March 24, 2006

Terry Kay
Deputy Director, Hospital and Ambulatory Policy Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard, C4-01-15
Baltimore, Maryland 21244

Dear Mr. Kay:

The undersigned organizations appreciate the opportunity to comment on various issues related to the methodological issues under consideration in determining resource-based practice expense relative values. The Centers for Medicare and Medicaid Services (CMS) February 15, 2006 Practice Expense Town Hall meeting presented a number of options that your staff are currently developing for a proposed rule to be released this summer. Rather than comment specifically on one or more of those four options discussed at the meeting, we offer input on the underlying assumptions utilized in many or all of the potential options under consideration.

Direct Expense

CMS continues to praise the results of the AMA/Specialty Society RVS Update Committee (RUC) review of direct practice expense inputs (ie, clinical staff, medical supplies, and equipment). The review and refinement of these inputs through the RUC's Practice Expense Advisory Committee (PEAC) resulted in dramatically improved inputs as compared to the original inputs identified via the Clinical Practice Expense Panels (CPEPs). CMS staff have referred to these direct practice expense inputs as the best micro-costed data available for a Medicare payment system. We believe that this is a result of significant efforts of the PEAC, specialty society advisors, and staff. We also commend CMS for your efforts during this refinement process and for your continued motivation to enhance these data.

Medical Supplies

While we believe that the inputs have been appropriately quantified, we are concerned that the pricing of these inputs may need refinement. Our first area of concern is in regard to high cost disposable medical supplies. There are many supply items that are priced above $200. Any inaccurate pricing of these supplies could create incentives for inappropriate shifts in the site-of-service. **We recommend that CMS begin pricing expensive (>$200) supplies on an annual basis, beginning with the 2007 physician payment schedule.**

Medical Equipment – Utilization Rate

In response to comments on the initial implementation of the resource-based practice expense methodology in 1998, CMS modified the Abt Associates equipment utilization assumption of 70% to a 50% assumed utilization for all procedure specific equipment. This equipment utilization rate has not been re-examined since 1998. **We believe that CMS should work with the physician community to examine whether variable utilization rates would more accurately price medical equipment at the procedure level.**

We understand that MedPAC will review certain high-cost equipment (MRI and CT) and may offer recommendations in their June 2006 report. The RUC has also discussed the potential to classify medical equipment into various low/medium/high categories, with utilization rates of 25%/50%/75%, respectively. However, the RUC acknowledged the difficulty in making new assumptions without adequate data. **We therefore support a review of equipment utilization rates. To ensure objectivity, this review should include all equipment (or potentially all equipment above a certain dollar threshold). Any savings achieved through this review should be redistributed within the Medicare physician payment system to avoid further depletion of an already inadequate funding pool.**

Indirect Expense Allocation

The allocation of indirect expense is inherently an arbitrary decision based upon judgments regarding how overhead costs (rent, administrative staff, office supplies and equipment) may be attributed to specific services. CMS has requested specific comments on a number of these "judgments" at the February 16 Town Hall meeting and in written documents following this meeting. We are unable to provide a "consensus" decision on any of these "judgments" or variables at this time. **We recommend that CMS should seek the input of the RUC at its April 26-30, 2006 on the following issues:**

- Which methods of allocation are most appropriate: physician work, physician time, and/or direct expense? When using a combination of these allocations, should each be given the same weight in the allocation?

- Within the direct expense portion of the allocation, should supplies and/or equipment costs be used to allocate indirect expenses? CMS indicates that there is some argument for equipment (eg, more space, shielding, reinforcement of floors), while remaining more skeptical regarding the use of supplies as an allocation.

CMS should consider all of the comments that are received from specialty societies by March 24th and then request feedback from the RUC on a number of options that CMS may wish to consider and model for the 2006 proposed rule. For example, CMS has indicated that one additional option may be to apply a simple method of deriving code-specific indirect practice expense relative values utilizing the specialty-specific indirect percentages of total costs from the SMS and supplemental surveys and applying that directly to some combination of the direct expense and work relative values.

CMS has requested input on a variety of suggestions for allocating indirect costs. Specific examples of the effect of alternative approaches to indirect cost allocation, including methodologies to address services without a physician work RVUs, would be very helpful to the RUC's discussion in April. In the absence of concrete information about the operation and impact of different indirect cost methodologies, the RUC may struggle to provide meaningful guidance to CMS. Neither the AMA nor any of the specialties can accurately and credibly model the impact of alternative methods as well as CMS could. We urge CMS to provide impact data for alternative indirect cost methodologies for purposes of discussion at the April RUC meeting.

We recommend that CMS seek RUC input on the indirect cost methodology and specific allocation methods at the April 26-30, 2006 RUC meeting.

Multi-Specialty Practice Expense Survey

CMS currently utilizes practice expense data and physician hours from the 1995-1999 AMA Socioeconomic Monitoring System (SMS) survey to calculate a "practice expense per hour" estimation for each specialty. The AMA discontinued the SMS survey in 2000. Since this time, the practice expense per hour data has been modified for certain specialties that have conducted supplemental surveys to collect more recent data. CMS has stated that although the agency expects to utilize the current supplemental survey data beginning on January 1, 2007, it does not plan, at this time, to accept any new supplemental survey data.

Regardless of what CMS decides on the supplemental survey, there will be a need for updated data. At that time, all of medicine should be surveyed at once, using a consistent approach. The specialties, who have previously conducted supplemental surveys, should be part of a multi-specialty survey effort, as their data will one day be outdated. Those specialties will argue that their data should be implemented and utilized until new data from a multi-specialty practice expense survey are available. Other specialties may comment to you that CMS should refrain from any further practice expense methodological changes until data from a multi-specialty practice expense are available. **We are all in agreement, however, that moving forward, it is imperative that a multi-specialty practice expense survey be conducted to collect recent, reliable,**

consistent practice expense data for all specialties and health care professionals. We urge CMS to work with the AMA and other physician and health professions organizations to achieve this goal.

Transition and Impacts

We understand the CMS desire to utilize the improvements in the direct expense data and to simplify the practice expense methodology. However, we are concerned that 2007 may be a devastating year for many practicing physicians in the United States. Physicians are facing a conversion factor reduction from the failed SGR formula, budget neutrality adjustments from the current Five-Year Review, elimination of the physician work Geographical Practice Cost Index (GPCI) floor and reductions in payments to imaging services resulting from the Deficit Reduction Act (DRA). Any change in the practice expense methodology will result in redistribution, and therefore, some specialties will face yet another source of reduction in payments. **If CMS is determined nonetheless to proceed with practice expense changes next year, we urge you to transition any practice expense methodological changes over a period of not less than three years. In addition, we recommend that CMS implement limits to the potential practice expense payment changes to individual medical services to protect patient access.**

We appreciate the opportunity to comment on the resource-based practice expense methodology and look forward to continued dialogue as you consider changes to improve this component of Medicare physician payment.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Academy of Facial, Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology – Head and Neck Surgery
American Academy of Pain Medicine
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Academy of Physician Assistants
American Association for Geriatric Psychiatry
American Association of Clinical Endocrinologists
American Association of Clinical Urologists
American Association of Neurological Surgeons
American Association of Neuromuscular and Electrodiagnostic Medicine

American Association of Oral and Maxillofacial Surgeons
American Association of Orthopaedic Surgeons
American Chiropractic Association
American Clinical Neurophysiology Society
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Nurse Practitioners
American College of Obstetricians and Gynecologists
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Rheumatology
American College of Surgeons
American Dental Association
American Dietetic Association
American Geriatrics Society
American Institute of Ultrasound in Medicine
American Medical Association
American Medical Directors Association
American Medical Group Association
American Occupational Therapy Association
American Optometric Association
American Osteopathic Academy of Orthopedics
American Osteopathic Association
American Pediatric Surgery Association
American Physical Therapy Association
American Podiatric Medical Association
American Psychiatric Association
American Roentgen Ray Society
American Society for Aesthetic Plastic Surgery
American Society for Reproductive Medicine
American Society for Surgery of the Hand
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society of General Surgeons
American Society of Nephrology
American Society of Plastic Surgeons
American Speech-Language-Hearing Association

American Thoracic Society
American Urological Association
Association of American Medical Colleges
Child Neurology Society
Congress of Neurological Surgeons
Emergency Department Practice Management Association
Infectious Diseases Society of America
International Spine Intervention Society
Joint Council of Allergy, Asthma and Immunology
Medical Group Management Association
National Association of Social Workers
North American Spine Society
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Maternal-Fetal Medicine
Society for Vascular Surgery
Society of American Gastrointestinal Endoscopic Surgeons
Society of Interventional Radiology
Society of Nuclear Medicine
The Endocrine Society