Alliance of Specialty Medicine

Sound Policy. Quality Care.

December 30, 2010

Donald Berwick, MD
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
Posted electronically

Re: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011
CMS-1503-FC

Dear Dr. Berwick:

The Alliance of Specialty Medicine (Alliance) and its member organizations are pleased to provide comments on several of the final changes to the Medicare Physician Fee Schedule for CY 2011. The Alliance is a coalition of 10 national medical specialty societies representing more than 200,000 physicians and surgeons. We are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

Establishment of Interim Final RVUs for CY 2011

The Alliance is concerned about the increased rate of CMS rejection of AMA RUC recommended work values for 2011. The Alliance continues to support the AMA's Relative Value Update Committee (RUC) and its' efforts to improve the accuracy of the Medicare Physician Fee Schedule (MPFS) Resource-Based Relative Value Scale (RBRVS). For 2011, CMS received RUC recommendations for 291 new, revised and potentially misvalued codes. Of the 291, CMS indicated that it only accepted 207 (71 percent) of the AMA RUC-recommended values; providing alternative values for the remaining 84 (29 percent). Historically, the rate of acceptance of the AMA RUC recommendations has been much higher; typically 90 percent or greater. CMS stated in the final rule that "in response to concerns expressed by MedPAC, the Congress, and other stakeholders regarding the accurate valuation of services under the PFS, we have intensified our scrutiny of the work valuations of new, revised, and potentially misvalued codes." We understand that CMS has expended significant effort in evaluating RUC-recommended values, employing "rigorous clinical review" to examine pre-, post-, and intra-service components of physicians' work. We acknowledge that the ACA directs the Secretary to establish a process to validate RVUs within the PFS. We also understand that the RUC process is not perfect. However, in the Final Rule, CMS does not describe any new policies or approaches it employed to validate RVUs. Rather, the Final Rule appears to merely detail a higher rejection rate of RUC recommended physician work values based on "clinical review" that is not described. We do not know what type of clinicians conducted this review or what process was used.

The Alliance believes that the AMA RUC recommended physician work values typically represent the most thoroughly vetted estimates for the value of physician work available at this time. The RUC provides a deliberative process for evaluating physician work, which uses standard physician work estimation surveys to develop physician work RVU recommendations, ensuring relativity within the RBRVS. The significant increase in the percentage of RUC recommended values rejected by CMS is not well supported or explained. In most instances, CMS has not provided any substantive evidence for rejecting the RUC recommendations nor does CMS provide substantive evidence in support of the alternative values CMS assigned. The alternative values often contradict

both the RUC survey data and building block estimates, which are based on long-standing, established methodologies used in fairly valuing physicians' work.

The valuation of procedures and services can impact access to care across the nation. Undervaluation of a service can result in underpayment and inability of physicians to provide the service in question. The Alliance believes that the AMA RUC valuation process has evolved to effectively address many of the recent concerns raised by MedPAC, Congress and other critics. This process currently represents the best practice for fairly establishing values for physician work under the RBRVS. We do not support CMS' substitution of a duplicative review process that may not be informed by practicing procedural and cognitive physicians and that results in such a significant increase in the rejection of RUC recommended physician work values.

The Alliance is pleased that CMS has proposed making the Medicare Refinement Process more transparent. However, we find that the Refinement Panel appeals process used to challenge RUC recommendations has not yet been adequately developed and requires greater transparency. This lack of a clear appeals process may be driving many of the complaints about the RUC process that have been surfacing in the media and among legislators in recent months. The Alliance feels it would be more beneficial for CMS to direct its limited resources to enhancing the Refinement Panel process by making it more open and transparent rather than waste valuable public resources trying to replicate the work of the RUC.

Electronic Prescribing Penalties

The Alliance has serious concerns with the decision of CMS to finalize its proposal to base the initial round of e-prescribing penalties on claims-based reporting during the first six months of 2011. The "Medicare Improvements for Patients and Providers Act of 2008" (MIPPA) (P.L. 110-275), which created the e-prescribing program, clearly supports delaying penalties against physicians who do not e-prescribe to 2012. Despite the opportunity for delay, CMS is requiring that an eligible physician report the e-prescribing G-code at least ten times for applicable Medicare office visits and services for the January 1, 2011 through June 30, 2011 reporting period in order to avoid penalties in 2012. With a reporting period that begins only a couple of months after the final rule was published, physicians simply will not have adequate time to purchase and implement electronic prescribing software. We urge CMS to revise the 2012 and 2013 penalty criteria. Financial penalties should only be levied in 2012 and 2013 against Medicare eligible physicians who fail to meet the e-prescribing reporting requirements or fail to qualify for an exemption by the end of 2012 or by the end of 2013.

As determined by CMS, physicians will not be able to receive incentives from both the Medicare e-prescribing and Medicare EHR incentive programs simultaneously. Therefore, in 2011, 2012, and 2013, physicians must choose to participate in only one of these programs. Many physicians who have not yet purchased an e-prescribing or an EHR system, including many specialists for which such certified systems are still rare, have decided to forego the e-prescribing incentive program and focus their limited time and resources on evaluating options for a comprehensive EHR. The members of the Alliance were very disappointed to learn that CMS finalized its proposed provision to penalize physicians who successfully fulfill the criteria of the Medicare EHR incentive program, which entails adoption of a comprehensive EHR that does more than just enable e-prescribing. Under the final rule, these physicians must also meet the e-prescribing incentive program requirements in order to avoid the penalty. This policy seems duplicative, incongruous and contradictory to CMS's stated goal of improving the quality, efficiency, and coordination of care. It is unreasonable to penalize physicians who are working in good faith to adopt a certified EHR product for participation in the Medicare EHR incentive program. Furthermore, given the difficult economic environment, it makes little sense to force physicians to purchase and use a stand-alone e-prescribing program during the initial months of 2011, simply to avoid penalties that, by law, need not be imposed until 2012.

We are also disappointed that, in the final rule, CMS only permitted claims-based reporting for the e-prescribing program and did not offer any options for physicians to use a qualified registry or EHR to report e-prescribing activity. It is most regrettable that it is not "operationally feasible" for CMS to accept data submissions from electronic health records and registries in the required time frame. This means that physicians who use a qualified registry or EHR will also have to submit claims with the G code in order to avoid a penalty- a process that is duplicative and time-consuming and will reduce physician time with patients.

We reiterate the concerns expressed by many commenters during the public comment period on the proposed PFS rule for CY 2011 and urge the federal government to better align the overlapping Medicare HIT incentive

programs. This is essential to minimize confusion and prevent the imposition of unnecessary financial and administrative burdens on physician practices.

The Alliance of Specialty Medicine supports the goals of improving quality of care and care coordination processes. We recognize that physician adoption of electronic health records will further these goals. Implementation of the provision to base 2012and 2013 e-prescribing penalties on claims reporting in 2011 is unreasonable, impractical, and will only hamper adoption of electronic health records by creating unnecessary costs and confusion. We ask CMS to extend the reporting period for the e-prescribing program so that 2012 and 2013 penalties are based on reporting during those years and not 2011. We also ask CMS to develop an exception to the e-prescribing penalties in 2012 for eligible providers who earn the Medicare EHR incentive in 2011 or 2012. Finally, we request that CMS provide regular feedback reports on physician participation in the e-prescribing program and create a standardized appeals process for physicians that want to appeal determinations related to eligibility and incentive qualification.

Thank you for your attention to our concerns and to the unique needs and contributions of specialty medicine. We would be happy to discuss the issues raised in further detail, as needed. We look forward to working with you to meet the needs of Medicare and Medicaid patients. Please contact: Inger Saphire-Bernstein (410-6893745) isaphirebernstein@auanet.org or Rachel Groman (202-446-2030) rgroman@neurosurgery.org if you have any questions on this letter.

Sincerely,
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Gastroenterological Association
American Society of Cataract & Refractive Surgery
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
Heart Rhythm Society
National Association of Spine Specialists
Society for Cardiovascular Angiography and Interventions