January 2, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1502-FC and CMS-1325-F
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Certain Provisions Related to the Competitive Acquisition Program of Outpatient Drugs and Biologicals Under Part B

Dear Ms. Norwalk:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the final rule entitled the “Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2007 and Certain Provisions Related to the Competitive Acquisition Program of Outpatient Drugs and Biologicals Under Part B,” as published in the Dec. 1, 2006 Federal Register. We appreciate the Centers for Medicare & Medicaid Services’ (CMS) outreach to the provider community and their willingness to participate in constructive dialogue to improve the Medicare program. We look forward to continuing our collaborative work on this and other administrative simplification issues. For these reasons, MGMA offers the following critiques and recommendations related to this rule, as outlined below.

MGMA, founded in 1926, is the nation’s principal voice for medical group practice. MGMA’s 20,000 members manage and lead more than 12,000 organizations in which more than 242,000 physicians practice. Our individual members, who include practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently, so physician time and resources can be focused on patient care.

**Sustainable growth rate (SGR)**

For the past five years, providers have anticipated cuts to Medicare payments. In fact, without congressional action, physicians would have been cut over 20 percent since 2001. The Medicare Payment Advisory Commission estimates that payment will be cut every year for the foreseeable future, a trend that will have grave consequences on the health care system as a whole. If the current trend continues, providers will face difficult decisions as they evaluate the economic practicability of caring for Medicare beneficiaries. The economic viability of practices is further undermined by the widespread use of the Medicare physician fee schedule as a benchmark for private insurance reimbursement rates.
MGMA has conducted extensive surveys of medical practice costs for more than 50 years. MGMA-collected data indicate that the cost of operating a group practice rose by an average 4.5 percent per year over the last 10 years. In fact, between 2000 and 2005, MGMA data show that operating costs have risen more than 26.1 percent. Medicare reimbursement rates for physician services have fallen far short of the increased cost of delivering quality services to Medicare patients. Agency-initiated administrative modifications can help mitigate the anticipated cuts for CY2007 and beyond.

**Definition of “physician services”**

The statutory language of the Social Security Act that defines the payment update formula requires CMS to assess the allowed and actual expenditures of the Medicare program. MGMA maintains that the definition used by CMS for “physician services” in the sustainable growth rate (SGR) formula is inappropriate. MGMA believes this definition is incorrect due to the inclusion of the cost of physician administered outpatient prescription drugs.

A significant factor in the growth in Medicare expenditures has been the introduction of the program’s coverage of costly new prescription drugs administered in the physician’s office. Since the SGR base year, SGR spending for physician-administered drugs has more than doubled. These expenses reflect the acquisition of products rather than services rendered by a medical professional and therefore are different than “physician services.” The inclusion of drugs in the definition of physician services is inaccurate and runs counter to CMS’ stated goal of paying appropriately for drugs and physician services. MGMA asserts that the definition of “physician services,” as required by the statute, does not include the cost of prescription drugs.

A separate definition of physician services clearly distinguishes physician administered outpatient prescription drugs from services rendered by physicians. CMS adopted this definition in the Dec. 12, 2002 “Inherent Reasonableness” rule (67 FR 76684). Plainly, the definition of physician services must be applied consistently for fair and equitable administration of the Medicare program. Furthermore, the recent proposed rule to reform the payment system for physician administered prescription drugs establishes a separate venue to address the utilization and cost of drugs. MGMA strongly urges CMS to remove prescription drug expenditures from the definition of “physician services” used to calculate the physician payment update factor.

MGMA understands that CMS explored the legal ramifications of removing physician administered outpatient prescription drugs from the definition of physician services and appreciates CMS’ willingness to do so. MGMA realizes that CMS continues to have concerns about the removal of these drugs from the formula on a retrospective basis; however, MGMA urges CMS to remove these drugs from the definition of “physician services” used in the calculation of the physician payment update factor.

**Full impact of law and regulation**

The current SGR calculation fails to adequately capture the impact of changes to laws and regulations as required by law. For example, although Medicare has added new screening benefits, the formula fails to account for the downstream services that will result when the screenings reveal health problems. The same is true of the Medicare prescription drug benefit, which will unquestionably lead to more medical visits, and in turn will generate additional tests and care. The SGR does not account for this inevitable program spending.
Additionally, the impact of administrative coverage decisions is excluded from the SGR entirely even though those decisions may have as great an impact on patient demand for services as a statutory change. In last year’s rule, for example, CMS administratively extended screening glaucoma coverage to Hispanic patients over age 65. Such changes are likely to be highly beneficial for patients, but may contribute to negative reimbursement updates through the SGR calculation. MGMA believes CMS has the administrative authority to better account for the full impact of such changes to law and regulation, and vigorously urges CMS to assert this authority.

**MEI calculation**

Another component of the Medicare physician reimbursement formula that requires improvement is the Medicare Economic Index (MEI). The MEI was established in 1973 to reflect the rising cost of practicing medicine. However, the current MEI calculation is showing its age, and fails to incorporate all of the costs a physician group practice bears to care for patients. MGMA agrees with a recommendation by the Practicing Physicians Advisory Council made to CMS in 2004 that the MEI be expanded to reflect costs such as compliance with extensive new billing regulations, including hiring new staff and increased training for current staff to comply with expanding regulations. The MEI also should reflect steps taken to improve patient safety and include those additional costs not included in the MEI in 1973, but which clearly must be a part of the calculation today.

Additionally, the MEI must reflect the modern level of support staff. A particular concern to MGMA is that employee wages used in the MEI formula do not capture highly skilled professionals now considered essential for the delivery of medical services. These professionals include nurse practitioners, physician assistants, certified nurse specialists, nurse midwives, certified registered nurse anesthetists, occupational therapists, physical therapists, certified practice managers, computer professionals, transcriptionists and certified coders. MGMA recommends that CMS work with other government agencies such as the Bureau of Labor Statistics and private organizations to identify other nationally collected data sources or to collaborate the development of survey methodology and data collection if no such source currently exists.

MGMA urges CMS to work with Congress to eliminate the SGR and develop a methodology that will accurately reflect the increase in the cost of practicing medicine.

**The Tax Relief and Health Care Act of 2006**

After the release of the 2007 Medicare physician fee schedule, Congress acted to mitigate the anticipated reduction in physician payment rates. MGMA appreciates the efforts of Congress and the Administration that resulted in the mitigation of anticipated cuts in Medicare physician payment resulting from the flawed SGR formula. However, the provisions of H.R. 6111, the Tax Relief and Health Care Act of 2006, also affect a number of other program policies. MGMA urges CMS to promulgate any necessary regulations as quickly as possible in consultation with providers. Specifically, MGMA requests that the Medicare physician fee schedule be reissued to incorporate the changes resulting from H.R. 6111, as well as the two correction notices published after the publication of the final fee schedule. There is a great deal of confusion among providers regarding which values should be used to determine payment, especially given the recent changes to the law, the improper values contained within the Dec. 1 rule and the incorrect amounts contained within the documents disseminated by the carriers containing the payments for Medicare-covered services. Additionally, ample and timely provider materials, written in easy-to-understand language, must be available at the same time to decrease provider uncertainty and
misunderstandings during this transition. MGMA looks forward to partnering with CMS during this and other conversions.

Physician Voluntary Reporting Program (PVRP)

MGMA supports quality improvement activities that focus on improving patient care, outcomes, satisfaction and the cost-effective use of resources. The 1.5 percent bonus incentive payment to physicians who report on quality measures through the Medicare PVRP is a step in the right direction; however, many issues and questions remain. These include:

- Is the 1.5 percent bonus only calculated on the claim that is submitted with the codes or the practice’s entire Medicare book of business?
- How will the legislatively-mandated cap be calculated?
- When will the bonuses be paid on a quarterly basis or held until 2008 and paid in one lump sum? If this is a capped bonus pool, is it possible that CMS will run out of funds, even though providers have met all of the requirements for participation?
- Will bonus monies count as new monies against the SGR baseline?
- Can practices that are participating in the other CMS demos also choose to participate in the PVRP program?
- Can non-physician providers report under the PVRP?
- How will scope be defined under the PVRP? Would self-selection of applicable measures based on the practice’s definition of their scope be allowed under the 2007 PVRP?
- What are CMS’s plans for meeting the validation requirement contained within the new law?
- What are CMS’ plans for analyzing the cost burden to various specialty practices and practice settings? For example, a large percentage of practices do not yet have EMRs available to them.
- What plans are being made by the Medicare contractors for receiving this data?
- Is reporting the data enough - will there be certain thresholds that need to be met for each measure? Will the bonus be 1.5 percent, no matter what the outcome is?

Additionally, MGMA is concerned that groups will have to make the decision to participate with little information about the return on their investment, since bonuses will be calculated and paid out in 2008. MGMA urges CMS to issue guidance on the PVRP as early as April, so that organizations, such as MGMA, have adequate time to disseminate information and educate practice managers who will lead quality reporting efforts in their groups.

Resource-based practice expense RVUs

MGMA brings a particularly valuable perspective to this issue. As a research oriented organization, MGMA has collected practice expense data since 1955. Our data collection involves group practices which range in size from two to several hundred physicians. As such, we understand the magnitude and complexity of CMS’ task. In addition, MGMA represents an equal proportion of primary and specialty care practices that are in the primary care and specialty care sectors. Consequently, we are able to detach ourselves from the “outcome” and focus primarily on the “methodology” applied.
Methodology

MGMA supports CMS’ decision to implement a bottom-up methodology as opposed to the previous top-down approach. While the results of both approaches depend on the quality of the medical practice expense data collected, MGMA believes the bottom-up approach has a greater likelihood of providing accurate values. History has shown that calculating practice expenses using a data based methodology is more accurate when compared to a method that uses estimates of actual inputs.

In previous years, CMS has provided a significant amount of specificity regarding the process for developing the practice expense methodology. This year CMS did not include in the final rule a thorough explanation of the calculations to allow specialties to determine their individual impact level of the practice expense changes to their specialty. CMS did not present sufficient examples to the provider community to make the change in methodology transparent. MGMA recommends that CMS provide explicit examples for selected specialties to demonstrate to the provider community how the methodology is calculated. In addition, CMS provides data on the first and fourth year of the transition period; however, there is no data provided on the impact of the changes to the methodology for years two and three. MGMA recommends that CMS provide that information to the provider community in an interim final rule with comment period.

Data Source

As in previous comments, MGMA maintains its concern that the practice expenses methodology is based on the American Medical Association’s (AMA) Socioeconomic Monitoring System (SMS) data, which is dated, and the Clinical Practice Expert Panel’s (CPEP) data, which is extremely subjective. The SMS data used to calculate practice expenses for CY2007 is from 1995-1999. MGMA recommends CMS conduct a new SMS survey in order to develop more accurate data that would result in equality for all specialties. The entity or organization contracted to conduct this new survey needs to be one that has proven its reliability in this area previously.

MGMA agrees with CMS that while the AMA SMS survey data is dated, a survey of this nature is the most appropriate and only primary data set in existence to determine specialty specific cost pools. We believe that not only does a new survey need to be conducted, but the methodology for conducting the survey needs to be enhanced as described below.

It is critical that the unit of observation used in a new survey reflect the organization rather than individual physicians who are owners or part-owners of their practices. The primary responsibility of the particular respondents is often the practice of medicine rather than the business operations of the practice. There are several reasons why the organization is preferable. First, the respondent must have both adequate knowledge about the business of medical practices and a comprehensive understanding about the information being sought. Second, the respondent must have the ability to access such information for the entire practice.

While AMA’s survey response rate has been strong historically at about 60 percent, not all respondents answered the practice expense portion of the survey. Specifically, the 1996 SMS report based on 1995 data indicates that 4004 overall respondents to the survey, 2352 were self-employed physicians and therefore eligible to report data on practice expenses. Of the 2352, 1552 provided total professional expenses, 1595 payroll, 1504 medical equipment, 1538 medical supply optimal resources, and 1573 office expenses. The overall response rate to the practice expense portion was 39.9 percent. While we understand that it is difficult for physicians who are owners or part-time owners of practices to respond to the practice expense portion, MGMA is
hopeful that the response rate and thus the quality of responses will improve when the practice becomes the unit of observation.

Presently, AMA is collecting data on clinical labor, supplies, equipment and other practice costs. MGMA recommends that the entity chosen to conduct a new survey refine the expense categories to identify ancillary service expenses and activity data. Our experience has shown that medical groups with radiology or laboratory ancillary services have different expense experience than medical groups that do not have these services. Future refinements of the practice expense Relative Value Unit (RVU) component should isolate the effect of ancillary services from the total expense profile of the practice. This can only be accomplished if ancillary service expense data is separately collected.

When conducting a new survey, there must to be a mechanism to validate data. The benefit of collecting data from profit and loss statements is that the practice expense responses cannot be exaggerated.

MGMA remains concerned about the quality of the data gathered by the CPEPs but is pleased that it plays less of a role in the bottom-up methodology. As CMS, or an entity in its place, considers the practice expense issue, it must seek input from practice managers, especially since the information sought focuses largely on clinical and administrative staff time and not on physician time. Assuming the make-up of the panels is appropriate, they have the potential to refine the CPEP’s data. However, to the extent that the panels will not have access to any actual practice expense data gathered from physician practices, they will have limited effectiveness. Nevertheless, convening panels could help identify egregious errors and/or highly anomalous results. MGMA recommends that panels be convened subsequent to the accumulation of actual practice expense data to allow them to complete their work based on more accurate information.

MGMA is concerned about the process that CMS used to determine practice expenses. The bottom-up methodology loses an element of the data that provides for the significant differences between practices of the same specialty. To create a resource-based approach that conforms to real-world practice costs, CMS must collect actual service-level practice expense data directly from physician practices and base both direct and indirect PE RVUs on that data. Such data would give CMS a far more accurate database for direct costs than the current estimates developed by the CPEPs’ process. Recognizing time constraints established by Congress and limited resources, at the very least, CMS should undertake a limited study on a cross-section of practice settings nationwide to obtain actual practice expense data from physicians’ offices. The agency could use this data, however limited, to validate or refine the existing data obtained through the panels’ process.

Four-year transition

MGMA supports a transition period and applauds CMS for the development of a transition period. We appreciate CMS’ consideration of the other upcoming regulatory and legislative changes for CY 2007; however, we believe that the implementation timeline is not ideal because of the level of uncertainty surrounding the cumulative impact of the reductions in reimbursements on medical practices. MGMA recommends that CMS delay the implementation of practice expenses until all of the provisions within the Medicare Modernization Act have been implemented. This would allow all specialties sufficient time to implement provisions regulated prior to the practice expense changes.
MGMA believes that CMS should reconsider applying the budget neutrality adjustment factor to work RVUs. CMS does not provide an adequate rationale for shifting the budget neutrality adjustor to the work RVUs. In the past, CMS has suggested the same proposal and the provider community responded negatively. By placing the budget neutrality factor on the work RVUs, the effect to specialties is varied because of the different levels of work involved. Constant variation in the work RVUs due to budget neutrality adjustments hinders the process of establishing work RVUs for new and revised services. MGMA recommends that CMS apply the budget neutrality adjustor to the conversion factor in order to make the calculations more equitable and understandable to the provider community. MGMA believes that applying the budget neutrality to the conversion factor will have less impact on other payers who use the Medicare resourced-based relative value scale and be consistent with the notion that budget neutrality.

CMS is moving towards making pricing information for physicians, hospitals and other providers more transparent. MGMA recommends that CMS apply the principles of transparency to the Medicare policy that govern these prices. By applying the budget neutrality adjustment to the conversion factor, pricing information to the provider community will be more transparent. Transparency of the financial effect of these changes will apply physicians and policymakers to more easily understand the impact of the cuts. In order to achieve CMS’ goal of transparency of pricing information, the budget neutrality adjustments should be made to the conversion factor.

**Geographic practice cost indices (GPCIs)**

As noted in our previous comments, MGMA remains opposed to CMS using inappropriate data sources to calculate the GPCIs. This includes the use of census data to calculate GPCI values. The very nature of the data render the values outdated by the time CMS is able to utilize the information. Additionally, although the statute mandates updating the GPCI values every three years, they are in essence updated every 10 years since the census is collected once every decade. MGMA maintains that this is unacceptable. A separate source with more timely data must be identified to adhere to the three year update schedule that Congress intended. MGMA recommends that CMS work with other government agencies, including the Bureau of Labor Statistics and private organizations, to identify alternative data sources. Alternatively, CMS should work with these groups to identify an appropriately indexed data source to meet the statutory requirements.

Of particular concern to MGMA is that employee wages used in the GPCI formula do not capture highly skilled professionals now considered essential for the delivery of medical services. While it remains true that the 2000 census definitions of certain medical professionals are more expansive than the 1990 definitions, limited improvements result for the updated GPCI values. The wages of several prominent professions continue to be excluded, including physician assistants, occupational and physical therapists, certified practice managers, IT professionals, transcriptionists and certified coders. MGMA recommends that CMS revise the GPCIs to include these employees to ensure that the occupations used in the formula reflect the numerous categories of medical workers found in modern practices.

As in years past, the office rental indices used to calculate the practice expense GPCIs are based on the Department of Housing and Urban Development’s (HUD) residential apartment rent data. While MGMA is sympathetic to the difficulty CMS has in identifying alternative sources for pricing medical office space, MGMA remains opposed to the use of residential and not
commercial data for this purpose. Such use is inconsistent with the core objective of the Balanced
Budget Act of 1997 to make Medicare payments resource based.

As noted in previous comments, MGMA also highlights the findings of the General
Accountability Office (GAO) in their March 2005 report on HUD estimates of fair market rents
(GAO-05-342). The report identified major concerns raised by the HUD estimates, substantiating
the level of inaccuracy reported by many MGMA members. The report also explains that HUD
will soon use a new data source, the American Community Survey (ACS). It is important to note
that ACS processes rates differently than HUD has in the past. With this impending data shift,
MGMA urges CMS to work with HUD and the Bureau of Labor Statistics to determine whether
the values populating the GPCI calculations for medical practice rent are accurate and will meet
the agency’s needs once ACS data is adopted by HUD.

**Deficit Reduction Act (DRA) provisions**

*Imaging*

MGMA appreciates CMS’ decision to limit the reduction of the technical component for multiple
imaging services performed on contiguous body parts to 25 percent, rather than the proposed 50
percent, for calendar year 2007. MGMA remains concerned that the 25 percent reduction is
arbitrary. While CMS claims to have based this figure on data relating to costs, it still has not
released its actual calculations used to justify the 25 percent reduction. MGMA maintains that the
proposed cuts do not cover costs and would limit patient access to imaging services. We urge
CMS to share the data used to make this policy change, severely impacting certain specialties.
While MGMA appreciates CMS’ decision to calculate the multiple services reduction before
applying the statutorily-mandated cap (the OPPS amount), we urge further consideration and
evaluation of the multiple services reduction before it is implemented.

Furthermore, MGMA reiterates its request that CMS educate providers of diagnostic imaging
services and Medicare contractors regarding their continued ability to bill globally for diagnostic
imaging services subject to the reduction. As previously experienced with physician scarcity and
health professional shortage area payments, global payments for services with technical
components that are treated differently caused major system errors and necessitated that these
codes be unbundled for several months. MGMA seeks clarification and assurances that these
services may continue to be billed globally.

*Therapy Cap*

CMS implemented two annual therapy caps, one for speech-language pathology and outpatient
physical therapy and another for outpatient occupational therapy, on Jan. 1, 2006. In Section
5107(a) of the Deficit Reduction Act of 2005, which was enacted on Feb. 8, 2006, Congress
mandated that the Secretary of the Department of Health and Human Services create an
exceptions process for the therapy caps.

At the time of publication, the exceptions process was scheduled to expire on Dec. 31, 2006.
However, since that time, Congress has extended the exceptions process for another year. To
date, CMS has yet to inform providers how the therapy exceptions process will work for 2007.
MGMA requests that CMS continue to utilize the exceptions process implemented in 2006 and
urges CMS to make this information available to providers quickly. MGMA believes that the
continuity of a process would lessen possible administrative burdens and is willing to assist in the
education of providers regarding this process.
Abdominal aortic aneurism screening

Effective Jan. 1, 2007, CMS will reimburse physicians for the provision of abdominal aortic aneurism (AAA) screening. MGMA is pleased to learn that CMS has already promulgated the carrier transmittal and provider education materials to ensure that both Medicare carriers and providers are alerted to this new service available to Medicare beneficiaries. MGMA urges CMS to promulgate additional provider education materials when additional risk factors are identified as part of the national coverage determination process. Furthermore, MGMA recommends that this information be included in the functionality for the standardized electronic eligibility transaction (X12 4010 A1 270/271) implemented by Medicare. The eligibility status reported to the provider should contain information generated by all Medicare carriers, so providers can determine in advance whether a Medicare beneficiary is eligible for an AAA screening. While beneficiaries will receive most of their health care services within one carrier’s jurisdiction, it is foreseeable that a beneficiary may receive services in multiple jurisdictions. Providers should receive complete information as a result of the electronic eligibility transaction.

End-Stage Renal Disease (ESRD) Provisions

Hospital data used

MGMA remains concerned about the appropriateness of using acute care hospital wage index data in the calculation of the ESRD-Composite Payment Wage Rate Index. This index is used to determine payment to both hospital-based and independent ESRD facilities. The use of only hospital data in this calculation would indicate that wages in hospital-based and ambulatory facilities are the same or similar in nature; however, no such determination has been made. In fact, the costs for hospital-based facilities and ambulatory centers vary greatly. The ESRD-Composite Payment Wage Rate Index needs to take into consideration wages paid in independent facilities, in addition to those paid in acute care hospital inpatient settings. MGMA urges CMS to locate an alternative data source that reflects information directly tied to ESRD facilities.

Use of Floor/Ceiling Values

CMS has again reduced the wage index floor for the ESRD-Composite Payment Wage Rate Index in the face of cuts to physician reimbursement. This decrease will penalize ESRD facilities that have already faced cuts from the transition to the average sales price drug reimbursement methodology. These cuts to facilities’ reimbursement will make it even more difficult to recruit and retain qualified personnel in areas affected by the removal of this floor.

Reassignment and Physician Self-Referral

MGMA is pleased that CMS decided not to finalize its proposals relating to reassignment and the physician self-referral law. As indicated in MGMA’s comments to the proposed rule, MGMA believes that the proposed restrictions were overly broad and premature. CMS’ proposals would have precluded many legitimate business arrangements between healthcare providers and inhibited flexibility for group practices.

MGMA would welcome the opportunity to meet with CMS to discuss these provisions further. If CMS decides to move forward with major changes of general applicability to the reassignment and Stark rules, MGMA urges CMS to publish any changes in a new proposed rule, especially
considering that CMS has yet to publish an actual proposal with respect to new restrictions on the reassignment of the professional component of services.

**Employee Access to Claims Billed on Reassignment**

While MGMA shares CMS’ interest in program integrity, MGMA continues to oppose the new requirements on employee access to billing records. Congress authorized CMS to develop additional protections related to reassignment by contractors. It evidenced no intent to change the reassignment rules, which have applied to owners and employees of physician practices for decades. Nor is there any evidence of which MGMA is aware to suggest that this is a current program integrity issue.

While employed providers generally have some access to records in the practice, they do not necessarily have unfettered access to all billing records. This is a matter generally left to the terms of a provider’s employment contract with the practice, record retention and storage policies and common sense as billing or audit issues arise. Overlaying new regulatory requirements on this aspect of the employer-employee relationship is fraught with potential issues not addressed by this proposal. For example:

1. Does the requirement extend to employees? For how long?
2. Can it be used to harass a former employer in a manner unrelated to any legitimate concern about prior Medicare billings?
3. What about standard contract provisions that prevent a former employee from taking group records as part of a non-compete or non-solicitation provision in the employment contract?
4. What does “unrestricted” mean? Who decides?
5. Does it mean access to original records or only copies? Who pays for copying costs, retrieval from storage and/or separation of one provider’s records from those of the others, of Medicare records from those related to other payers?
6. How much time does the group have to produce the records?
7. What if the records are no longer available?
8. How does the group prevent unauthorized disclosure of HIPAA-protected patient information now in the hands of a former employee?

Not only does CMS fail to adequately address these questions, but many are simply not answerable in a “one size fits all” manner. Were CMS to try to answer them all, this perhaps well-intended change would become a major new regulatory burden at a time when both government and physician practices are seeking ways to simplify the administration of healthcare.

Instead, CMS denies the need to even address these questions, leaving them up to “common sense.” MGMA does not oppose applying common sense solutions, rather than government intrusion into group practice management; however, this is a situation where CMS is leaving practices with too many unanswered questions, which will only lead to increased confusion. Here, it is the government interfering with the common sense solution: leaving this question to negotiations between employers and employees.

One of the many benefits of group practice is the use of centralized administrative staff to perform billing and records functions, leaving providers the time and opportunity to focus on clinical care. While both the group and the employed providers generally share liability to Medicare if billing problems exist, it is generally the group’s obligation to have systems in place to prevent them to the extent possible and to resolve them if and when they arise. Most groups
have billing compliance programs. It is those programs that set the framework for involvement of individual providers in order to ensure integrity. MGMA believes that is the better approach to protecting program integrity, not the addition of yet another regulatory requirement.

**Independent Diagnostic Testing Facility (IDTF) Issues**

CMS’ proposal to adopt performance standards for independent diagnostic testing facilities (IDTFs) raises several concerns. MGMA believes that requiring federal certification of IDTFs will not control the growth in utilization or cost of IDTF services and will not ensure that medical imaging studies are being performed in a high quality, clinically appropriate manner. Rather, compliance with and implementation of these standards will further increase costs to individual medical practices and will yield little information for policy makers or health care consumers.

IDTF certification imposes a new layer of federal regulation on physicians providing diagnostic imaging services. CMS has not given any explanation of how the new standards will result in substantial savings. Before imposing additional administrative hurdles for IDTFs, CMS should evaluate the effectiveness of current requirements in order to ensure that additional regulations will not merely impose more costly burdens without achieving CMS’ stated goals.

In addition, the medical community is working to ensure the quality and safety of medical imaging performed by developing residency training standards and CMS programs for ultrasound, MR, CT, and PET. They are also developing appropriateness criteria and practice guidelines for reasonable incorporation of these technologies into patient care. Performance measures and other quality-improvement tools are also being considered. CMS should recognize and not duplicate or override efforts being made by the medical community to ensure quality and safety. IDTFs are already subject to specialty-specific requirements, as well as state laws and regulations currently in place that stipulate equipment quality controls and technologist training requirements. CMS should support the efforts of the medical community to develop specialty-neutral standards for IDTFs.

MGMA appreciates CMS’ elimination of the requirement that comprehensive liability insurance coverage be at least 20 percent of an IDTF’s average annual Medicare billings. This requirement was overly burdensome and would have required complex and ongoing calculations by IDTFs to ensure compliance. MGMA remains concerned, however, about the proposed prohibition on solicitation of patients. Though CMS’ commentary regarding this proposal indicates that IDTFs will be allowed to use public advertising as a method of providing information to patients, CMS did not clarify the language of the standard to make this clear. Instead, it maintained the requirement that IDTFs only accept patients referred by an attending physician. This standard limits the ability of Medicare beneficiaries to be informed about and to select their health care providers and requires the beneficiary to rely on the referral arrangements developed by his or her attending physician. MGMA supports a beneficiary’s ability to be fully informed about health care providers and to be allowed to direct his or her care.

Finally, MGMA asks CMS to delay the effective date of this regulation to give existing IDTFs time to comply with its requirements. These standards were only made final on November 1, 2006 and only published in the Federal Register on December 1, 2006, IDTFs will have had, at most, 2 months to comply with these requirements. Given that IDTFs are currently bracing themselves for huge cuts in reimbursement rates, CMS should provide more time to comply with the IDTF standards.
MGMA appreciates your consideration of these comments and looks forward to collaborating to educate medical group practices on the numerous Medicare program changes. If you have any questions, please contact Lisa P. Goldstein in the Government Affairs Department at (202) 293-3450.

Sincerely,

[Signature]

William F. Jessee, MD, FACMPE
President and Chief Executive Officer