Dear Colleague:

I am writing to ask that you join me in sending the attached letter to the Centers for Medicare and Medicaid Services (CMS), urging the Agency for better transparency and allowing providers the opportunity to fairly and meaningfully participate in the Agency's rulemaking process.

CMS is statutorily required to periodically review the value of Medicare services and medical codes and to identify potentially misvalued services. Congress expanded this authority under the Patient Protection and Affordable Care Act. In doing so, for example, my office has learned that CMS does not announce major reimbursement changes until just a few weeks before these policies are implemented. The letter simply asks the Agency to announce these changes earlier in the year to give providers and stakeholders the opportunity to participate in the public rulemaking process.

Significant changes were recently made to reimbursement levels of certain services in specialties such as gastroenterology, orthopedic surgery, nephrology, diagnostic radiology, urology, thoracic surgery and pain management as a result of the misvalued code review authority. However, our medical provider constituents are unable to discover or prepare for significant reimbursement changes until those changes were just days from taking effect. Providers, medical practices of all sizes, medical societies, and other stakeholders must be afforded adequate time to review and comment on fee schedule changes, as well as prepare for major reimbursement changes to their practices and patients.

I thank you for considering joining me on this very important issue impacting our constituents and Medicare providers. Please contact Robb Walton (robb.walton@mail.house.gov) on my staff if you would like to be added as a co-signer on the letter. **The deadline to sign on is April 11.**

Sincerely,

Bill Cassidy M.D.
Member of Congress

Marilyn B. Tavenner, MHA, BSN, RN
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P. O. Box 8013
Baltimore, MD 21244-8013

Dear Administrator Tavenner:

We are writing to express our concern with the current process for establishing changes to Medicare Part B physician payments. Specifically, we are aware that significant changes are being made to Medicare physician payments without the opportunity for stakeholders to express concerns regarding the methodology or assumptions being made by the Centers for Medicare and Medicaid Services (CMS) as part of the proposed rulemaking process. As a result, these processes lack transparency and deprive health care providers and the recipients of their services the opportunity to fairly and meaningfully participate in the Agency's rulemaking.

CMS is statutorily required to periodically review the value of Medicare codes and to identify potentially misvalued services. CMS historically uses as guidance the recommendations from outside entities that are not official federal advisory panels to help accomplish this mandate. The Agency also undergoes a separate and independent analysis for determining code relative value units (RVUs). 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 affords our physician-constituents very little time to prepare for the impact of reimbursement changes to their practices and patient care. Waiting until the final rule to release this information also hamstrings the ability of interested stakeholders to respond to CMS' determinations before new reimbursement rates take effect. Depriving health care professionals the opportunity to contribute their unique expertise in assessing the value of services is counter to the intent of federal rulemaking.

Providers, professional medical societies, and other stakeholders must be afforded adequate time to review and comment on fee schedule changes, as well as prepare for reimbursement changes. November publication of the final rule provides less than 60 days of notice for dramatic changes in reimbursement levels. For example, significant changes were recently made to reimbursement levels of certain codes in specialties such as gastroenterology, orthopedic surgery, nephrology, diagnostic radiology, urology, and pain management as a result of the misvalued code review authority. However, these physicians were unable to discover or prepare for significant reimbursement changes until those changes were just weeks from taking effect. We believe that current processes are unfair and deeply impact small-business operations and patient care.

We ask CMS to take any and all steps necessary to ensure that the rulemaking process for changes to the Medicare physician fee schedule under the misvalued codes initiative is transparent and allows for sufficient input by stakeholders well before the new values are implemented. As an important first step, we ask CMS to begin publishing these reimbursement changes in the annual proposed rules as opposed to waiting until the interim final rules.

We look forward to hearing of CMS' plans for developing a more transparent process in this regard.