January 3, 2011

Donald M. Berwick, MD, MPP
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1503-FC

Dear Dr. Berwick:

The American College of Physicians (ACP), representing over 130,000 internists and students, appreciates the opportunity to comment on: *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule with Comment Period.* This ACP comment letter addresses several issues of importance to the College: the primary care incentive program, the interim final relative values, and the electronic prescribing incentive program.

Section 5501: Expanding Access to Primary Care Services and General Surgery Services

ACP commends CMS on its implementation of Sec. 5501(a) in the ACA and views it as a needed step toward increasing interest in the practice of general internal medicine and other primary care specialties. ACP was concerned that key aspects of the CMS proposed implementation of the PCIP program would unduly restrict the number of primary care general internists and other primary care physicians who would qualify for the incentive payment.

ACP thanks CMS for its modification, in the final rule, of the definition of the total amount of allowed charges of which a minimum 60% must be derived from specified primary care services. We are encouraged that this modification will expand the number of physicians who will be eligible for the incentive payment.

V. Addressing Interim Final Relative Value Units from CY 2011 and Establishing Interim Relative Value Units for CY 2011

ACP is dismayed that CMS did not accept the RUC recommendations for the subsequent observation services (CPT codes 99224, 99225, and 99226), and disagrees with the interim final values assigned to subsequent observation services. ACP requests that CMS

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accept the RUC-recommended values and service times for subsequent observation services. The College believes that the values determined by the survey process, and later recommended by the RUC, are correct. The collected survey data show that subsequent observation services closely approximate subsequent hospital services. RUC survey respondents, randomly chosen internists and surgeons, clearly indicated through their choice of key reference services (CPT codes 99231, 99232, 99233) that the subsequent observation services' physician work values are strikingly similar to those of subsequent hospital services.

In the final rule, CMS values the subsequent observation services codes less than the subsequent hospital care codes because the agency believes that the acuity level of the typical observation patient is less than that of the typical hospital patient. ACP does not believe that is the appropriate comparison when considering subsequent observation services. The subsequent observation services should be compared to subsequent hospital services. Subsequent observation patients are judged by their treating physician to be too ill to discharge, but are not ill enough to be admitted to the hospital under the CMS admission criteria. Consequently, these patients are held in observation status for more than the typical 24 hours and are receiving services that are comparable to that for inpatients.

ACP requests that CMS accept the pre-service, intra-service, and post-service times for the subsequent observation services codes, as recommended by the RUC. All the time components are required in order to determine the medically necessary care for the patient. The agency's decision to remove the pre-service and post-service times and to reduce the work values by 25% is completely arbitrary, and creates values that support its own assumptions about the amount of work required for these services. Removal of the pre-service and post-service times produces rank-order anomalies within the Evaluation and Management services codes.

ACP continues to recommend that the three subsequent observation services codes be valued at the levels that were determined appropriate by the RUC. Those recommended values are:

CPT CODE	**RUC-recommended work RVU**	**RUC-recommended Pre-service time**	**RUC-recommended Intra-service time**	**RUC-recommended Post-service time**
99224	0.76	5	10	5
99225	1.39	9	20	10
99226	2.00	10	30	15

If the RUC recommendations are not accepted, ACP also recommends that CMS more fully explain the rationale for its decisions. ACP encourages CMS to describe its valuation for these codes, in detail. Specifically, the College asks CMS to provide a detailed explanation of how it arrived at the 25% devaluation of the physician work values, to explain why it believes there is no pre-service or post-service physician work

involved, and to indicate which services the agency views as comparable in terms of physicians work and time.

Section 132: Incentives for Electronic Prescribing (eRx)–The Electronic Prescribing Incentive Program

ACP reiterates its support of the efforts of the federal government to facilitate the implementation of eRx use throughout the system. The effective use of eRx will promote increased quality, efficiency, and safety to the care provided to Medicare beneficiaries. ACP also supports CMS's stated intent to develop a plan to better align the measurement reporting requirements among the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR), and eRx incentive programs

ACP remains concerned that the late release of the 2011 Final Rule and the almost immediate 6-month reporting period to determine eligibility for the payment adjustment in 2012 will not provide sufficient time for many practices to implement a qualified eRx system. This will particularly handicap primary care practices that have limited access to needed capital and that are already struggling to meet other quality improvement expectations (e.g. transition to ICD-10; establishment of EHR capabilities, etc).

ACP supports CMS's stated willingness to explore the potential of expanding the qualifying reporting period into 2012.

ACP is disappointed that the hardship exemption categories were not expanded. The College believes CMS underestimates the significant burden of eRx implementation at this time on small, particularly primary care practices, and is concerned that this unnecessary, added burden may contribute to an increase in these physicians leaving the field, e.g., early retirement. The College continues to believe that these exemption categories are too limited, and should be expanded to include at least small practices (1-2 physicians) and practices located in health professional shortage areas.

Thank you for considering the ACP comments. Please contact Debra Henley Lansey, Associate for Regulatory and Insurer Affairs, by phone at 202-261-4544 or e-mail to DLansey@acponline.org if you have questions and/or need additional information.

Sincerely,

Donald W. Hatton, MD, FACP
Chair, Medical Services Committee