



December 29, 2008

Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1403-FC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-1403-FC. 42 CFR Parts 405, 409, et al.

Dear Acting Administrator Weems:

The American College of Physicians (ACP), representing over 126,000 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 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); Final Rule.*

Conversion Factor and the Update

ACP appreciates the Centers for Medicare and Medicaid Services (CMS) role in realizing and implementing a positive update of 1.1% for 2009. We urge CMS to continue working with the Congress to achieve positive updates in future years.

Budget Neutrality Adjustor

ACP is pleased with the CMS implementation of the statutory provision requiring it to make the budget neutrality adjustment needed to accommodate the recent Five-Year Review changes to the conversion factor (CF). We believe that applying the budget neutrality adjustment to the CF as opposed to the work relative value units (RVUs) is the preferred methodology and is consistent with the methodology used for adjusting the physician fee schedule in past years.

Misvalued Codes

ACP shares the concern expressed by the Medicare Payment Advisory Commission (MedPAC) and others that the fee schedule contains misvalued services that can cause distortions. The College is especially concerned with how distortions adversely impact primary care and other services furnished by internists.

ACP supports the efforts of CMS and the Relative Value Scale Update Committee (RUC) to identify potentially misvalued services using a series of objective screens, including emphasis on fast-growing services and focus on services for which the relative value is based on the original Harvard study. However, ACP continues to doubt whether this process alone can sufficiently identify and then correct overvalued services. The College agrees with MedPAC that an independent review panel comprised of individuals with diverse expertise would be a valuable supplement to the RUC and its efforts.

Further, ACP continues to urge CMS to change its current assumption that all equipment is used 50% of the time and ACP is concerned that the issue is not addressed in this year's proposed rule. ACP supports the creation of mutually exclusive categories of equipment with different utilization rates.

Independent Diagnostic Testing Facilities

ACP supports the CMS decision to refrain from implementing its proposal to require physician practices that perform diagnostic testing services to enroll as Independent Diagnostic Testing Facilities (IDTF). Finalizing this proposal would have created a significant administrative burden that is unlikely to increase quality or further safeguard against abuse.

While the CMS statement that it has deferred implementation of the proposal while it continues to review public comments seems to indicate intent to move forward, ACP recommends that the agency take no further action. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted into law in July of 2008, provision that requires that all physician practices that provide advanced diagnostic imaging services such as magnetic resonance imaging (MRI) and computed tomography (CT) be accredited by an appropriate organization significantly changes the environment and seems to obviate the need for the agency to implement this proposal. At a minimum, CMS should assess the implementation of the accreditation requirements for advanced diagnostic imaging before it gives further consideration to this proposal.

Computer-Generated Fax Exemption

We commend CMS on reversing its position and, thus, retaining the computer-generated fax exemption. The agency's decision will help physicians in transitioning to e-prescribing.

Physician Quality Reporting Program

ACP is pleased that CMS is expending more effort on physician education and resource tools for Physician Quality Reporting Initiative (PQRI). We appreciate that the agency's outreach to key constituencies is aimed at promoting more awareness and participation in the program. We are encouraged that CMS continues to offer a variety of reporting options and reporting periods, as enabling physicians to select an option that best fits their practice will help grow interest and participation.

Specifically, the College recommends that CMS

- Release information on the selection of registries eligible to transmit data on behalf of physicians and the associated reporting specifications as promptly as possible. While the nature of registries involves electronic storage and retrieval of information, announcing eligible registries well into a reporting period can make participation through this option more daunting.
- Disseminate the lessons the agency has learned from the 2008 measures group reporting experience as soon as possible so that those interested in this option, which does not require reporting on patients throughout the year, can benefit in a manner still timely to influence their 2009 participation.
- Notifying a physician reporting a measures group once he or she has met the requirements for successful reporting. While ACP supports continued physician reporting after meeting initial requirements and throughout a reporting period, timely feedback to those using this reporting option would seem most feasible and would help to address widespread physician concern about the lack of timely feedback/interim reports.
- Continue to work to refine the process relating to reporting and performance score feedback reports, including layout and accessibility.
- Thoroughly test electronic health record-based reporting so as to be able to implement it as a reporting option through which physicians can earn a bonus payment promptly and smoothly.
- Provide reward commensurate with the reporting effort and the impact of the evidence-based care on the patient and the health care system.

The College strongly believes, however, that the significant problems internists and other physicians have experienced in their attempt to participate—not qualifying for a bonus they thought they earned, receiving a bonus payment amount less than expected, being unable to access their feedback on the CMS secure website—pose serious challenges to future growth of the program. While we appreciate that CMS issued a December 2008 report on the 2007 PQRI experience and identified solutions to a number of the identified problems, a sustained effort to evaluate and improve the program is essential. ACP recommends that CMS continue to work with the College and others to review the experience of the program, learn from it, and make improvements.

Physician Certification and Re-certification

ACP appreciates the CMS decision to study the physician certification and recertification of patient home health care plans issue further before taking any action. In our comment letter in response to the 2009 fee schedule proposed rule, the College urged the agency to discuss its specific concerns and ideas for potential solutions with ACP and other organizations representing the physicians who would be most directly affected by a change. We are pleased that CMS is amenable and looking forward to engaging in a discussion of potential appropriate next steps.

Initial Preventive Physical Examination

ACP supports the expansion of the period during which a beneficiary is eligible to receive a covered initial preventive physical examination (IPPE) from six to 12 months.

This action and the waiving of the deductible help to decrease the barriers beneficiaries face in receiving this service.

The College recommends that CMS address another significant obstacle by reassessing the value that determines that payment for this service. While CMS rejected the ACP request to use the value assigned to the existing Current Procedural Terminology Preventive Medicine service code for a Medicare–age beneficiary when initially valuing the IPPE, the College has supported numerous requests from the RUC asking that it be allowed to recommend a value for the IPPE service. The IPPE was already undervalued and the deficiency in the payment only increases with the definition of the service expanded to include body-mass index assessment and end-of-life planning services.

E-Prescribing Incentive Program

ACP appreciates the daunting task that CMS faces in having six months to establish the E-prescribing Incentive Program and commends the agency for its outreach. The College believes that one significant barrier to physician participation within the E-prescribing Incentive Program is the relatively laborious process of reporting HCPCS G-codes on the CMS-1500 form. The College strongly recommends that CMS proceed with its stated plan to implement a non-claims based e-prescribing incentive eligibility and payment determination method as planned for 2010, if not sooner; and that the agency identify the technical and other aspects that may pose implementation challenges early in the process.

Further, the College recommends that CMS develop procedures to provide physicians with feedback at various intervals throughout 2009, e.g., quarterly, regarding their performance on the e-prescribing incentive performance measure. This will provide assurance to those physicians who are correctly reporting and an opportunity for those physicians who are reporting incorrectly to modify their approach. Inability to provide immediate or interim feedback in the PQRI bonus program has been a major shortcoming and source of physician frustration.

Finally, the College recommends that CMS work with the Certification Commission for Health Information Technology (CCHIT) to ensure that the Commission initiates a certification process for free-standing e-prescribing systems no later than in 2009. This certification should serve, at a minimum, as a guide to physicians on whether a system meets the standards required to participate within the E-prescribing Incentive Program. The College believes that the availability of this type of assurance will promote program participation.

We encourage CMS to think strategically about the longer term goal rewarding use of e-prescribing to its full capability. Linking incentives to use of full e-prescribing functionality may be prudent after physicians gain e-prescribing experience and once the development of the e-prescribing environment, which involves many stakeholders, sufficiently evolves.

Payment for Preadministration-Related Services for Intravenous Infusion of Immune Globulin

ACP is apprehensive about the CMS decision to discontinue payment for this pre-administration service (HCPCS code G0332). We acknowledge the reasoning that, based on the Office of Inspector General report, the market has now stabilized, increasing the supply and access to IVIG. We note that the change is significant as it results in an average revenue loss of \$75.00 per IVIG session.

ACP urges CMS to continue to monitor the market for pre-administration cost for another one or two years, to be certain that the current price stability is not a temporary one. We believe that if prices again begin to fluctuate significantly, the inability of physicians to recover their provision costs could result in decreased beneficiary immunization rates.

ACP appreciates the opportunity to provide its insight on these many topics of concern to internal medicine specialists. If you have questions on any of our recommendations or positions, please contact Debra Lansey, Associate in the Regulatory and Insurer Affairs Department, at dlansey@acponline.org or (202) 261-4544.

Sincerely,

A handwritten signature in cursive script, appearing to read "Yul Ejnes MD".

Yul Ejnes, MD, FACP
Chair, Medical Service Committee