September 30, 2005

Mark B. McClellan, MD, PhD, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1502-P

Dear Dr. McClellan:

The American College of Physicians (ACP), representing 119,000 internists and medical students, is pleased to comment on the Centers for Medicare and Medicaid (CMS) proposed rule "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006," published in the August 8, 2005 *Federal Register*. The ACP comments address the following issues:

Resource-based Practice Expense Relative Value Units (RVUs);
Practice Expense Proposals for Calendar Year 2006
Miscellaneous Practice Expense Issues: Clinical Labor for G Codes Related to Home Health and Hospice Physician Supervision, Certification and Recertification
Medicine Telehealth Services;
Medical Nutrition Therapy
Definition of an Interactive Telecommunications System
Multiple Procedure Reduction for Diagnostic Imaging
Sustainable Growth Rate

As requested, our specific comments, below, are contained under the headings referenced in the August 8, 2005 *Federal Register* notice.

Resource-Based Practice Expense RVUs

Practice Expense Proposals for Calendar Year 2006

Use of Bottom-Up Methodology to Calculate Direct Practice Expense Costs: ACP supports the CMS proposal to use the "bottom-up" methodology to calculate direct practice expense costs. ACP has long supported a bottom up approach to establishing

practice expense RVUs. The College agrees with CMS that the clinical labor, supplies, and equipment inputs identified by the Clinical Practice Expert Panel (CPEP) and refined by the Practice Expense Advisory Committee should be used to determine direct practice expense costs and be factored into the calculation of practice expense RVUs. We agree with the CMS statements that its proposed methodology will be more accurate because the practice expense inputs are better refined and more current than those it has historically used; and because the bottom-up methodology assumes that the costs of the clinical labor, supplies, and equipment are the same for a given service, regardless of the specialty that is performing it. This assumption does not hold true under the top-down direct cost methodology, where the specialty-specific scaling factors create widely differing input costs for the same service.

Submission of Supplemental Survey Data: ACP supports the use of current, reliable physician practice costs data. We note the substantial increase in practice expense per hour that CMS proposes to implement for specialties for which the agency accepted supplemental survey data. While an extension of the recently expired deadline for specialties to submit supplemental data would likely result in submission of data by some additional specialties, it is unlikely that all specialties would participate. Therefore, ACP recommends that CMS commit to engaging stakeholders to establish a process to update practice expense costs that will include all specialties. A CMS-established stakeholder process would help the agency address the issues that it identified in this proposal for consideration: whether it would be preferable and feasible to have a Socioeconomic Monitoring Survey (SMS)-like survey of only indirect costs for all specialties and whether a more formula-based methodology independent of the SMS data should be adopted.

ACP supports the CMS goal of making its practice expense methodology more accurate, more intuitive, and more stable, and the College looks forward to working with the agency to achieve this goal.

Transitioning the Resulting Practice Expense RVUs over a Four-Year Period: ACP supports the CMS proposal to transition practice expense RVU changes resulting from methodological changes in this proposed rule over a four-year period. ACP reiterates its recommendation to convene a multi-stakeholder process to address indirect practice expense methodological issues so that the agency can make further changes before final implementation.

Miscellaneous Practice Expense Issues: Clinical Labor for G Codes Related to Home Health and Hospice Physician Supervision, Certification and Recertification

ACP requests that CMS elaborate on the sequence of events that generated the decrease in practice expense RVU for the G codes for care plan oversight, G0181-G0182, and for home health care plan certification and recertification, G0179-G0180, under its proposal. We understand the rationale behind the CMS proposal to incorporate the most recent direct clinical labor practice expense input, established by CMS through the implementation of the 2004 Medicare fee schedule, into the payment for these codes.

However, we are unclear as to how CMS generated the specific practice expense RVU for these four G codes in this proposal. CMS cross walked the direct clinical labor practice expense for Current Procedural Terminology (CPT) code 99375, care plan oversight for a patient receiving home health care services, when it established and assigned a practice expense RVUs to G0179 and G0180 through the 2001 Medicare fee schedule. In this proposal, CMS states that it revised the direct clinical labor practice expense input for CPT 99375 and 99378, care plan oversight for a patient receiving hospice care, in 2004. However, we note that the CMS-assigned non facility practice expense RVU for CPT 99375 has remained relatively stable since 2003: 1.57 in 2003; 1.55 in 2004; and 1.55 in 2005 (the 2006 proposed rule does not contain a proposed practice expense RVU for CPT 99375). While we realize that a practice expense RVU can change for a variety of reasons, we question why the practice expense RVU for the four G codes in this proposed rule decrease significantly more than the RVU decrease for CPT 99375 from 2003 to 2004.

Medicine Telehealth Services

Medical Nutrition Therapy

ACP agrees with the CMS proposal to add medical nutrition therapy (MNT) provided to an individual beneficiary to the list of Medicare-covered telehealth services. ACP requests that CMS clarify that Medicare will pay a physician practice for MNT provided to individual beneficiaries through interactive telecommunications systems by a qualified provider—a registered dietician or other nutrition professional—employed by the physician when the qualified provider reassigns his or her right to payment to the physician practice as an employer.

CMS should adjust the Sustainable Growth Rate expenditure target if it decides to cover additional telehealth services.

Definition of an Interactive Telecommunications System

ACP recommends that CMS revise its definition of an interactive telecommunications system to include two-way audio and one-way video telecommunication equipment. Although two-way video may add value to a telehealth consultation by allowing the patient and presenting provider to see the body language and non-verbal communication presented by the consulting physician, we believe that including one-way video will expand access to beneficial telehealth services. Telehealth consultations can enrich the delivery of medical care at remote sites such as rural areas and can provide rural physicians with current medical information that may not be readily available in an isolated setting. Medicare reimbursement should be made for physician services that are reasonable and necessary, safe and effective, medically appropriate and provided in accordance with accepted standards of medical practice. The technology used to deliver the services should not be the primary consideration.

Multiple Procedure Reduction for Diagnostic Imaging

The ACP supports the provision in the proposed rule that reduces payment for the Technical Component (TC) of certain diagnostic imaging procedures that are furnished in a single session and occur on contiguous body parts. These reductions affect diagnostic imaging services in 11 designated families of procedures defined by modality and contiguous body area. We agree that practice expenses are less for subsequent imaging procedures that occur under the above conditions. The College believes that this policy is a reasonable way to partially address the rapid and sustained growth in the volume of imaging services provided to Medicare beneficiaries. The College also strongly encourages CMS to adequately consult and involve physicians in the process of expanding imaging coding edits.

Sustainable Growth Rate

ACP believes that the Sustainable Growth Rate (SGR) formula is flawed and should be replaced. The time to replace the SGR is now as physicians face an across-the-board payment reduction of over 4 percent in 2006 and a cumulative 26 percent from 2006-2011. Many physicians, particularly those in small office settings who treat the majority of Medicare beneficiaries, cannot remain in practice with this level of reimbursement reduction. The underlying flaw of the SGR formula is the link between the performance of the overall economy and the actual cost of providing physician services. The medical needs of individual patients are not related to the overall economy.

ACP urges Congress to pass legislation to replace the SGR formula with a system linked to changes in the actual costs of medical practice. ACP supports basing updates on the projected change in input prices less an adjustment for productivity growth, as has been recommended by MedPAC and included in the Medicare Value-Based Purchasing for Physicians' Services Act of 2005 (H.R. 3617) recently introduced by Representative Nancy Johnson. We urge CMS to cooperate in this effort to replace the current SGR formula and to help ensure adequate access to physician services for Medicare beneficiaries.

Until Congress replaces the SGR, CMS must use its administrative authority to make adjustments to the SGR that more accurately reflect physician contributions to increased expenditures. Specifically, ACP recommends that CMS remove, retroactive to the inception of the SGR, the physician-administered drugs from the SGR formula calculation; and include the full cost of new Medicare benefits and coverage decisions in the SGR target. In July 2004, nearly 100 physician organizations sent a joint letter to Dr. McClellan urging CMS to exercise its administrative authority to take these actions. In July 2005, House Ways and Means Committee Chair, Representative Bill Thomas, and Ways and Means Subcommittee on Health Chair, Representative Nancy Johnson, sent a joint letter to Dr. McClellan urging similar action.

ACP supports the MedPAC recommendation that volume should be managed, not by expenditure targets such as the SGR formula, but through a process in which the reasons for each significant volume increase are identified, and specific measures are taken either administratively or through legislation to control those increases not related to improvements in quality of care. Addressing volume through careful analysis and consideration, with appropriate policy interventions, will be far more effective in assuring that appropriate care is provided than the flawed SGR.

The ACP has taken a leadership role in efforts to introduce health information technology (HIT) and pay-for-quality initiatives within the physician office setting. We believe these efforts have the potential to help control the growth in Medicare spending outlined in the proposed rule through facilitating more efficient, effective care. Unfortunately, the significant reimbursement cuts projected from the current SGR formula will make it impossible for the average physician to purchase the necessary HIT—and implement the changes in their work flow—to participate in these efforts. The SGR must be replaced with a reimbursement method that is linked to increases in the actual costs of medical practice to allow for these HIT and pay-for-quality initiatives to be successfully implemented.

ACP appreciates the opportunity to comment. Please contact Brett Baker, Director, Regulatory and Insurer Affairs, by phone at (202) 261-4533 or e-mail at bbaker@acponline.org if you have questions.

Sincerely,

Joseph W. Stubbs, MD, FACP
Chair, Medical Service Committee