December 21, 2006

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1321-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore MD 21244-1850

RE: CMS-1321-FC

Dear Ms. Norwalk:

The American College of Physicians (ACP), representing more than 120,000 physicians specializing in internal medicine and medical students, is pleased to have the opportunity to comment on the final rule on revisions of payment policies for physicians in the Medicare program (CMS-1321-FC).

Resource-Based Practice Expense (PE) Relative Value Units (RVUs)
ACP agrees with the Centers for Medicare and Medicaid Services (CMS) decision to implement its proposal to calculate indirect practice expense using a bottom-up approach. This new approach should help to improve the transparency of the inputs into physician payments. ACP also agrees with the decision to implement the proposal to phase-in the practice expense calculation changes over a four-year period. ACP believes this phased approach will allow physicians to adjust to any drastic changes in payment that result from the new methodology.

ACP understands the CMS decision to accept the supplementary practice expense surveys submitted by specialties. These specialties met the requirements set out by CMS. However, it is important to note the disparity in indirect practice expense that can be seen between those specialties that completed supplemental surveys and those that did not. This large disparity once again highlights the importance of the upcoming multi-specialty practice expense survey coordinated by the American Medical Association (AMA). ACP was pleased to see CMS continuing to support this effort through comments in the final rule.

ACP has made a financial commitment to this multispecialty practice expense survey in order to ensure that all specialties receive fair treatment when determining indirect practice expense. This is of utmost importance in maintaining an appropriate relative value system that is fair to all specialties. ACP looks forward to reviewing the results of the pilot test of this survey at upcoming meetings and the eventual inclusion of this data in the practice expense calculation.

ACP disagrees with the CMS decision to use adjusted work RVUs in calculating indirect practice expense. This decision further devalues physician work that is already devalued by the decision to adjust the work for budget neutrality in the first place. This issue was made particularly complex by what was termed an error in the preamble of the rule which stated that CMS decided to use unadjusted RVUs. CMS made the decision to publish unadjusted RVUs with the understanding that these are the true relative values of these codes. Given the mistake in printing and the recognition of the unadjusted values as the true relative values, ACP urges CMS to reverse its published correction and use unadjusted work values in calculating indirect practice expense.

ACP, in its comments on the June 29, 2006 proposed rule (CMS-1512-PN) recommended that CMS implement two proposals regarding practice expense on which it had requested guidance in the past. ACP recommended that CMS reduce the 11% interest assumption used in pricing equipment to more closely reflect market conditions. ACP also recommended that CMS change the utilization rate assumption of 50% to reflect the much-higher utilization of very expensive equipment. CMS, in its final rule, notes that the Medicare Payment Advisory Commission (MedPAC) has also made such a recommendation. ACP believes that this issue is still very important.

ACP is pleased that CMS has committed to examine the issue of this element of the methodology in its comments attached to the final rule. ACP urges CMS to implement these changes as it continues to refine the practice expense methodology. The interest rate assumption should be greatly reduced to reflect market rates for the costs of capital rather than the 11% assumption that is currently used. The utilization assumption for most high-cost equipment should be increased based on a review of the actual utilization of this equipment which is likely much higher. These changes will allow physicians to receive a more accurate payment for services and reduce incentives for physicians to invest in high-expense equipment beyond its clinical utility.

Deficit Reduction Act (DRA)

ACP requests that CMS continue to closely examine the issue of imaging payments and the reductions in payments for contiguous body parts. ACP notes that MedPAC requested more information about the analysis presented to CMS which triggered the decision to continue with a 25% reduction in payment instead of a 50% reduction, but further information was not provided in the final rule. ACP finds it unfortunate that savings achieved through these reductions will not be returned to physicians in the form of a budget neutrality adjustment but continues to believe that all services should be reimbursed fairly.

ACP supports the CMS decision to implement the ultrasound abdominal aortic aneurysm (AAA) benefit as proposed. This newly reimbursed service should be of great use to those who are eligible for it. However, ACP repeats its concerns that fewer beneficiaries will receive this benefit than appropriate because it is tied to the Initial Preventive Physical Examination (IPPE). As has been stated in the past, this code is undervalued and confusing to physicians and for those reasons it is rarely used. If CMS increases the

value of the IPPE to fully recognize the work and other inputs, it will increase beneficiary access to this important service and any services that are tied to it.

ACP also supports the required elimination of the deductible for colorectal screening, but once again notes that counseling provided to patients prior to covered screenings is not a covered service. ACP is encouraged by the recent announcements by CMS highlighting interest in prevention, but requests that all services related to preventive services be properly paid. By recognizing the important work of primary care physicians in contributing to the overall care of Medicare beneficiaries, the program can see improved health in those patients and potential cost savings as more preventive benefits are used.

Health Care Information Transparency Initiative

ACP supports the initiative to increase the transparency of health care costs to patients. Patients should always have the opportunity to understand the costs of the services that will be provided to them in a healthcare setting. However, after reviewing the material that is intended to serve as information for patients on the CMS website released after the close of the comment period, ACP is concerned that this information does not meet the CMS stated requirement of being "useful". ACP understands that this is merely a first step in this initiative, but the information presented as an example of prices for physician services would be unintelligible to all but the savviest Medicare beneficiary. In order for this effort to be successful, the information presented must be understandable to the ordinary beneficiary that is faced with making health care choices.

Even if CMS can improve pricing information to the point that the average beneficiary can understand it, there is still much progress to be made. Understanding the cost of a single service will not necessarily lead a beneficiary to make health choices that are most beneficial to the goals of the individual. In order for patients to make the best decisions, there must be an understanding of the total cost of care, a far more complex number than the payment assigned to a single CPT code. Obtaining this information will take time and ACP encourages CMS to be diligent in pursuing the goal of making accurate and useful information available to beneficiaries.

Five Year Review of Work Relative Value Units

Evaluation and Management Services

ACP commends CMS for its decision to implement its changes to the values of evaluation and management services as proposed. As CMS noted, there was strong support from many commenters in support of this change, including both the RUC and MedPAC. ACP also commends CMS for being careful to reject criticism from other parties and their flawed analysis that was not appropriate for cognitive services. The recognition that cognitive services must be valued in a way that is appropriate for the patients of today was a very important one. ACP was pleased to see that CMS recognized the increasing disease burden of the Medicare patients.

ACP agrees with the CMS decision to not accept a recommendation to transition the E/M changes over time. As discussed in the final rule, work changes have never been transitioned in the past and there is no compelling argument to start doing so now.

ACP urges CMS to adjust the values assigned for End Stage Renal Disease (ESRD) services to reflect the updated values in E/M services used as building blocks for the values of these codes as was suggested in ACP's comments on the proposed rules. The devaluation of these codes is not appropriate and they should be increased to match those codes on which they were based.

ACP supports the CMS decision to include nursing facility codes, home visit codes, and domiciliary codes in the 5 year review based on data that will be presented in 2007. ACP looks forward to reviewing this data during the RUC process.

Cardiothoracic Surgery
ACP disagrees with the CMS decision to not finalize its proposal on the work values of cardiothoracic surgery codes. As CMS notes in both the proposed and the final rule, the work values for these codes were not established using the standard survey process. They were instead established using data from the Society of Thoracic Surgery (STS) database. ACP acknowledges the value of the STS database for patient quality purposes and as a supplement to RUC work surveys. However, in a relative value system, it is of utmost importance to maintain the same tool in determining the work values for codes. Based on the comments in the proposed and final rule, CMS seems to agree that the methodology used for these codes is flawed, but then makes the decision to accept higher work values. ACP urges CMS to maintain the standard of a single process that will maintain the appropriate relativity of the system.

Other Issues under the Five Year Review
ACP appreciates the interest of CMS in further examining the issue of the appropriateness of paying for services under 10 or 90 day global periods. Physicians should be appropriately reimbursed for the work that they perform. ACP again urges CMS to perform a study to determine if the visits contained in the surgical packages are consistent with the number of visits performed on a typical patient. The study should also determine the cost of additional administrative work for CMS and any unintended consequences of any potential changes to the global periods.

Budget Neutrality
ACP strongly disagrees with the CMS method of achieving budget neutrality necessitated by the increases in values that were part of the five year review. Nearly all of the physician organizations disagreed with the CMS proposal to adjust work downward in order to achieve budget neutrality. An adjustment to the conversion factor would be preferable because it recognizes that budget neutrality is a fiscal issue and not an issue of relativity. ACP notes that one of the stated reasons that CMS choose to implement this proposal was because of the anticipated negative update to the conversion factor. With the passage of the Tax Relief and Health Care Act of 2006 after the release of the final rule, there will not be a negative update on the conversion factor. ACP urges CMS to

recognize this change and make the budget neutrality adjustment to the conversion factor instead of to work.

ACP does appreciate the CMS commitment to publish the unadjusted RVUs, but is concerned that private payers will follow the lead of CMS and use adjusted RVUs to calculate payment. ACP strongly encourages CMS to reexamine this issue and make budget neutrality adjustments through the use of the conversion factor.

Review Process
ACP agrees with the comment of MedPAC stating that there are not appropriate mechanisms within the current system to identify overvalued codes. While the 5 year review process is very good at identifying undervalued codes, there is no incentive to identify misvalued codes. ACP supports the RUC efforts to examine this issue further and asks CMS continue to pay attention to this very serious issue.

In addition to the RUC review of this issue, ACP reiterates its recommendation for an outside panel to be responsible for investigating the issue of overvalued codes. This independent expert panel could best be charged with examining these issues.

Interim Relative Value Units

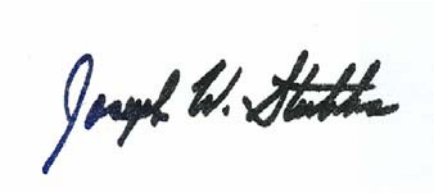
Work Relative Value Unit Refinement of Interim Relative Value Units
ACP commends CMS for publishing the RVUs for all services, including those that are not covered by Medicare. Most private insurers in the country use some form of RBRVS to establish payments and publishing all of the available data will make the payments for all services consistent with the values determined by the RUC. ACP asks that CMS continue to publish the values for all services on an annual basis.

Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology Codes
ACP strongly disagrees with the CMS decision to consider anticoagulation management codes (99363 and 99364) to be bundled into the work of evaluation and management codes. The initial impetus for the creation of this code was the statement by CMS that these services were not managed as well as they should be and that the existing coding structure failed to provide incentives to optimize care. In reaction to this, ACP created a code that would recognize the very important work that a physician does in managing this very serious medication regimen. The complete range of this work is not reimbursed under the current system. During the creation of the code, the CPT editorial panel and the RUC were very careful to create protections in the code that would prevent work from anticoagulation management being included in selecting the level of evaluation and management codes. CMS did not offer any explanation for its decision to bundle these codes into E/M services. The new CPT codes are recognition of the important work of managing serious disease and the CMS decision to not pay for this service could have a devastating impact. ACP reviewed a proposed Correct Coding Initiative (CCI) edit to be used to prevent the billing of a 99211 on the same day of these codes. ACP opposed this edit based on the possibility that such an event could take place on the rare occasion, but

will support the edit if it will prevent any potential fraud that CMS envisions. ACP strongly encourages CMS to reverse its decision and pay for these services in the future.

ACP appreciates the opportunity to comment on this final rule. If you have any questions, please contact Brian Whitman, Senior Analyst for Regulatory and Insurer Affairs at (202) 261-4544 or bwhitman@acponline.org. Thank you.

Sincerely,



Joseph Stubbs, MD
Chairman, Medical Service Committee