentives, had they existed, by reducing payment rates for these drugs in an effort to bring reimbursement for actual drug costs and drug administration fees in line with physicians' actual costs.

According to the Congressional Budget Office, the uneven growth in drug-related expenditures and physician related expenditures has resulted in a target for physician services that is about one-half percent lower than it would be if drug and lab tests were not included in the SGR. In light of the advances of medical research and various efforts to support the acceleration of drug development and market readiness, it is anticipated that the number of and costs associated with physician-administered drugs will increase, thus worsening this problem under the current system.

Thus, it is requested that CMS use its administrative authority to remove drugs from the SGR system in the CY 2005 Physician Fee Schedule Rule, retroactive to the SGR base year (April 1, 1996 to March 31, 1997).

Average Sales Price

In accordance with the MMA, effective January 1, 2005, payment for many covered prescription drugs will be based on manufacturers' average sales price (ASP). It has been recommended previously that CMS provide the physician community with ASP data for all impacted drugs as soon as possible. It is recognized that this payment system transition requires considerable data gathering and analysis by CMS. However, physicians are dependent upon the results to make financial planning decisions. The original list of ASPs published by CMS as part of the 2005 proposed fee schedule included data for only 31 covered drugs and did not include drugs administered by some specialties, such as those used to treat infectious diseases.

Thus, it is requested that CMS publish a complete list of covered drugs as soon as possible. Further, drug payment rates published in the final rule should be considered interim so that CMS can update rates if further refinements to the data indicate that updates are warranted.

Section 413--Professional Shortage Areas

The MMA provides a new 5% incentive payment to physicians providing services in physician primary care and specialty care scarcity areas. These payments will be effective from January 1, 2005 to December 31, 2007. The MMA also required CMS to publish the counties identified as primary and specialty shortage areas as part of the proposed and final rules for the applicable years. The counties were not included in the CY 2005 proposed rule.

CMS is urged to publish the list of primary and specialty shortage areas as soon as possible and to make the availability of the list broadly known to the physician community.

Section 952—Revisions to Reassignment Provisions

Section 952 of MMA revises the reassignment provisions with respect to services provided offsite from the entity billing Medicare. Specifically, MMA permits independent contractor physicians or nonphysician practitioners to reassign payment for Medicare-covered services, regardless of site of service, as long as there is a contractual arrangement between the physician and nonphysician practitioner and the entity that submits the bill for those services. Previously, such reassignment arrangements were not

available for services furnished offsite from the facility or health care delivery system that submitted the bill.

Academic medical centers and other physician practices employ contract physicians and nonphysician practitioners who practice in offsite locations, such as those associated with branch campuses or in community outreach locations. This expansion of the provisions will now enable reassignment and create the ability for an academic health center to enter into consistent billing relationships with its entire workforce, regardless of employment status or practice location, thus eliminating the need for differentiated arrangements.

Section 611 – Initial Preventive Physical Examinations

Section 611 of the MMA provides a new Medicare benefit for coverage of an initial preventive physical examination for new beneficiaries. Previously, Medicare law had not allowed for payment for routine physical examinations or checkups. Accordingly, CMS had interpreted services to be excluded from coverage prior to MMA.

The MMA defines an “initial preventive physical exam” to include:

- (1) a physical examination (including measurement of height, weight, and blood pressure, and an electrocardiogram, but excluding clinical laboratory tests) with the goal of health promotion and disease detection; and
- (2) Education, counseling, and referral with respect to screening and other covered preventive benefits separately authorized under Medicare Part B.

In implementing this new benefit, the proposed rule sets forth additional comprehensive criteria for defining the term “initial preventive physical examination,” and CMS is requesting public comment on this definition. It is recommended that the specifics of the exam, except as required by and stated in statute, be determined by the examining physician/provider based on the specific patient and within the parameters described under MMA. This recommendation is consistent with the recent deliberations by the Practicing Physicians Advisory Council (PPAC) at its August 30, 2004 meeting.

In billing for the new initial preventive physical exam, physicians will have to separately report the physical exam and any affiliated services provided pursuant to the exam. CMS proposes to establish a new HCPCS code, G0XX2, "Initial preventive physical examination," which includes an electrocardiogram (EKG). Other Medicare-covered preventive services would be separately reportable using the existing codes for those services. CMS proposes to assign this code a total of 3.29 relative value units in the office setting, the equivalent to the relative value units for a level three office visit plus a

complete EKG, 93000. Also as noted by PPAC at its August 2004 meeting, it would seem more appropriate to allow payment for the new visits to be commensurate with the level of service provided. The physician/practitioner will be in the best position to understand the level of service required for each individual patient, based on her/his health status, previous treatment and previous relationship with that patient. Although the proposal to provide payment commensurate with a level 3 office visit was based on review of data for a population of patients, it represents just that—a population based average, and does not necessarily correlate with the services needed by and thus billed for each patient.

Also, CMS should examine whether a new "G" code for the service is necessary, since physicians currently are allowed to use existing CPT codes with appropriate "V" diagnosis codes when billing for other existing screening tests. Covered initial preventive physical exams could be billed with the appropriate existing CPT code for preventive medicine visits (99381-99397) and an EKG code (e.g., 93000) with the appropriate "V" diagnosis code (e.g., V70.0). We encourage CMS to work within current CPT code determination processes to establish the most appropriate codes to be used for these services.

Further, CMS proposes that when the work of a problem-oriented E/M service is provided at the same encounter as the initial preventive physical exam, Medicare will only allow a medically necessary E/M service up to a level 2 (i.e., 99202 or 99212) to be reported. This proposal is based on the fact that some of the components for a medically necessary E/M visit are reflected in the new HCPCS code.

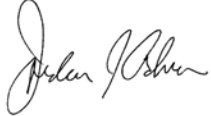
Setting a limit to the level of problem-oriented E/M service that physicians may bill when this work is performed in conjunction with an initial preventive physical examination is problematic. This cap suggests that patient will only present with self-limited or minor problems (established patients) or problems of low to moderate severity (new patients). In light of the multi-system/chronic conditions that afflict many Medicare beneficiaries, it seems unlikely that all beneficiaries will present with such low-levels of severity. Physicians are able to report a problem-oriented E/M service in conjunction with a preventive medicine service without regard to the level of problem-oriented E/M service. It is urged that CMS follow current CPT practice in this regard.

Finally, as discussed above, it is strongly urged that CMS not include expenditures for these new benefits required by law and regulation in future calculations of the SGR.

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The AAMC appreciates the opportunity to comment on the proposed rule. Please do not hesitate to contact me or my staff (Robert Dickler or Denise Dodero at 202-828-0490) if we can be of assistance.

Sincerely,

A handwritten signature in black ink, appearing to read "Jordan J. Cohen". The signature is fluid and cursive, with the first name "Jordan" being the most prominent.

Jordan J. Cohen, M.D.

Cc: Robert Dickler
Senior Vice President

Denise Dodero
Associate Vice President