November 17, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-3321-NC

Dear Acting Administrator Slavitt:

The American Association of Clinical Urologists (AACU), a professional association representing thousands of urologists from across the country, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services’ (CMS) request for information, CMS-3321-NC.

While CMS-3321-NC contains requests for information on a number of important and interesting issues, the AACU will limit its comments to: a proposed subcategory to assess clinical improvement activities, as defined under section 1848[q][2][C][v][iii] of Social Security Act (the “Act”), as amended, entitled “Promoting Health Equity and Continuity,” that would collect information on a physician’s participation, or lack thereof, in Medicaid, health insurance exchange plans and other activities for use in the determination of his or her Medicare payments. The AACU opposes the establishment of any such subcategory.

For years, the AACU has been involved at the state level educating and advocating on the importance of medical practice freedom, namely preventing states from tying medical licensure to a physician’s participation in a particular third-party payer program, like Medicaid, for example. While the proposed subcategory would not affect physician licensure, like tying licensure to participation in a particular third-party payer program, its use in determining Medicare physician payments would likewise potentially result in significantly negative consequences.

Physician practices vary dramatically throughout our large and diverse country, in size, scope, patient population, financial stability, to name a few factors. Physicians set up their medical practices in a manner to best serve their patients and preserve their practices in light of these and other factors. In doing so, physicians choose to treat patients covered by private insurance plans, Medicare, Medicaid, some combination of them, or none of them.
For those physicians who treat Medicare patients, their compensation, under the Medicare program in which they voluntarily chose to participate, should not be affected by their participation in any other kind of third-party payer system. First, using such participation in determining Medicare physician payments could adversely affect many physicians who choose to treat Medicare patients. Second, the administrative and financial burdens incurred by treating patients insured under a particular third-party payer system may be too great for certain practices, limiting any potential positive effect of creating the “Promoting Health Equity and Continuity” subcategory in the first place. Third, in light of narrow networks, some physicians may be precluded from participating in particular exchange plans. In short, the use of the proposed subcategory to determine Medicare physician payments has the potential to prompt physicians to stop treating Medicare patients, or for those contemplating retirement or the viability of their medical practices, motivate them to leave the practice of medicine altogether, a troubling occurrence in the this day of physician shortages.

Accordingly, the AACU opposes the proposed adoption and use of the subcategory entitled, “Promoting Health Equity and Continuity” as described in CMS-3321-NC. The AACU appreciates the opportunity to comment, and is available for questions.

Sincerely,

Jeffrey M. Frankel, MD,
Health Policy Chair AACU

JMF:drs