



January 3, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1524-FC
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, Maryland 21244-1850

RE: Medicare Program; Payment Policies under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012 (CMS-1524-FC)

Dear Ms. Tavenner:

On behalf of the 5,000 cardiologists in private practice and within integrated organizations across the country that we represent, the Cardiology Advocacy Alliance (CAA) submits the following observations about the final 2012 Medicare physician fee schedule rule with comment period. CAA's mission is to support the sustainability of the cardiovascular professional regardless of practice setting. CAA represents the common interests of the cardiovascular patient and professional on such issues and encourages its members to advocate for their patients and their practices. CAA member practices devote themselves to continuous quality improvement and use benchmarking data and other tools to ensure that they are offering the highest quality care to their patients. As such, the super majority of CAA members have electronic medical records and already have attained the meaningful use threshold for Phase I.

As CAA has observed in the past, our membership continues to be very concerned about the economic realities of providing quality cardiac medical care in the private practice setting. Over the coming years, we believe that the number of private practice cardiologists nationwide will be reduced by half with physician groups selling to hospitals and integrated systems or becoming full-time employees of a hospital system. The loss of private practice cardiologists will significantly alter the marketplace dynamics of health care delivery. As the Centers for Medicare & Medicaid Services (CMS) is well aware, the cost of providing services under the Hospital Outpatient Prospective Payment System is significantly higher than the same services reimbursed under the Physician Fee Schedule. Thus, CAA continues to urge CMS to consider the long-term effects of payment policies and reimbursement changes on the specialty of cardiology.

Potentially Misvalued Services Under the Physician Fee Schedule

CAA appreciates the Agency's inclusion of the list of potentially misvalued codes in both the proposed and final rule with comment period. The inclusion in the proposed rule provides notice to practices that changes are likely to these codes and for them to work with their professional associations to provide feedback to the American Medical Association Relative Value Update Committee (AMA RUC) on the codes.

As observed in the final rule with comment period, CAA agrees that time and motion studies would be very time consuming for the Agency and medical professionals being observed; thus likely cost prohibitive. While CAA concludes

that actual observation of how medicine is practiced is the best source for data on time and resource intensity for health care services, this actual data is not the foundation for the current system which is generally based on correlation of a few medical services and historical valuations (multispecialty points of comparison services).

Specifically, CMS solicited feedback on other data sources and possible methodologies for developing a system-wide validation system (76 FR 73055). CAA commends CMS to push forward on this laudable aspect of the entire payment system for all payers. Yet, the basis of the system used today is a mix of the AMA's Socioeconomic Monitoring Survey (SMS) data and Supplemental Survey data along with the newer Physician Practice Information Survey (PPIS). **CAA does not view the PPIS as a statistically valid measure of physician expenses and strenuously objects to Medicare basing physician reimbursement on this flawed survey.**

CAA is concerned that the CMS survey process has lost much of its credibility within specialty organizations and among physicians from moving to the PPIS. The validation system would enable CMS to demonstrate reliability and validity of data. To this end, CAA recommends that the Agency take into account the shortcomings of the PPIS when considering other data sources; circular logic using PPIS data to validate PPIS data is not sufficient. More clearly, CAA recommends that the data set must include a **statistically valid, representative sample of physicians** providing medical services to Medicare beneficiaries for the code in question. These requirements were met by the SMS data and each supplemental survey adopted by CMS. However, the PPIS does not meet current requirements established for code revalidation. Consider that in the 2010 PPIS, 100 cardiologists returned surveys with only 53 complete responses. The sample number comprises roughly one-quarter of 1 percent of cardiologists nationwide. Further, 70 percent of the qualifying surveys were physicians from large multi-specialty groups or academia, rather than private practice settings. This limited response creates a biased pool of unreliable data that must be validated through secondary sources of information.

Yet, like other commenters, CAA does not support the Medicare Payment Advisory Commission (MedPAC) recommendation to "consider collecting data on a recurring basis from a cohort of practices and other facilities where physicians and other nonphysician clinical practitioners work." (76 FR 73054-5) As noted above, the data for establishing and revaluing Relative Value Units must be statistically valid and representative of the medical community. The RVU values are used not only by Medicare for payment but nearly every other payer for commercial and Medicaid populations. Thus, the Agency must make the accuracy of this information paramount to its ongoing efforts to improve the system. CAA looks forward to working with CMS as it develops the validation system.

CAA applauds CMS' consolidation of the code review and incorporation of reviewing work and practice expense of one code under review. Further, CAA agrees that a comprehensive five-year review of malpractice values is warranted as there has historically been few significant swings in malpractice rates for services. However, while CAA appreciates that CMS will be "sensitive to the number of codes identified as potentially misvalued for any given specialty" (76 FR 73056), the turnover in Agency staff and changing approaches of each Administration leaves specialties open for a considerable review and validation burden that often are in the high volume low work RVU codes and multispecialty points of comparison services. **Therefore, CAA strongly urges CMS, as it has in past comments, to (1) establish reasonable caps on the number of code(s) and code families and (2) set time limitations for code review.** Simply, an annual review of codes undermines one of the long-held benefits of the Medicare program: predictability. Further, it wastes already limited resources. At the very least, **CMS should limit review of a code to once every three years, unless compelling technological development and/or statistically valid documentation shows that the code should be re-evaluated more frequently than every three years.**

Expanding the Multiple Procedure Payment Reduction (MPPR) Policy - CY 2012 Expansion of the MPPR Policy to the Professional Component of Advance Imaging Services

CAA opposes the finalized policy to implement a 25 percent reduction on the professional component of certain subsequent advanced imaging services. The reduction is arbitrary and **CAA strongly urges CMS to publish the underlying data and analysis supporting the Agency's findings that "specific activities included in furnishing advanced imaging scans together supports a reduction between 27.3 and 43.1 percent."** (76 FR 73077)

However, CAA understands that in a letter dated December 16, 2011 (attached), Amy Bassano, Director of the Hospital & Ambulatory Policy Group in the Center for Medicare Management within CMS stated that "operational limitations prevent

[CMS and its contractors] from applying the imaging MPPR to group practices beginning January 1, 2012.” **CAA seeks clarification if this means that physicians that are not in group practices or bill in such a way where a group National Provider Identifier is not included on the claim will have the reduction applied to the certain advanced imaging services under the program. Also, CAA seeks clarification if the Agency plans to work with its contractors and implement the program at a later date and what notice will be afforded to group practices of the implementation. Lastly, CAA seeks clarification on how the Agency will reattribute the \$50 million (76 FR 73455) not achieved by non-implementation/delayed implementation of this policy.** According to the final rule with comment period, these monies were redistributed through budget neutrality as a “small increase to the conversion factor and a small adjustment to all practice expense RVUs.”

Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Window Policy and impact on Wholly Owned or Wholly Operated Physician Offices

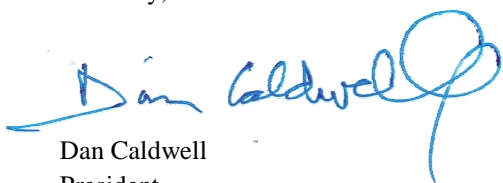
CAA greatly appreciates the implementation delay of this policy until July 1, 2012. However, CAA remains concerned that even with this 6 month development period, that the disparity and inoperability between hospital and group practice claims systems will continue to make implementation for hospitals and wholly owned or wholly operated physician offices extremely difficult and solutions very expensive. Thus, **CAA recommends that CMS make the second half of 2012 a testing period for hospitals and group practices to implement policies and solutions to automate this process of holding claims for validation and documentation.**

Physician Quality Improvements

In this final rule with comment period, CMS endorsed a consistent policy of enabling physicians and medical groups to choose claims, registry or Electronic Health Record (EHR) reporting for quality initiatives. CAA is very pleased with this approach. Yet, the incentive payments associated with reporting is based upon stale data from years prior. It is CAA’s continued position that incentive payments must be closer in time to the clinical behaviors the Agency is promoting. Therefore, **CAA urges CMS to base incentive and penalties for quality, electronic prescribing and EHR use on the previous year reporting instead of data submitted up to two years prior.**

Thank you very much for the opportunity to share our thoughts on this final rule. CAA realizes that CMS is called upon to accomplish an extremely difficult and complex task to ensure that Medicare dollars are appropriately spent. Our members and staff are available as resources to you as you examine and address the concerns outlined above. Please feel free to contact Jen Searfoss, Executive Director, at 202-505-2221 or jen@cardiologycaa.com for any assistance.

Sincerely,



Dan Caldwell
President



Mark Victor, M.D.
Vice President, Medical Affairs

Enclosure