

Congress of the United States

House of Representatives

Washington, D.C. 20515

April 8, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Administrator Tavenner:

As you know, we are strong supporters of the accurate valuation of Medicare physician reimbursement rates, as recently reaffirmed in our bi-partisan, bicameral permanent SGR legislation. Additionally, with expanded authority under the Affordable Care Act (ACA), the Centers for Medicare and Medicaid Services (CMS) has engaged in a vigorous effort since 2009 to identify more than 1,000 potentially misvalued payment codes and, when codes are found to be misvalued, to revise those payments accordingly. CMS has historically sought recommendations from outside stakeholders, including the AMA-convened Relative Value Scale Update Committee (RUC), to incorporate provider insight into this process. CMS similarly established a public nomination process for potentially misvalued codes through which other individuals and stakeholder groups may submit nominations for review of potentially misvalued codes. The Agency also undergoes a separate and independent analysis to validate relative value units (RVUs) of identified misvalued codes.

While we are fully supportive of these efforts, we are writing to request your consideration of a more transparent, timelier approach to incorporate stakeholder feedback into changes to Medicare Part B physician payments. Specifically, we request that the Agency follow the full notice and comment rulemaking process, including a notice of proposed rates in the proposed regulation ("rule"), a 60-day comment period for solicitation of public feedback, and codification through final rulemaking. These changes will improve upon the current process, which considers public feedback on new policies only *after* providers are subject to the new payment rates.

Providers must be afforded adequate time to review and comment on fee schedule changes, as well as prepare for reimbursement changes, before they become effective. When the results of CMS' analysis and the rationale for payment modifications are not released in the annual proposed rule, but instead in the final rule, it only affords physicians 60 days to prepare for the impact of reimbursement changes to their practices and patient care. Similarly, waiting until the final rule to release this information also constrains CMS' ability to incorporate stakeholders' insights into payment decisions prior to the revised reimbursement rates taking effect. This lack of transparency at a crucial phase of policy development robs health care providers and their patients the opportunity to fairly and meaningfully voice their approval or concern.

The Honorable Marilyn Tavenner

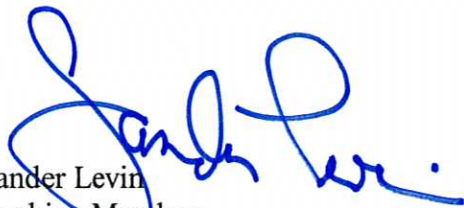
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We therefore request revising the current process by publishing these reimbursement changes in the annual proposed rule as opposed to waiting until the interim final rule.

We thank you for your consideration.

Sincerely,



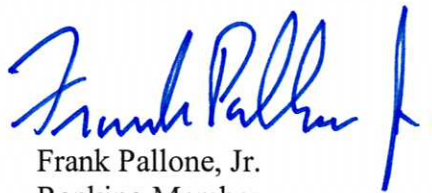
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Committee on Ways and Means



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Committee on Energy and Commerce



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