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Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Submitted electronically at: http://www.regulations.gov

Re: CMS-1503-P, Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Proposed Rule; 75 Fed. Reg. 40040 (July 13, 2010).

Dear Dr. Berwick,

The Association of American Medical Colleges (AAMC) is a not-for-profit association representing all 133 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. The Association appreciates the opportunity to comment on The Center for Medicare and Medicaid Services's (CMS) proposed rule, *Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011***.**

Our comments focus on the following proposals:

- revising and rebasing of the Medicare Economic Index (MEI);
- modifications to the geographic adjustments;
- implementation of the e-prescribing incentive penalties;
- group reporting options for the Physician Quality Reporting Initiative (PQRI) and the e-prescribing incentive program; and
- the physician feedback program.

Sustainable Growth Rate (SGR)

The AAMC recognizes that under current legislation physicians face a projected negative 6.1% update, on top of the expected 23% reduction in December. Academic medical centers (AMCs) and their faculty physicians are committed to providing the best possible care to Medicare beneficiaries and other patients. The uncertainty faced by faculty physicians and all other Medicare providers because of the continuous cycle of looming payment reductions followed by short-term patches is unsustainable. The AAMC supports a full repeal of the SGR and

encourages CMS to work with Congress to revise the physician payment formula to resolve this situation.

Revising and Rebasing the Medicare Economic Index (MEI)

The MEI is an integral part of physician payments. Not only is it used in the annual physician update, but the index's weights are used in the calculation of geographic adjustments, as well as in determining the aggregate proportion paid for physician work, practice expense, and professional liability insurance. The AAMC strongly supports a process to ensure the MEI accurately reflects the costs of providing physician services; however, as will be explained below, **it is premature for CMS to revise and rebase the MEI for the 2011 physician fee schedule.**

CMS proposes to rebase the MEI to CY 2006 and to revise the inputs as well. Specifically, CMS plans to remove pharmaceutical drugs, because drugs were removed from the corresponding SGR calculation in 2010. CMS also proposes to modify the office expense category by dividing the single weight – office expense – into a series of nine subcategories. The agency provides no rationale to justify the changes in office expense, nor did it solicit advice on new inputs to the index. While the proposed modifications do not adjust the aggregate index, the changes to the individual weights have a profound impact on the payment for individual services. Practice expense and professional liability insurance relative value units (RVUs) have all increased and the conversion factor has decreased. The new weights also have an impact on the calculation for practice expense geographic adjustments.

The agency seems to have recognized the need for an extensive review of the MEI by proposing "to convene a technical advisory panel later this year to review all aspects of the MEI" (p. 40095). **The AAMC believes that it is premature to finalize proposals that will significantly change the MEI prior to receiving recommendations from the technical advisory panel. We strongly support convening the technical advisory panel and engaging in rulemaking at a future time based on its recommendations.**

Updating the Geographic Practice Cost Indices (GPCIs)

The proposed rule outlines a series of technical changes to the geographic practice cost indices for physician work, practice expenses (PE), and professional liability insurance. The AAMC appreciates that many of the modifications are required by legislation. These include provisions from the Affordable Care Act (ACA) to blend local and national rates for practice expense labor and rent, with a hold harmless provision to ensure high cost areas do not experience decreases due to the blending. CMS must also establish a 1.0 GPCI practice expense floor for frontier states. The AAMC also understands that CMS is required to update the GPCIs every three years and is required to provide a two year period to transition to the new GPCIs.

The AAMC is very concerned, however, that additional GPCI proposals (especially those for PE GPCIs) have a large, and unjustified, negative impact on large urban areas where many major

academic centers are located. Practice expenses are composed of employee labor, office expenses, and medical and other supplies; only the labor and rent portions of the practice expense are geographically adjusted. Using the assumption that the other expenses are paid on a national market, CMS does not apply a geographic adjustment to those expenses. The AAMC encourages CMS to revisit this assumption as there may be other costs, such as professional services, that vary among localities.

CMS uses the MEI to determine the percent of the PE GPCI that should be adjusted for labor and rent. With the new MEI weights, the proportion of practice expense which is adjusted (currently 73% of practice expenses) would be reduced to only 58% of practice expenses.[1] Most of this change is attributable to a reduction in the rent adjustment based on the new MEI inputs. The decrease in the percent of practice expense adjusted means that high cost localities, such as Boston, San Francisco, Manhattan and New Orleans, will experience lower practice expense GPCIs, despite being located in areas with extraordinarily expensive commercial rents. This outcome seems counter to the ACA "hold harmless" provision.

As noted above, the AAMC strongly believes that the MEI proposal should be withdrawn pending recommendations from the technical advisory panel. **Changes to the GPCIs that are not mandated by law should likewise await the results of this panel and other Federal activities, such as the summit on geographic disparity issues that Secretary Sebelius has agreed to convene and the Institute of Medicine study on geographic adjustment factors.**

Proposed Implementation of E-prescribing Incentive Program

The 2011 proposed rule outlines the criteria for successful e-prescribers for the 2011 e-prescribing (eRx) incentive program and for the first time discusses proposals to implement the e-prescribing penalties for 2012 and 2013. The AAMC supports most of the eRx incentive payments proposals but urges CMS to make major revisions to the proposed implementation of eRx penalties. As will be described below, the AAMC urges CMS to revise the proposals related to: (1) the time periods that will be used to identify providers who will be subject to the penalty and (2) the imposition of penalties on eligible professionals (EPs) who receive Medicare electronic health record (EHR) incentives but do not meet the eRx requirements.

When Congress enacted the Medicare EHR incentive program, it recognized that e-prescribing was an integral component of EHR adoption. To avoid double payments for e-prescribing, it mandated that EPs could not receive payments from both the eRx incentive program and the Medicare EHR incentive program. While the eRx penalty provisions are not referenced in the American Recovery and Reinvestment Act (the law that establishes the EHR "meaningful use" incentive program), it defies logic to believe that Congress intended meaningful users to be subject to an eRx penalty. If CMS finalizes the proposal to penalize EPs who receive EHR incentives but do not meet eRx requirements, it would mean that the only way for a meaningful

[1] In the current MEI, rent accounts for 30% of practice expense and labor is 43%. In the proposed MEI, rent is only 18% of practice expense and labor is 40%.

user to avoid a penalty is to collect and report data for two different e-prescribing measures: one for the EHR incentive program and another for the eRx program, the latter being done solely to avoid the eRx penalty. This would be extremely burdensome to EPs who already are struggling to implement EHRs while understanding the various Federal reporting programs and how they interact with each other. **The AAMC strongly urges CMS to exempt EPs who receive Medicare EHR incentives from the eRx penalties.** If CMS believes it does not have the authority to do this, we encourage the agency to ask Congress to clarify its intent. There is time to do so prior to the imposition of penalties in 2012, though we note that it is important for providers to clearly understand the rules as soon as possible.

The AAMC also disagrees with the CMS proposal to use the 6-month reporting period—January 1 through June 30, 2011—to determine the eligible professionals and physician groups that would be subject to the 2012 eRx penalty. Doing so would unfairly penalize those EPs who successfully e-prescribe during the latter part of 2011 or during 2012 for what CMS has characterized as "administrative efficiencies" (75 *Fed. Reg.* 40208). Such "efficiencies" should not be allowed to become barriers to encouraging and rewarding those EPs who meet the e-prescribing standards even though they do so later rather than sooner.

In addition, CMS proposes to use calendar year 2011 to determine who is a successful e-prescriber for the 2013 penalty. CMS states that using data from 2011 "would be the most effective means of encouraging EPs and group practices to adopt and use electronic prescribing systems since anyone who does not qualify for an incentive in 2011 would be subject to a payment adjustment in 2013" (75 *Fed. Reg.* 40210). The AAMC strongly disagrees with this reasoning for the same reasons we disagree with making the 2012 determination using data from the first 6 months of 2011—it significantly and unreasonably contracts the period of time for coming into compliance and can result in the imposition of penalties on those EPs who actually are meeting the eRx requirements.

It is not unusual for CMS to review and adjust payments, nor is it unusual for incentives to be paid many months after the reporting period ends, as is the case with the PQRI program. The Medicare Improvements for Patients and Providers Act (MIPPA) gives CMS maximum flexibility to determine what constitutes a "reporting period" for purposes of the eRx penalty by saying that it is "a period specified by the Secretary." (Section 1848(a)(5)(D)(iii) of the Social Security Act). **Therefore, the AAMC recommends that for the 2012 penalty CMS use the full calendar year 2012 to determine the EPs and groups to which penalty will apply, and that for 2013, CMS use the full 2013 calendar year**.

CMS should retain the requirement that EPs must report eRx on at least 10 encounters to avoid the imposition of the penalty. While this volume is lower than the volume that is needed to qualify for the eRx incentive payment, it represents a good faith effort by the EP to report e-prescribing.

The AAMC also asks CMS to provide an exemption for EPs who routinely prescribe controlled substances. Until recently, these professionals were unable to prescribe these medications

electronically. Although the Drug Enforcement Agency has recently released regulations to allow this functionality, vendors are still incorporating the specifications. EPs who write a substantial number of prescriptions of controlled substances should have the opportunity to incorporate e-prescribing into their practice without the worry of a potential penalty.

Finally, when implementing eRx penalties, CMS should consider that the e-prescribing incentive program is relatively new and has not yet been evaluated. To date, CMS has not released any summary results about the e-prescribing program, including how many EPs are reporting and how many are earning incentives. Providers have not received feedback reports on their progress for 2009 or 2010. Given the lack of feedback, CMS should ensure that EPs who attempt to report but are unsuccessful due to the data submission process are not penalized.

eRx Group Reporting

In addition to the issues discussed above that pertain to EP reporting, the AAMC is concerned about the CMS proposed criteria for applying penalties to group practices. As proposed, group practices that choose to report eRx as a group must meet the volume reporting thresholds in six months to avoid the penalty, but have 12 months to meet the volume requirements for the incentive payment. CMS states that "group practices would not be disadvantaged" by this proposal because the number of e-prescriptions reported by each EP in a group is, on average, lower than what is needed for individual reporting. The AAMC disagrees. In determining the volume for the group incentive payment, CMS assumes that not all EPs in the practice would be e-prescribing. The same assumption should be applied for purposes of the penalty determination. If CMS finalizes the proposed 6-month reporting threshold, then the Agency should **lower the reporting volume that is needed for groups to avoid the penalty.**

In addition, the AAMC asks for clarification about how the penalties will be applied to the group practice. According to the proposed rule, CMS will "conduct our analysis for each unique [tax ID number] TIN/[national provider identifier] NPI combination so as not to disadvantage EPs who may have joined the group practice after January 1, 2011." (p. 40209). Since the group reporting requirements are at the TIN level, it is unclear how this analysis and penalty will be applied.

Finally, **the AAMC asks CMS to clarify the way in which it intends to calculate the group e-prescribing incentives if individual members of the group have received Medicare EHR incentives.**

Proposed Changes to the Physician Quality Reporting Initiative

The AAMC is pleased with several of the proposed modifications to the 2011 PQRI. In particular, we support the decision to lower the reporting threshold for claims-based reporting from 80% to 50%. Additionally, the increased number of measures that can be reported through EHR reporting is a welcome improvement. We look forward to working with CMS as it aligns PQRI and the quality reporting for the Medicare EHR incentive program in the next year.

Maintenance of Certification Programs (MOCP)

The Affordable Care Act created an additional 0.5% incentive in 2011 for EPs who satisfactorily submit data on quality measures and who more frequently than is required to qualify or maintain board certification status participate in an MOCP for a year and complete an MOCP (including a practice assessment.)

The AAMC appreciates that CMS recognizes the variability across MOCPs and has provided flexibility to the specialty boards to provide the details about their program. The AAMC also supports the proposal that an EP can submit data to PQRI through any of the current reporting mechanisms. We believe this option provides EPs with the maximum flexibility in submitting data to PQRI. It also allows more MOCPs to participate in the program, because the MOCP would not need to be a qualified registry for data submission. As the MOCP program is new, it may be necessary for CMS to provide additional guidance to ensure that the program is implemented in a clear and consistent way. The AAMC suggests that CMS work with affected stakeholders, as needed, so that as many EPs as possible have the opportunity to qualify for this incentive.

Group Practice Reporting Option (GPRO)

The AAMC is pleased that CMS has expanded the group reporting options for 2011: one option is for groups with at least 200 NPIs/TIN (GPRO I) and another option is for groups with fewer than 200 eligible professionals (GPRO II). While GPRO I requires practices to collect data on a sample of patients and uses a special data collection tool, the new GPRO II option uses the same measures and reporting mechanisms that are used in the traditional PQRI program. Specifically, group practices must report on a certain number of measures groups and on additional measures through either claims-based reporting or registry reporting. The AAMC encourages CMS to evaluate GPRO I and GPRO II options and summarize the benefits and difficulties of each option. If GPRO II proves to be a popular option, CMS should offer practices with greater than 200 NPIs per TIN the option to report under GPRO I or GPRO II. In the future, CMS should consider aligning the two group reporting options, so that all practice groups, regardless of size, have similar reporting options.

A significant advantage of GPRO II is that the risk to individual professionals who are successfully reporting PQRI data is less than for GPRO I. Under GPRO II, if a group is unable to successfully submit data, CMS will evaluate the performance of individual EPs within the group to see if the individuals are eligible for an incentive. The AAMC has requested that this option be made available to groups greater than 200, but CMS has not done so. **To encourage group reporting for large practices, and to reduce the risk to individual physicians if the practices do not qualify for an incentive, the AAMC again requests that CMS allow the individual EPs within GPRO I to continue reporting through traditional methods. Thus, those participants might be eligible for incentives if the group practice does not successfully submit data.**

Primary Care Incentive Payment and HPSA Surgical Incentive Payments

The ACA established two bonus payments that start in 2011 and extend to the end of 2015. The primary care incentive payment (PCIP) provides a 10 percent bonus for primary care services provided by primary care practitioners. The HPSA Surgical Incentive Program (HSIP) provides a 10 percent bonus for major surgeries provided by general surgeons in a health professional shortage area. The ACA defined many of the parameters of these programs, and in general AAMC supports most of the proposals.

The AAMC is concerned, however, about the length of time it would take professionals newly enrolled in Medicare to receive the primary care incentive payment. By law, CMS must define primary care practitioners based on the specialty and on the percent of primary care services provided in a prior period. CMS proposes to calculate the percent of primary care services using the most recent calendar year of claims data available, which for the 2011 incentive would be CY 2009. This means that newly-enrolled professionals, such as physicians who recently finished their primary care residencies, would have to wait two years to be eligible to receive the incentive. Considering that the bonus is authorized for only five years, and that the law is designed to reward those physicians who choose primary care, this is an unacceptable delay.

CMS should adopt the goal of distributing the PCIP to all providers who meet the legislative requirements; therefore, the agency should consider other methods for determining whether practitioners newly enrolled to Medicare are primary care practitioners. For example, CMS could use data from the last quarter of 2010 to determine primary care status for practitioners newly enrolled in 2010. While this determination would have to occur during the 2011 bonus period, CMS could either make a retroactive bonus payment or decide that newly enrolled practitioners would receive an annual payment instead of a quarterly one. The AAMC encourages CMS to make the bonus available to all qualified primary care practitioners and would be happy to work with CMS to make this happen.

The AAMC is also concerned about the definition of "allowed services" in the calculation of the percent of primary care services provided. CMS proposes a broad definition that would include all Medicare Part B charges. This definition is likely to make it more difficult for a physician to reach the required 60 percent threshold needed to qualify for the bonus and is contrary to the language of the statute which refers to services "under this part." In this context, "under this part" refers to primary care services, all of which are furnished under the physician fee schedule. Therefore, the AAMC requests that CMS consider only services under the physician fee schedule.

Physician Feedback Reports and Value-based Modifier

The AAMC supports many of the modifications to Phase 2 of the physician confidential feedback report program including:

- measuring resources for group practices as well as individual physicians;

- removing episode-level resource reporting until a Medicare-specific episode grouper has been selected;
- pairing quality scores with the resource measurement; and
- distributing the reports electronically.

One additional change to Phase 2 is a change in the risk adjustment methodology for per-capita costs. In Phase I of the feedback program, CMS included socioeconomic status (SES) factors, "such as the median income per capita in the county where the physician practices" in the risk adjustment for per-capita costs. In Phase 2, the SES adjustment was removed because CMS concluded these factors "did little to improve the fit of the model." (75 *Fed.Reg*. 40115). The AAMC believes that in a risk adjustment methodology, socioeconomic status is an important variable. However, SES should be associated with the **patient** not the location where the physician provides the service. For instance, it is possible that a physician may be located in one zip code, but that many of his/her patients come from another zip code that represents a significantly different SES than that of the physician's practice location. In an internal readmission analysis that the AAMC conducted in conjunction with University HealthSystem Consortium, we discovered an association between readmission rates and income, one component of SES. Because inpatient hospitalizations are often the primary driver of healthcare costs, we think this readmission/income association is likely to have an impact on overall resource use for the patient and should be included in future resource measurement.

We also believe that resource use for patients who have substance abuse and mental health comorbidities should either be removed from resource analysis or put into a separate analytic cohort. Often, these patients are noncompliant for reasons that are outside the control of the physicians who treat them. Physicians who serve these patient populations should not be unfairly penalized.

CMS is soliciting comments on statistical issues which could affect resource use measurement. For two of the issues – attribution and benchmarking – the AAMC suggests that the methodology take into account the multiple missions of academic clinical faculty who provide patient care while simultaneously training medical students, residents and other healthcare professionals, as well as conducting research. Faculty physicians provide specialized services and treat complex referral patients. An AAMC analysis of Medicare hospitalizations showed that teaching hospitals cared for seventy-two percent of all Medicare patient transfers and that the median case mix index for all patients, both transfers and others, was higher at teaching hospitals than at non-teaching hospitals.[2] CMS should not adopt a system that will penalize faculty physicians because they are willing to treat these complex patients. The AAMC encourages CMS to consider developing benchmarks specific to the academic community. This would ensure that differences due to the nature of academic medicine are controlled for in the benchmark comparisons.

[2] AAMC Analysis in Brief: Hospital Transfers of Medicare Patients. February 2009. http://www.aamc.org/data/aib/aibissues/aibvol9_no1.pdf

Finally, the AAMC asks CMS to keep stakeholders informed of its findings from Phase 2 and to solicit input as it moves forward in measuring resource use. This becomes especially important as composite scores for resource use will influence the physician value-based modifier to be implemented in 2015.

Public Reporting

The AAMC supports the CMS proposal for a Physician Compare website in 2011 to report the names of the EPs or group practices that submit data for the 2011 PQRI, meet the proposed criteria for satisfactory reporting, and qualify for an incentive.

CMS is required to start reporting performance rates as of 2013. The AAMC believes that reporting performance rates rather than reporting the names of EPs who satisfactorily submit data requires a different level of scrutiny. The AAMC suggests that CMS work with stakeholders to:

- Develop reliable, comparable benchmarks, with a sufficient sample size to ensure validity;

- Provide an opportunity for physicians, other eligible professionals, and group practices to review their data before it is made public. The agency must allow groups to review data—both their individual data and comparative benchmarks—before it is publicly reported. At a minimum, a process should be established that allows for prior review and comment before data are made public. As with Hospital Compare, providers should have the right to suppress any data that are inaccurate; and

- Establish a method for ensuring that any publicly reported information is: (i) correctly attributed to those involved in the care; (ii) appropriately risk-adjusted; and (iii) accurate, user-friendly, relevant and helpful to the consumer/patient. CMS must educate consumers/patients about the publicly reported performance measures and corresponding benchmarks.

We appreciate the opportunity to share these comments with you. If you have questions, please contact either Ivy Baer (ibaer@aamc.org) or Mary Patton (mpatton@aamc.org) of my staff, both of whom may be reached at 202-828-0490.

Sincerely,

Joanne Conroy, M.D.
Chief Health Care Officer

Cc: Mary Patton, AAMC
Ivy Baer, AAMC