December 15, 2006

Leslie V. Norwalk
Acting Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS-1321-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Norwalk:

I am writing on behalf of the American Academy of Family Physicians, which represents more than 94,000 family physicians and medical students nationwide. Specifically, I am writing to offer our comments on the final rule with comment period regarding "Medicare Program: Revisions to Payment Policies, Five-Year Review of Work Relative Value Units, Changes to the Practice Expense Methodology Under the Physician Fee Schedule, and Other Changes to Payment Under Part B; Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; and Ambulance Inflation Factor Update for CY 2007," as published in the *Federal Register* on December 1, 2006.

CMS invited comments on the interim relative value units (RVUs) for selected codes identified in Addendum C of the final rule as well as the physician self-referral designated health services listed in Tables 18 and 19 of the final rule. We will comment on each of these areas in turn; however, we first want to comment on some of the decisions CMS made related to the Five-Year Review and the practice expense methodology. We will also comment on some aspects of CMS's estimate of the Sustainable Growth Rate (SGR) for 2007. Our comments may be summarized as follows:

- We want to thank CMS for finalizing its proposal to accept the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) recommendations for evaluation and management (E/M) services and for implementing those recommendations in full beginning January 1, 2007.
- We are deeply disappointed that CMS chose to proceed with its proposal to institute an adjustment to the work RVUs in its payment allowance formula.
- We want to compliment CMS on its decision to proceed with its proposed changes to its practice expense methodology; however, CMS appears to have used work RVUs with budget neutrality applied in the indirect practice expense allocation, despite CMS's clear written statement that this would not occur.
- We believe that CMS should change its decision to consider the newly created anticoagulation management codes (99363 and 99364) bundled into the E/M codes.
- We appreciate CMS's delay in issuing final regulations regarding proposed changes to its reassignment and physician self-referral rules relating to diagnostic tests.
- We believe that CMS's estimate of the SGR for 2007 includes two estimations that hold down the SGR in ways that do not appear supported by CMS's own data.

Above all, the AAFP wants to do its part to ensure Medicare patients' access to primary care services.

Five-Year Review

First, we want to thank CMS for finalizing its proposal to accept the RUC recommendations for E/M services and for implementing those recommendations in full beginning January 1, 2007. Like CMS, we understand how contentious this issue has been, and we appreciate CMS's validation of the RUC recommendations in this regard, particularly in light of the large budget neutrality adjustment necessitated by acceptance of the RUC recommendations. The adjustment in the RVUs for E/M services is a first step in restoring viability to primary care offices.

Regarding the final budget neutrality adjustment, we are deeply disappointed that CMS chose to proceed with its proposal to institute an adjustment to the work RVUs in its payment allowance formula. For the reasons outlined in our comments on the proposed rule, we continue to believe that an adjustment to the conversion factor was the more appropriate option. As noted in the final rule, the AMA, the RUC, and many other organizations representing those directly affected by this issue also believe an adjustment to the conversion factor is the preferred option. We regret that CMS chose to ignore this prevailing opinion and corresponding rationale. The AAFP strongly encourages CMS to rectify this adjustment methodology at the earliest possible time, no later than for the 2008 Medicare Physician Fee Schedule.

Practice Expense Methodology

We want to compliment CMS on its decision to proceed with its proposed changes to its practice expense methodology, including the move to a bottom-up approach and elimination of the non-physician work pool. While not perfect and still difficult to understand, the new methodology is preferable to the previous top-down approach and should be more intuitive and stable in the long run.

Regarding the new methodology, CMS stated in the final rule that it would not use the budget-neutralized work RVUs to calculate indirect practice expenses. However, Addendum B in the final rule appears to reflect practice expense RVUs that were computed using adjusted work RVUs. Thus, CMS appears to have used work RVUs with budget neutrality applied in the indirect practice expense allocation, despite CMS's clear written statement that this would not occur. We urge CMS to immediately correct this error and use the unadjusted work RVUs in the methodology.

Codes with Interim RVUs

We reviewed the new and revised codes in Addendum C, which will have interim RVUs for 2007. Among them were:

- 99363 Anticoagulation management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)
- 99364 Anticoagulation management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each

subsequent 90 days of therapy (must include a minimum of three INR measurements)

CMS accepted the RUC recommended RVUs for these codes but assigned them a status indicator of "B," which denotes that CMS believes these services are bundled into E/M services. CMS did not offer any rationale for its decision to bundle these new services.

We believe that CMS should change its decision to consider the newly created anticoagulation management codes (99363 and 99364) bundled into the E/M codes. We are hard-pressed to identify any rationale for this decision. During the creation of the code, the CPT Editorial Panel was very careful to create protections in the code that would prevent work from anticoagulation management being included in selecting the level of E/M codes. The RUC also observed these protections and clearly thought that these services were unique, stand-alone services. We note that its recommendations for the E/M services as part of the Five-Year Review did not include the value of these new services.

The new CPT codes are recognition of the important work of managing serious disease, and the CMS decision to not pay separately for this service appears arbitrary. Accordingly, we strongly urge CMS to change the status indicator of these codes from "B" to "A" (Active code), so they may be paid appropriately.

Re-assignment and Physician Self-Referral

We reviewed the list of additions and deletions to physician self-referral designated health services as presented in Tables 18 and 19 of the final rule. Upon review, the proposed additions and deletions appear appropriate.

We also noted CMS's decision not to issue final regulations at this time regarding proposed changes to its reassignment and physician self-referral rules relating to diagnostic tests. Instead, CMS indicates its intent to study these issues further and issue a final regulation in the future. We appreciate CMS's delay in issuing final regulations in this instance, so it may study the matter further. We are hopeful that this further study will help CMS address the concerns that we and others raised in response to the proposed changes, so the final regulations do not unduly impact legitimate group practice arrangements that enable Medicare beneficiaries to have the convenience of receiving medical services at one location.

Sustainable Growth Rate

As we reviewed CMS's estimate of the SGR for 2007, we were struck by two estimations that hold down the SGR in ways that do not appear supported by CMS's own data. The first of these is the estimated change in fees for drugs used to calculate the change in fees for physicians' services. In the final rule, CMS estimates a weighted-average change in fees for drugs included in the SGR (using the Average Sales Price (ASP) plus 6% methodology) of 4.0% for 2007. However, in Table 20 of the final rule, in which CMS estimates the increase in the Medicare Economic Index (MEI) for 2007, CMS estimates the percentage change in pharmaceuticals (based on the Producer Price Index) as 7.7% in 2007.

We fail to understand why CMS believes the price of drugs is increasing 7.7% for purposes of the MEI but is only allowing for a 4.0% increase in the fees for drugs for purposes of calculating the SGR. From our perspective, if CMS believes the price of drugs will increase 7.7% in 2007, then the same percentage should be used in the SGR calculations, since physicians normally set their

fees to at least cover their costs. We calculate that use of the 7.7% figure in the SGR calculations would increase the 2007 SGR estimate from 1.8% to 2.1%.

We continue to believe that drugs should not be included in the SGR calculations, but if CMS is going to include them, then they should account for them consistent with the MEI. As it is, CMS's disparate estimates simply represent an admission that Medicare fees for physician administered drugs (based on the ASP plus 6% methodology) are not keeping pace with the actual price of drugs paid by physician practices.

The second estimate with which we would like to take issue is the estimated decrease in traditional Medicare enrollment of 0.9%. Our problem with this estimate is that Medicare consistently underestimates the growth or overestimates the decline in traditional Medicare enrollment when making its initial estimates. For instance, according to the final rule, for the 2005 SGR, CMS initially estimated that enrollment would decrease 0.3%. A year later, CMS revised that estimate to an increase of 0.3%. Likewise, for the 2006 SGR, CMS's initial enrollment estimate was a -3.1%. Now, a year later, it is -2.2%.

Thus, we have to wonder if the 0.9% decrease estimated for the 2007 SGR is also off by 0.6-0.9%. We note it has already gone from -2.9% in March of this year to -0.9% in November. Assuming CMS's estimate is off by at least 0.6 percentage points would raise the SGR from 1.8% to approximately 2.3%. Combined with the change in the drug fee percentage noted above would increase the estimated SGR to 2.7%. All of which has implications for future updates in physician fees.

We understand that the SGR is a flawed formula, which is why we are working diligently to have Congress replace it with a truly "sustainable" growth rate. We realize that estimating the various components in the SGR is difficult. However, we do not believe that is an excuse for CMS to not learn from its own track record and to not be consistent in the way it estimates elements such as drug fees.

We appreciate this opportunity to comment on matters related to the Medicare Fee Schedule. As always, the American Academy of Family Physicians looks forward to working with CMS in its continued efforts to ensure access to appropriate physician services.

Sincerely,

Larry S. Fields MD

Larry S. Fields, M.D., FAAFP
Board Chair