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August 24, 2010

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Re: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Proposed Rule; File Code CMS-1503-P

Dear Administrator Berwick:

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to provide our comments regarding the Centers for Medicare and Medicaid Services' (CMS) proposed physician fee schedule rule for calendar year 2011. Our detailed comments are set forth below.

AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,000 members strong, AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP's members actively research, evaluate, diagnose, and treat psychiatric disorders and pride themselves on giving direction to and responding quickly to new developments in addressing the health care needs of children and their families.

Medicare Economic Index

AACAP supports the proposed comprehensive review of the Medicare Economic Index (MEI) and the convening of a technical panel as the MEI should reflect the realities of current medical practice. We appreciate CMS' attempt to use the most current and accurate data in the payment formulae and strongly supported the use of the Physician Practice Information Survey (PPIS) data in the last fee scheduled. However, we are concerned about implementing any reconfiguration of the MEI before the technical panel has completed its review and submitted recommendations. Until this review is completed, CMS should withdraw the proposed changes to the MEI for

calendar year 2011, as well as the revisions to the relative value units (RVUs) and geographic practice cost indexes (GPCIs) that arise from the proposed changes to the MEI.

AACAP is concerned that these proposals disproportionately impact time-based and low overhead specialties like psychiatry. Unlike low work procedure codes, psychiatrists cannot compensate for lost income on time-based codes by increasing volume or intensity of services. However, we believe that it is services such as these that are the very type of care that the Administration would seek to reward and increase and that this change runs counter to the Administration's overall stated goals of increasing care coordination and placing more emphasis on quality of care.

CMS proposes to separate out and price nine new MEI components, including chemicals, paper, rubber, and plastics, and although data is referenced on these components, no rationale has been provided for the separation of these. Factors involved in modern medical practice are vastly different than when the MEI was first developed, and additional input is needed to ensure the revised MEI will adequately measure the costs of practicing medicine today. Physicians must comply with an array of government-imposed regulatory requirements that did not exist when the MEI was created. These include: Medicare prescription drug plans and formulary compliance; compliance with rules governing referrals and interactions with other providers; advanced beneficiary notices; limited English proficiency rules; Medicare audits; the Health Insurance Portability and Accountability Act and Americans with Disabilities Act; billing errors; quality monitoring and improvement; patient safety; electronic medical records and other new health information technology systems that facilitate physician improvement initiatives.

To ensure compliance with these requirements, physicians often must take actions that increase their practice costs, including hiring additional office staff, attorneys, and accountants or billing companies. These types of components are not currently taken into account in the make up of the MEI, and therefore the MEI undervalues actual medical cost increases. In addition to providing no rationale for the proposed revision in the inputs, such as rubber and plastics, these revisions do not do anything to improve the adequacy of the MEI. In the proposed rule, CMS estimates the 2011 MEI at just 0.3%, with the addition of the new detailed components doing nothing to increase it. With the MEI shrinking while costs continue to rise, today's physicians can detect no resemblance between the MEI and their everyday practice costs.

In addition to new office expense inputs, CMS proposes to re-weight the work, practice expense (PE), and liability expense components of the MEI to match the data from the PPIS. It further proposes to increase the PE and liability expense RVUs and decrease the conversion factor so that the relative value scale will match the new MEI weights. Implementation of changes to the MEI, the RVUs, and the conversion factor in 2011 would play havoc with 2011 payments for many physician specialties and localities based on proposed MEI changes that may change again, perhaps substantially, after the technical review panel is convened. At a time when physicians are already facing enormous pay cuts due to the Sustainable Growth Rate (SGR) formula, it does not make sense to move forward with proposed changes until CMS has a complete MEI proposal.

We urge CMS to delay all of these proposed changes until CMS has had an opportunity to convene the technical panel and thoroughly review the needed changes in the MEI. As an alternative, we request that CMS consider a phased-in implementation of such a change, similar to the four-year transition with the PPIS data from the calendar year 2010 fee schedule.

Physician Quality Reporting Initiative

AACAP applauds CMS' decision to change the definition of group practice from 200 to 2 in 2011 and CMS' decision to reduce the Physician Quality Reporting Initiative (PQRI) reporting sample requirement from 80% to 50% for FY2011. Both of these changes will encourage greater participation in the PQRI program. However, CMS must publish detailed specifications for individual measures and measures groups for the PQRI by November 15, 2010. Although CMS has until December 31, 2010 to post the detailed specifications, the earlier posting would ensure physicians have the requisite time to identify clinically relevant measures and understand their specifications before the first day of the program (January 1, 2011).

As part of the public reporting of the PQRI data, physicians and other providers involved in the treatment of a patient must have the opportunity for prior review and comment, and the right to appeal with regard to any data that is part of the public review process. Any such comments should also be included with any publicly report data.

Section 3002(c) of the "Affordable Care Act" (ACA) requires a mechanism under which a physician may provide data on quality measures through a Maintenance of Certification Program (MOCP) operated by a specialty body of the American Board of Medical Specialties (ABMS), with an additional 0.5% incentive payment for years 2011 through 2014 if certain requirements are met. These include satisfactorily submitting data on quality measures under the PQRI for a year and through the MOCP, and physicians must also participate in an MOCP for a year, more frequently than is required to qualify for or maintain Board certification status.

CMS must provide further clarification on the requisite steps and processes for participating in the PQRI and MOCP to qualify for the incentive. Without clear guidance, physicians will not be able to understand the necessary processes to qualify. If this additional reporting option is to succeed, CMS and the Boards must work together prior to January 1, 2011 to clarify the parameters and processes of this option. To engage in an MOCP "more frequently" in the current health environment could deter or prevent many physicians from electing the option in 2011. Most Boards do not have fully developed and tested practice assessments; therefore it is not possible for most physicians to participate in the program at all, much less "more frequently." This standard will also be difficult to meet because some practice assessment activity must be completed every one to four years. More frequent compliance could occur every two years, but would therefore not align with current PQRI reporting periods. Also, even if physicians are able to meeting the practice assessment "more frequently", there is a question of whether the Board has qualified as a registry under the PQRI program. This would further prohibit most physicians from participating.

Electronic Prescribing

We support CMS' proposed requirements for the 2011 electronic prescribing (e-prescribing) incentive payment program, which requires reporting on 25 unique services involving electronic

prescriptions. However, AACAP strongly opposes CMS' proposal to impose financial penalties in 2012 and 2013 against physicians based on their e-prescribing activity during the first six months of 2011. The proposal conflicts with the intent of the Medicare Improvements for Patients and Providers Act of 2008, which clearly delays penalties until 2012. In fact the law states that the penalty would apply "with respect to covered professional services furnished by an eligible professional during 2012, 2013, or 2014." Applying penalties to services rendered in 2011 is in direct conflict with the language of the law. Instead, we urge CMS to review 2012 and 2013 e-prescribing activity, and not 2011, in order to assess penalties for 2012 and 2013.

Further, the Drug Enforcement Administration has only recently released a final rule allowing electronic prescribing of controlled substances and outlining the requirements for such a system. While this policy change is welcome, the security and program requirements are steep and we are currently unaware of any prescribing software that will be on the market and affordable for physician use within the time frame of the 2012 and 2013 penalties. Because psychiatrists frequently prescribe controlled substances, we believe many of our members have limited their purchasing of a system until there are integrated and convenient systems on the market.

Therefore, AACAP urges that CMS revise the 2012 and 2013 penalty criteria. Financial penalties should only be levied in 2012 and 2013 against Medicare eligible physicians who fail to qualify for an exemption and fail to e-prescribe ten permissible prescriptions by the end of 2012 or by the end of 2013.

We also strongly recommend that CMS add more exception categories so that more physicians facing hardships will be eligible for an exemption from e-prescribing penalties in 2012 and 2013. Many physicians have postponed purchasing an e-prescribing software package or application in order to take advantage of Medicare and Medicaid Electronic Health Record (EHR) incentives per the American Recovery and Reinvestment Act, which is more flexible and allows for incentives even if physicians wait until 2014 to take part. Physicians should not be penalized because it makes more economic, practical sense to choose to participate in the EHR incentive program and for investing in a complete electronic system.

Reprocessing of Claims Due to Retroactive "Affordable Care Act" Provisions

In the ACA, Congress extended through December 31, 2010 a 5% increase for psychotherapy services which was originally passed as a part of the Medicare Improvements for Patients and Providers Act of 2008. While the original provision only included the increase through December 31, 2009, the ACA provisions were retroactive to the beginning of the calendar year. As with a number of other provisions in ACA which were retroactive, we have heard that there is significant confusion and delay in reprocessing the claims paid at the reduced rate. AACAP would ask that CMS disseminate guidance to the Medicare contractors, affected specialty societies, and physicians as to how these claims will be reprocessed and paid out.

Consultation Codes

In the 2010 physician fee schedule, CMS finalized a proposal to eliminate consultation codes which went into effect January 1, 2010. AACAP has expressed our objection to this proposal, as we believe it negatively impacts coordination of care and does not adequately compensate

physicians for the work they do on the sickest and most complex patients. We strongly urge CMS to reexamine the elimination of the consultation codes and reverse this decision.

Thank you for the opportunity to comment. We would be happy to speak with you further about our comments. Please contact Kristin Kroeger Ptakowski, Director of Government Affairs and Clinical Practice at kkroeger@aacap.org, 202-966-7300, ext 108.

Sincerely,

Laurence L Greenhill MD

Laurence Greenhill, M.D.
President