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Via Electronic Submission (www.regulations.gov)

August 30, 2012

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1590-P
7500 Security Blvd.
Baltimore, MD 21244-8013

Re: CY 2013 Physician Fee Schedule (PFS) Proposed Rule, File Code CMS-1590-P

Dear Ms. Tavenner:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS or the Agency) Proposed Rule entitled *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Part B for CY 2013*. 77 Fed. Reg. 42722 (July 30, 2012). The AAMC represents all 138 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, 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 proposed rule has significant long-term considerations for physicians, other clinicians, and group practices. CMS outlines a proposed framework for the value-based modifier (value modifier or VM), while simultaneously modifying the scope of group reporting. CMS also proposes a new discharge transition code that recognizes the costs to coordinate care. The issues are discussed in more detail on the following pages, but the AAMC's main concerns are listed below:

- The VM proposals force a massive shift to group reporting without adequate time for groups to implement the changes. Group reporting should be optional. Large group practices (groups of 100 or more eligible professionals) need to have more reporting options.
- The Physician Quality Reporting System (PQRS) group practice reporting option (GPRO) web interface reporting mechanism is one of two reporting options for large group practices; yet, the reporting option needs improvement. In particular, CMS needs

to adopt a primary-care attribution methodology. CMS also needs to invest the resources to ensure a smooth reporting process.

- The definition of a group practice needs to be more flexible than the single method of identifying groups by tax identification number (TIN).
- Measures for high-stakes programs, such as public reporting and the VM calculation, require stringent criteria for inclusion.
- Two years is too long between the performance period and the VM and PQRS payment adjustment periods.
- The new discharge care coordination transition code should be available to all providers who coordinate care post-discharge, not just to the provider who bills first.

VALUE MODIFIER AND PQRS PROPOSALS (pp. 44805-44982, 44991-45021)

The value modifier and PQRS proposals are interconnected and complex. The AAMC believes these proposals need to be addressed in an integrated fashion; therefore, our letter will broach these topics in the following order:

- Overview of VM and PQRS Group Reporting Proposals
- PQRS Group Practice Reporting Options
- Alternative Definitions for Group Practice
- GPRO Web Interface Reporting Mechanism
- Administrative Claims Reporting Mechanism
- Other PQRS Reporting Mechanisms for Groups
- Group Registration/Self-Nomination Process
- VM Cost Measures and Attribution Methodology
- VM Quality Measures and Outcome Measures
- VM Benchmarks
- VM Calculation: Quality Tiering
- VM for Pioneer and Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)
- Other Issues Related to the VM and PQRS

Overview of VM and PQRS Group Reporting Proposals

Section 3007 of the Affordable Care Act establishes a value-based modifier where physicians (or physician group practices) are paid differentially based on their performance on cost and quality measures. According to law, the VM will apply to certain physicians or groups of physicians by 2015 and to all physicians by 2017. The statute also requires that the VM be implemented in a budget neutral manner. CMS has the discretion to determine how the VM is calculated, the size of the VM, and to whom the 2015 VM would be applied. In the 2012 Physician Fee Schedule Final Rule, CMS finalized the 2013 calendar year (CY) as the performance period for the 2015

VM. CMS also finalized CY 2013 as the performance period for determining the first PQRS penalty: a 1.5 percent reduction for non-reporters starting in 2015.

In the CY 2013 PFS proposed rule, CMS outlined the remaining parts of the value modifier framework. The Agency considered five principles when developing the options for the 2015 VM proposal (77 *Fed. Reg.* at 44994):

- Measurement and alignment;
- Physician choice;
- Shared accountability;
- Actionable information; and,
- Gradual implementation.

CMS is proposing to apply the 2015 VM to all groups with at least 25 eligible professionals (EPs).¹ Groups must successfully report using one of the PQRS group reporting mechanisms or face a 1.0 percent reduction to their 2015 Medicare fees. This reduction is in addition to any potential PQRS penalties. Any group that successfully reports will be exempt from the VM negative adjustment, but will have the *option* to elect a pay-for-performance reimbursement. Groups that elect the pay-for-performance option will have their payments adjusted upwards or downwards based on their cost and quality scores. Group practices may also qualify for an additional incentive if they care for high-risk patients.

Concurrent with the VM proposal, CMS is proposing substantial revisions to the PQRS group reporting options. First, CMS is proposing to modify the definition of groups to include practices with at least two EPs per tax identification number (TIN). CMS also is proposing to expand the number of reporting mechanisms available to groups. In 2012, the only reporting option was a web-based tool, now called the group practice reporting option (GPRO) web interface². CMS is proposing in 2013 to offer a total of five group reporting options, including a low-burden “administrative claims” option that allows CMS to mine the provider’s billing claims data. The available reporting options depend on group size which is determined when a group registers for PQRS. For groups with 100 or more national provider identifiers (NPIs)/TIN, only two reporting options are offered: GPRO web interface or administrative claims data.

The following table provides a summary of how the PQRS and VM proposals change with the size of the group practice.

¹ Groups that are participating in a Pioneer Accountable Care Organization (ACO) or a Medicare Shared Savings Program (MSSP) ACO are exempt from the 2015 VM.

² GPRO technically stands for group practice report option. However in this comment letter, “GPRO” will refer specifically to the GPRO web interface reporting mechanism. The AAMC will reference “group reporting” when discussing group reporting across all reporting mechanisms.

Table 1: PQRS and Value Modifier Proposals by Group Size

| | 1 NPI Per TIN | 2-24 NPIs Per TIN | 25-99 NPIs Per TIN | 100+ NPIs Per TIN |
|-----------------------------------|--|--|---|---|
| PQRS Individual Reporting Options | Claims, Registry, EHR, or Administrative claims* | Claims, Registry, EHR OR Administrative claims* | No options if the group wants to avoid a -1% VM adjustment in 2015 | No options if the group wants to avoid a -1% VM adjustment in 2015 |
| PQRS Group Reporting Options | N/A | <ul style="list-style-type: none"> • Group Claims, Registry, EHR • Administrative claims* • No GPRO Webtool Interface | <ul style="list-style-type: none"> • Group Claims, Registry, EHR • GPRO Webtool Interface • Administrative claims* | <ul style="list-style-type: none"> • GPRO Webtool Interface • Administrative claims* • No claims, registry or EHR option |
| 2015 Value Modifier | N/A | N/A | <ul style="list-style-type: none"> • -1% if not satisfactorily reported to PQRS <u>as group</u> • 0% if report PQRS w/ option to do quality tiering | <ul style="list-style-type: none"> • -1% if not satisfactorily reported to PQRS <u>as group</u> • 0% if report PQRS w/ option to do quality tiering |

* Administrative claims reporting mechanism is proposed to be available for 2013 and 2014 as an alternative to avoid the 2015 and 2016 value modifier and PQRS penalties.

The AAMC supports the Agency's five principles for the VM implementation. The AAMC also supports selected components of the VM proposal that allow a gradual phase-in of pay-for-performance. In particular, the AAMC strongly supports the CMS proposal to make pay-for-performance optional for the 2015 VM. The AAMC also appreciates that the VM proposal includes an incentive that acknowledges the difficulty of caring for high-risk patients. Finally, while the AAMC believes that administrative claims are limited in terms of measuring quality, the Association appreciates that CMS has proposed a low-burden reporting mechanism for providers during this time of transition.

Overall, though, the AAMC is very concerned, for the reasons listed below, that the proposed VM implementation will fall short of CMS' desired principles.

- The obligatory shift from individual reporting to group reporting is a major policy change. Practices that have invested in individual reporting are not provided with an option that allows for a gradual phase-in. Instead, the CMS proposal disrupts their current reporting strategies, and requires that they change their system in a short period of time.
- PQRS group reporting does not align with the 2013 EHR Incentive Program and has limited alignment starting in 2014.
- The VM proposal has very limited reporting choices for large group practices.

- The GPRO web interface reporting mechanism, the only proactive reporting option for large group practices, is significantly different from other PQRS reporting options and can be difficult to report.
- The definition of group practice is too narrow and needs to be more flexible.
- The CY 2013 performance period is too far removed from the 2015 payment adjustments.
- The explosion in group reporting could produce many unexpected technical issues for calculating the VM. Issues can include the wide array of quality measures being submitted by different specialty groups and the applicability of attribution methods across different practice types.

To address these concerns, the AAMC urges CMS to make these changes in the final rule:

- Group reporting should be optional, not required.
- Large groups should have more options to report quality data, and groups need a reasonable amount of time to implement those reporting options.
- The GPRO web interface should be improved. At a minimum the attribution methodology needs to shift to a primary care attribution AND CMS needs to ensure a smooth data submission process.
- The definition of group practice needs to be flexible enough to allow multiple related TINs to create a group practice, or to allow a large TIN to divide into smaller group practices.
- The performance reporting period should be changed so that it is closer to the time when the payment adjustment is applied to the practice.

PQRS Group Practice Reporting Options

AAMC always has been a strong supporter of group reporting, but believes the decision to report as a group should be made by the group practice. Group reporting has many benefits. It allows practices to focus on a set of important common measures and encourages a systematic approach to care. However, there are drawbacks to group reporting too. The measures in group reporting tend to be primary-care focused and do not resonate with many specialists, particularly surgeons and subspecialists. Also, group reporting does not align with all the current federal quality reporting programs.

Currently, group reporting is optional which means each group can determine whether individual reporting or group reporting is the best choice for their practice. Organizations developed strategic plans for data collection and implementation based on these choices. If finalized, the CMS proposal would mean that organizations must change their reporting strategy. Large group practices have limited reporting choices (GPRO web interface or administrative claims data) and no choice regarding the measures to report as both reporting mechanisms have a standard set of measures.

An additional complication is that the final rule is scheduled to be displayed around November 1, 2012 and CMS proposes that groups need to register by the end of January 2013. Groups will have only three months to transition to group reporting.

CMS needs to craft proposals that recognize that the healthcare system is in a time of transition. The EHR Incentive Program is spurring the adoption of electronic health records and changing the way data is collected. Many organizations have focused on the EHR Incentive Program first to ensure that new systems are incorporated into clinician practice. Unfortunately, the EHR Incentive Program is an individual level program and currently does not have a group reporting option. The final Stage 2 rule, which was released on August 23, 2012, confirmed that a group reporting option for clinical quality measures will be available in 2014, but that option would only apply to EPs in the Medicare program, not to EPs in the Medicaid program. Requiring practices to do group reporting for the value modifier, when a comprehensive group reporting option does not exist in the EHR Incentive Program, is likely to divert resources from EHR adoption.

Given the concerns listed above, the AAMC recommends that CMS make the following revisions to its proposals:

- Provide an option for group practices to continue individual data submission. This is consistent with CMS' stated principle of allowing for provider choice.
- Expand the number of group reporting options for large group practices. These practices should be able to continue using the traditional PQRS reporting mechanisms (registry, claims-based, EHR.) In addition, CMS needs to clarify how the new group reporting options will be implemented.

Finally, CMS needs to continue to align the multiple federal programs and provide consistent guidance on the long-term strategy for quality reporting. Academic practices are willing to invest in quality reporting, but practice leaders are struggling to understand where reporting will be in the next five to ten years. Practice leaders also have difficulty explaining to clinicians the nuanced differences among the PQRS, VM, Medicare and Medicaid EHR Incentive Programs, and the E-Prescribing Incentive Programs. Each change in each program, whether large or small, incurs additional investment costs and leaves fewer resources available for improving access and patient care. The AAMC encourages CMS to eliminate the redundancies that exist across these programs.

Alternative Definitions for Group Practice

CMS currently identifies groups for the PQRS and the VM by tax identification number. The AAMC believes that TIN is one viable definition of "group" but has long supported alternative definitions. Due to a variety of business reasons unrelated to quality reporting, some faculty practice plans have multiple TINs. In these practice plans, the departments share common services, consider themselves to be part of the same physician practice, and are viewed by the public as being part of the same physician practice. Alternatively, a few large practices that

operate under a single TIN would like the option to define multiple groups within a TIN because that is how they functionally operate. If CMS finalizes the option that group practices need to report at the group level, it is essential that there be sufficient flexibility to allow groups to define themselves.

CMS can find a precedent for linking multiple TINs for quality and cost reporting in the Medicare Shared Savings Program Accountable Care Organization (MSSP ACO). Each ACO defines the “parent TIN” which provides a main contact for quality reporting coordination and payments. However, the data for the other TINs in the ACO (aka the “children TINs”) are used for population attribution assignment and the children TINs receive credit for the cost and quality of care for the ACO population. The AAMC believes this format could easily be adapted to PQRS and VM group reporting.

Unlike an MSSP ACO, PQRS and VM groups are not required to disperse funds; therefore, CMS can use a more simple process to allow multiple TINs to nominate themselves to be considered as a single group for quality and resource reporting purposes. The nomination could require that the group select a “parent” entity to facilitate coordination with CMS staff. To ensure that the TINs have a relationship to each other, CMS can incorporate the concepts of “public perception” and “shared systems” that the AAMC discussed in detail in the 2012 Physician Fee Schedule Proposed Rule comment letter

(<https://www.aamc.org/download/258472/data/aamccommentletteronthe2012physicianfeescheduleproposedrule.pdf>).

For groups that want to break a large TIN into smaller components, CMS can use data elements that currently exist in claims data, such as the group identification number. During the group registration process, the single TIN would be able to document that it wants to be measured at the smaller unit level.

Finally, CMS proposes groups that change TINs during the year cannot participate in any group reporting option. The AAMC does not support this proposal. The merging and splitting of group practices is part of the normal course of business. CMS should develop a mapping process where groups can change TINs without fearing PQRS or VM penalties.

The AAMC acknowledges that having multiple definitions for TINs may be somewhat more challenging for CMS to implement and monitor. However, in an era in which groups are paid based on their quality and cost performance, it is essential that CMS have an accurate definition of group. Having only one, inflexible definition will create barriers to successful group reporting. The alternative definitions proposed by the AAMC are designed to reduce regulatory burden for providers and accommodate the variety of health care models that currently exist. The AAMC would be happy to work with CMS to facilitate implementation of these alternative definitions.

GPRO Web Interface Reporting Mechanism

The GPRO web interface reporting mechanism is different from the other traditional PQRS reporting options. GPRO groups do not select their measures or their patient population. Instead, GPRO participants submit data on a single set of measures for a random sample of patients that are assigned to them by CMS. Group practices have a specified reporting window in which they have to complete the data submission, which is typically in the first quarter after the performance period is completed.

For performance years 2010 and 2011, all GPRO participants were large groups that had at least 200 NPIs/TIN. In 2012, CMS expanded GPRO web interface to groups with 25 or more NPIs/TIN, but created separate reporting requirements for groups with 25-99 NPIs/TIN and groups with 100 or more NPIs/TIN.

In 2010 and 2011, GPRO participants reported 26 measures, which covered four disease modules plus four preventive care measures. In 2012, the number of measures and disease modules increased. For 2013, CMS is proposing 18 measures, including some composite measures, in five disease modules plus preventive care and care coordination measures.

GPRO Academic Network

AAMC and University HealthSystem Consortium (UHC) convened the GPRO Academic Network, an informal network of academic medical centers that participated in GPRO for 2010 or 2011. The faculty practices in this group agreed to share their performance data and experiences so that they can learn from each other and share findings to help new groups succeed at GPRO reporting.

The original GPRO Academic Network contained 9 of the 35 groups that participated in the 2010 GPRO. In the fall of 2011, UHC and the AAMC completed a detailed benchmarking project with these members. UHC and AAMC staff also conducted semi-structured interviews with eight groups to understand how they operationalized GPRO reporting and the reasons for variance on quality measures. The high level findings from this work were shared with the academic community and CMS staff. A short summary of the 2010 GPRO experience is described in the body of this letter. In addition, a formal summary of this work will be published as an issue brief through the UHC-AAMC Faculty Practice Solutions Center.

Since the benchmarking project, UHC and the AAMC have kept in contact with groups through the 2011 GPRO reporting cycle. Nineteen groups that reported in the 2011 GPRO cycle participated in a recent teleconference to discuss the PFS proposed changes. To our knowledge, this effort represents the most comprehensive set of perspectives from GPRO participants. The following sections convey direct feedback from GPRO participants. In a few places, which are clearly indicated, the AAMC has inserted its own recommendations which were informed by the experiences of the GPRO Academic Network members. We believe these experiences and recommendations merit serious consideration by CMS.

Summary of 2010 GPRO Experience

Consistent with CMS' analysis on the entire 2010 GPRO cohort, the participants of the academic network had a wide variation in performance. The amount of variation differed across measures. In other words, for certain measures the group as a whole either did very well or very poorly, but in other measures the performance scores were much tighter. The reasons for the performance variation can be grouped into three broad categories.

- **Attribution.** Six of the eight groups indicated that the patient attribution methodology had an impact on performance. In 2010 and 2011, beneficiaries were attributed to group practices based on the plurality of outpatient/office visits. When the patients came to the practice for specialty care, the patient population on which the practice expected to be measured differed from patient population that was actually assigned. For example, one group shared that several patients in their diabetes module were being treated by the practice for cancer, not diabetes care. Another example from the 2011 GPRO: an orthopedic physician saw a patient four times for a broken arm, yet this patient was assigned to the preventive care colorectal screening measure. Attribution was noted as an issue most often for the diabetes module and preventive care measures.
- **Missing data or documentation errors.** When a service occurred outside the organization, the group practice frequently did not have the detailed results in the EHR or the documentation was hidden in a scanned note and not easily retrieved for quality reporting. In other situations, the service may have occurred, but the clinician did not document the service, or did not document it sufficiently for measurement purposes. This issue was mentioned by several practices for the diabetes foot exam measure. Physicians had documented "lower extremity" in the record, but that term did not meet the measure specification requirements.
- **Issues related to measure specifications.** Some preventive care measures did not provide an exclusion for patient refusal. In other measures, such as Hypertension Plan of Care, the group was unclear about how to report the measure. In addition, for complex patients, the clinicians believed the blood pressure was under control based on the circumstances of that patient even though the blood pressure threshold in the measure indicated poor control.

All groups had to dedicate resources to GPRO reporting. The core team ranged from 3 staff members to over 2 dozen. Most groups did a hybrid data collection: pulling in data from the EHR and supplementing with chart review. In fact, one of the best performers in the network (the organization did at least 5% better than the cohort average on 22 of the 26 quality measures) trained 50 nurses to do thorough supplemental chart abstractions.

Other than the concerns with attribution, most GPRO participants were fairly pleased with the 2010 reporting cycle. CMS managed its deadlines, there were few technical issues, and the groups were able to submit their data within the 5 week reporting window.

Summary of 2011 GPRO Experience

Unfortunately, the 2011 GPRO reporting cycle did not go as smoothly. While the patient attribution logic and the measures did not change in 2011, CMS hired a new contractor to convert the process from an access database tool to a web-based data collection tool. There were many delays and participants had to stop reporting on the first set of data due to programming errors in assigning patients to modules. The second data release was improved, but still had minor errors. In addition to the data issues, the web tool had multiple performance issues. Groups struggled with downloading and uploading data, response times were slow, and the system often timed-out. Specifications were inconsistent and in at least one case the date ranges for reporting a measure changed during the data submission cycle. The technical issues were compounded by poor communication from CMS, the contractor, and the QualityNet Help Desk. The AAMC acknowledges that CMS staff did work to improve the communications and technical issues; however, GPRO members had several months dealing with a very frustrating, costly, and time-consuming reporting experience.

When groups opt to participate in GPRO, the organizations know they have a very limited time window to complete the reporting and allocate resources accordingly. In the 2010 reporting cycle, the reporting window was late February through March 2011. In the 2011 reporting cycle, the dates were completely different:

- 3/19/2012: First patient file was released, several weeks after the original scheduled date.
- 3/28/2012: Reporting was suspended due to programming errors.
- 5/7/2012: Second patient file released.
- 7/16/2012: Final reporting submission date.

The technical and communication issues frustrated practices, but the shift in deadlines meant that allocated resources were not used. In addition, staff time was wasted trying to work through the programming and technical problems. Due to the issues, CMS promised the GPRO participants that they would be held harmless for the 2011 reporting cycle. Groups were given additional time to complete the data submission, and they were not required to complete the submission in order to receive their incentive. While these adjustments were helpful, it did not compensate the groups for their missed opportunity costs and lost resource costs.

It is unclear how much the technical problems may have affected the 2011 performance results. At a minimum, the quality data may not be as complete and thorough because the groups did not have access to the same resources. The AAMC cautions CMS to consider these issues when reviewing and reporting on the 2011 GPRO performance results.

Changes to Improve the GPRO Web Process for 2012 and 2013

The 2012 GPRO reporting submission process will occur in early 2013. The 2012 GPRO measure set includes new measures and new disease modules, which means groups have to report on more patients. The stakes for 2012 are higher as well because CMS plans to post the performance results on the Physician Compare website. (Please see the Physician Compare section of this letter for additional AAMC comments.) For the 2013 GPRO reporting cycle, if the VM proposal is finalized, CMS should expect a large number of groups to sign up for the GPRO web interface reporting option. There must be evidence that this reporting option will work well.

The reporting process for 2011 was unacceptable. The following are recommendations from the GPRO Academic Network to avoid the difficulties experienced in 2011 and to improve the reporting process overall.

Modify the Attribution and Module Assignment Methodology

CMS should move to a primary-care attribution methodology. In part due to feedback from GPRO participants, CMS agreed to implement a new attribution methodology in 2012, but it is unclear whether that methodology will resolve the attribution issues described above. The GPRO Academic Network participants believe that a primary-care based assignment methodology, such as the MSSP ACO methodology, would be an improvement to the 2010/2011 GPRO methodology.³ There are two reasons for the recommendation: 1) most of the GPRO measures are primary-care measures and 2) the methodology would be consistent with the MSSP ACO program. CMS should adopt the ACO methodology and also inform the GPRO participants of the impact of the new methodology on their assigned patient population.

CMS can improve the attribution for the quality module assignment by requiring that at least one diagnosis (and preferably at least 2 diagnoses from two different service dates) come from the claims billed by the TIN. This would minimize the confusion of confirming which patients have which conditions.

These two suggestions should substantially improve attribution assignment. In the long term, the AAMC believes CMS should implement a prospective identification mechanism that relies on the patient to identify who he/she considers to be his/her primary physician.

Recommendations to Improve the Reporting Submission Process

- CMS needs to properly invest in testing and resources to ensure the previously encountered technical problems and delays do not occur in future reporting years. To be a good partner, CMS needs to hold itself accountable to its own deadlines. If deadlines are not met, then groups should be held harmless and not be required to

³ The practices cannot fully evaluate the different attribution options because they lack the data to run a complete analysis.

submit data. The AAMC also believes that the quality measures should not be publicly reported or used for pay-for-performance programs when there have been significant technical problems that could impact data completeness or measure performance.

- CMS should provide the final beneficiary file as soon as possible, ideally by December 1 of the performance year. If that is not possible, then groups should have the file a minimum of 2 weeks prior to the start of the reporting period. This provides groups the opportunity to match patients to their internal files and pull records before the reporting period begins.
- CMS needs to finalize the specifications early so that groups can prepare for reporting. Specifications should not change during the reporting process.
- CMS should extend the time period for successful reporting. The AAMC believes this will be especially important as more measures are added to GPRO and the number of GPRO participants increase. In addition, as more EPs transition to full-year reporting periods for the EHR Incentive Program, the data submission windows for two programs will overlap. A longer GPRO reporting window could alleviate the reporting burden.
- CMS should provide the option for qualified vendors to submit on behalf of a group practice.
- CMS should provide more user friendly ways to extract the GPRO data from the web interface. The groups should be able to extract the data in Excel, Access, or a flat, delimited file. Groups should also be able to download their final rates in a format other than PDF.

Request for Additional Data

Similar to ACOs, the AAMC believes GPROs should have the option to receive additional data, particularly the cost data, on its assigned patients. Participants should have the ability to see summary data or to review detailed claims files. CMS should consult the GPRO participants so that the data is delivered in a digestible and useable format. In order to be actionable, the data files must be timely.

Review of Measures

Finally, the GPRO web interface is different from most PQRS reporting options because the providers do not have a choice in which measures they have to report. The AAMC believes that with the unique reporting structure of GPRO and the high stakes involved, that the GPRO measures should be evaluated separately from the PQRS measures during the Measures Application Process (MAP) pre-rulemaking process.

Administrative Claims Reporting Mechanism

CMS is proposing that for purposes of avoiding the PQRS and VM penalties for 2015 and 2016 administrative claims data can be used as a temporary reporting option. In this reporting option, CMS analyzes the administrative claims that the group practices already have submitted. Groups do not need to submit any additional quality data. With administrative claims, groups and individual EPs can avoid penalties, but cannot earn a PQRS reporting incentive.

AAMC appreciates that CMS is proposing a low-cost, low-burden reporting option during this time of transition. While the AAMC believes that claims-based measures are far from ideal, the administrative claims reporting option is not duplicative of other programs or burdensome to the physician practices. It also provides a reprieve while group practices determine their long-term group reporting strategies.

Because the EHR Incentive Program and the VM proposals are not completely aligned, the AAMC believes the administrative claims option needs to be available for more than 2 years. In addition, administrative claims should be a default for any group that attempts to report PQRS measures via another mechanism, but for some reason is not successful.

Similar to the GPRO web interface measures, the administrative claims measures are not optional. Measures in the administrative claims option should be endorsed by the National Quality Forum (NQF) for physician group measurement. In addition, the AAMC asks that the MAP review the administrative claims measures separately from other PQRS measures as part of the MAP's pre-rulemaking review process. The AAMC also asks CMS to clarify which measures would be included in administrative claims options. Table 63 "Proposed Measures ...Using Administrative Claims for the 2015 and 2016 PQRS Payment Adjustment" (77 Fed. Reg. at 44987) and Table 66 "Proposed Measures for Administrative Claims Option for 2015 and 2016" (77 Fed. Reg. at 44999) do not match.

Finally, CMS needs to be very clear in its educational material to providers that the administrative claims data option is different from the traditional claims-based reporting mechanism that currently exists in PQRS.

Other PQRS Reporting Mechanisms for Groups

CMS is proposing to expand the traditional PQRS individual reporting mechanisms (EHR, registry, and claims-based) to groups with 99 or fewer NPIs. The AAMC believes these reporting options should be available to groups with 100 or more NPIs as well.

The proposed rule does not go into detail about how the group reporting options will work. For example, would a practice need to submit the same measures for all clinicians in the entire group in order to meet the criteria? Or would a certain percentage of individuals in the group need to achieve satisfactory reporting? The AAMC asks CMS to clarify how these individual reporting options translate into group reporting. The AAMC also notes that "measures groups," which are

sets of related measures, are not available in the group reporting options and asks CMS to reconsider the role of these measure sets in group reporting.

There is no group reporting option for the 2013 EHR Incentive Program, so CMS is proposing to define a successful group as a group in which all EPs successfully report. The AAMC believes that threshold is too high. With 100 percent EPs reporting, group reporting would not be any different from the current individual reporting. The AAMC urges CMS to significantly reduce this threshold.

Group Registration/Self-Nomination Process

CMS is proposing that groups would need to self-nominate by January 31, 2013, via a web interface. At the time of registration, a group would establish its size and identify the reporting mechanism for data submission. CMS proposes that groups cannot change their reporting mechanism after registering.

The AAMC supports using a web-based portal for registration. Based on feedback from members in the GPRO Academic Network, a web process should be simpler than the previous requirement of a letter submission. The AAMC also asks that CMS implement a feedback process so that groups are notified in a timely manner whether or not they have been accepted as a group.

The AAMC is concerned about the January 31 registration deadline. If that date is finalized, it would leave only three months from issuance of the final rule to the date on which groups would have to register and select a reporting mechanism. During that time, potential groups would need to be educated about the options and select the most appropriate option. The AAMC asks that CMS extend the registration at least to the end of March 2013.

In addition, groups should have until the end of 2013 to register for, or to change their reporting mechanism to, the administrative claims reporting option. In the proposed rule, CMS states that it needs to know in advance which groups are doing administrative claims, but the AAMC believes this could be done at the end of the year when CMS mines the claims data. CMS has not provided a persuasive argument for retaining the proposed deadline of January 31 for the administrative claims option.

Finally, for purposes of the value modifier, CMS is proposing to use the same group size that is used for PQRS. The rule does not explain how CMS plans to identify groups that do not register through PQRS. Before finalizing this proposal, CMS must work with stakeholders to develop a process to identify groups that do not register through PQRS.

VM Cost Measures and Attribution Methodology

CMS is proposing to use the PQRS GPRO web interface attribution methodology to identify the patient population for the cost measurement. CMS plans to include total per capita costs for the attributed patient population as well as total per capita costs for four condition groups: coronary artery disease, COPD, diabetes, and heart failure. The costs are standardized and risk adjusted. CMS is in the process of developing an episode grouper and will provide feedback on episode measurement in the 2013 quality and resource use reports (QRUR), but episode costs will not be included in the 2015 VM calculations.

The AAMC agrees that the cost measures used in the VM must be standardized and risk adjusted. The AAMC particularly supports the removal of inpatient add-on payments such as indirect medical education (IME) and disproportionate share (DSH) from the inpatient resource calculations. As CMS starts to analyze episode-based payments for the Medicare population, the Agency should engage stakeholders to seek feedback on how the measures are applied and reported. The AAMC also requests that CMS submit all cost measures for the VM to NQF for endorsement.

In regards to the attribution methodology, the AAMC strongly encourages CMS to evaluate the impact of different attribution methodologies on the cost results for Medicare providers. A study by Mehrotra and colleagues suggests that attribution can change the cost results.⁴ Although the group practices lack the data to fully understand the impact of the different attribution methodologies on the population size and cost results, the UHC-AAMC GPRO Academic Network participants recommend that CMS adopt a primary-care based attribution methodology to improve the quality measurement. In order to have a transparent system, CMS should invest in understanding the impact of different attribution rules and share the results with Medicare providers (both individuals and groups) illustrating the impact of different attribution rules to their patient population and the related costs of the population.

Ultimately, in a pay-for-performance system, it is essential that providers, beneficiaries, and CMS all agree on the attributed patient population. As discussed in the GPRO web interface section of this letter, attribution problems can influence quality performance and potentially influence the cost performance. In the long term, CMS should implement a prospective assignment mechanism where the beneficiary self-attributes to the appropriate provider or group practice.

VM Quality Measures and Outcome Measures

CMS proposes to use the measures that a provider has submitted via PQRS for the VM calculation. In addition, CMS plans to calculate four outcome measures for all groups in 2013 using claims data:

⁴ Mehrotra A, Adams JL, Thomas JW, McGlynn EA. The effect of different attribution rules on individual physician cost profiles. *Ann Intern Med.* 2010 May 18;152(10):649-54.

- Composite of Acute Prevention Quality Indicators. This is a composite of three ambulatory care sensitive conditions (ACSC) hospitalization rates for bacterial pneumonia, UTI, and dehydration.
- Composite of Chronic Prevention Quality Indicators. This is a composite of ACSC hospitalization rates for diabetes, COPD, and heart failure.
- All-Cause Readmission Rates
- 30-day Post-Discharge Visit

The AAMC does not support the inclusion of any of the proposed outcome measures for the VM program because these measures were not designed for physician-level measurement. The ACSCs are community level measures and were designed to be reported as a hospitalization rate per 100,000 people in the population. The All-Cause Readmission and 30-Day Post Discharge Visit are facility measures designed to measure a specific facility's admissions. It is unclear how any of these measures would translate to a population for a physician group. The group panel size is typically much smaller than a community population and a group practice's patients can be discharged from several different hospitals. The AAMC recognizes that physicians are integral to a well-run, coordinated healthcare system, but we question the value of holding physicians accountable for these measures when they are not even aware of who their assigned patients are at the time of the admission or discharge. The AAMC believes that prior to inclusion in any pay-for-performance program the outcome measures need robust risk adjustment and to be endorsed for physician or group-level measurement.

The AAMC also does not support including all measures from the 2013 GPRO web interface in the VM calculation. GPRO is different from other reporting mechanisms because a physician group does not have the option to choose the measures and often does not know who its patients are until after the performance year is over. AAMC believes that CMS should be flexible and exclude the following measures from the 2015 VM:

- Measures new to the GPRO web interface in the 2013 reporting year.
- Measures which are not NQF-endorsed for physicians or physician group practices.

We also are concerned about measures with absolute thresholds. The targets may not be appropriate for a complex patient whose optimal range may be different from those of a non-complex patient. Without appropriate risk adjustment, providers taking care of these complex patients may have worse scores and incorrectly appear to be delivering poor quality care. Similarly, we are concerned about measures that do not allow a clinician to indicate that the patient has declined the service. Some participants in the GPRO Academic Network noted low performance was due in part to the inability to document these exclusions. We believe these measures should be modified before inclusion in any pay-for-performance program.

VM Benchmarks

For the cost benchmarks, CMS proposes to compare all groups that have the same cost attribution methodology. For the quality measures, CMS plans to compare the results across all providers that report the quality measure, regardless of how the data was submitted.

The AAMC believes not all groups are comparable and asks that CMS evaluate potential peer groups for cost and quality measures. Cohorts could be identified by any of the following characteristics:

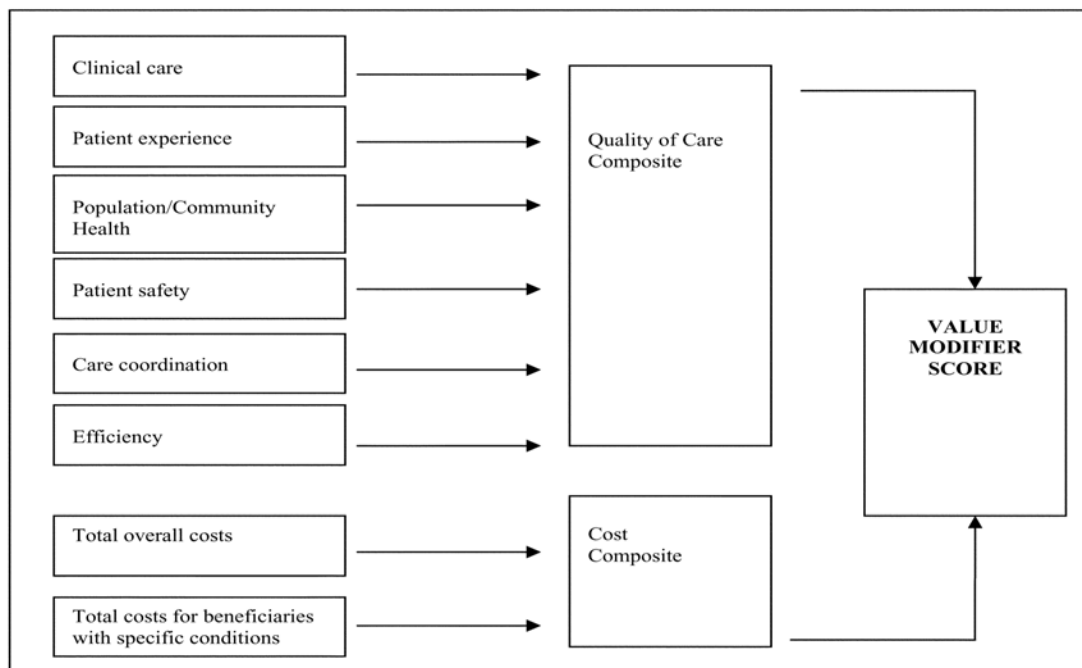
- Size of attributed patient population
- Percent of dual-eligible patients, disabled patients, and end-stage renal disease patients
- Number of EPs in the group practice
- Multispecialty versus single specialty practices
- Percent of generalists versus specialists in a practice
- Academic versus non-academic practices
- Reporting mechanism for quality data

In its annual summary reports, CMS should publish these results by the individual cohorts.

VM Calculation: Quality Tiering

To determine the actual value modifier adjustment, CMS is proposing a quality tiering methodology. Each cost and quality score is standardized and aggregated into domains which then roll into two composites. (See Figure 1.)

Figure 1: Value Modifier Score



In quality tiering, providers are placed into outlier buckets based on their quality composite and cost composite. Outliers are determined based on a single standard deviation. The payment adjustment varies based on which cell the provider ends up in. (See Table 2.) The maximum potential loss is negative one percent. The maximum reward (“x”) will not be determined until the end of the performance period, after the incentive pool is determined. Providers who treat high-risk patients are also eligible for an additional incentive if they perform well.

Table 2: Quality Tiering

| Quality/Cost | Low Cost | Average Cost | High Cost |
|---------------------|-----------------|---------------------|------------------|
| High Quality | 2.0x* | 1.0x* | 0.0% |
| Average Quality | 1.0x* | 0.0% | -0.5% |
| Low Quality | 0.0% | -0.5% | -1.0% |

* Eligible for additional potential 1x reimbursement for caring for high risk patients. High risk is determined by HCC score of attributed patients.

CMS is also seeking feedback on whether a Total Performance Score (TPS) methodology, similar to the inpatient Value-Based Purchasing (VBP) program, should be used instead of quality tiering. In TPS, providers can receive incremental adjustments that reward for improvement as well as attaining a specific score.

The AAMC believes the proposed quality tiering is a reasonable approach for the first few years of the VM program. Quality tiering is easier to explain to providers than TPS. While TPS allows providers to receive credit for improvement, currently CMS does not have good baseline data needed to document improvement. CMS should reevaluate whether to move to a TPS model in a few years, after the methodologies for physician reporting have been evaluated and stabilized.

In determining the outliers for quality tiering, CMS should provide the distribution data for the cost and quality composites, as well as scatter plots of the two composite metrics together. This data is necessary to evaluate the appropriateness of using a single standard deviation as the outlier cutoff. The AAMC also asks CMS to not finalize this portion of the methodology until stakeholders have had the opportunity to review the data distribution.

The AAMC supports the concept of rewarding providers for managing high risk patients, but remains concerned about how the high risk patients are identified. CMS proposes to use HCC risk score, which is a score based on the conditions documented in claims. CMS also should consider the influence of socio-economic factors and the complexity of dual-eligible, disabled, and end-stage renal disease (ESRD) patients when identifying high-risk patients. The AAMC also is concerned that treating complex patients could increase cost scores, even if the costs are risk adjusted. The AAMC asks that CMS extend the high-risk reward to providers with average or high costs who also have average or above average quality score.

Quality tiering is optional for the 2015 VM. Given the new reporting options and the timing of the feedback reports, the AAMC believes groups should not have to elect quality tiering until after the group has submitted its 2013 PQR quality data.

VM for Pioneer and MSSP ACOs

AAMC believes the Pioneer and MSSP ACOs programs currently reward high-value health care. The ACOs only share savings if they can provide high quality care to a population of patients at a lower cost. The AAMC supports exempting ACOs from the value modifier program and encourages CMS to continue exempting these organizations in the future.

Other Issues Related to the VM and PQRS

Individual clinicians frequently change groups between the performance period and the time the payment adjustments are applied. The AAMC asks CMS to clarify that should a physician leave an organization and move to a different group that physician will be measured based on the new group's VM and PQRS results.

CMS is seeking feedback on whether PQRS data should be collected through the National Health Information Network (NwHIN). The AAMC supports the concept of the NwHIN, but does not believe it is ready for PQRS data submission.

PHYSICIAN COMPARE (pp. 44802-44805)

CMS already has stated that beginning in 2013 the Agency will report the performance rates for quality measures submitted through the 2012 GPRO web interface. Measures would need to meet the "minimum sample size and ...prove to be statistically valid and reliable." (77 *Fed. Reg.* at 44803) In addition, CMS proposes several new changes to Physician Compare for the upcoming years:

- Reduce the minimum sample size from 25 observations to 20 for data posted in CY 2013.
- Publicly report results from the patient experience tool, Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) in 2014 for performance period in 2013 for all PQRS groups.
 - Publicly report CG-CAHPS for ACOs in 2013, based on 2012 performance period.
- Report the ambulatory care sensitive condition (ACSC) rates for providers with at least 20 observations.
- Report composite measures for certain disease modules for GPRO web interface.

The AAMC continually has supported public reporting; however, we are concerned that in the current high-stakes environment, the proposals do not meet the stringent criteria necessary to provide accurate and informative data. The AAMC recommends that the following occur prior to posting any measure on Physician Compare:

- Measures should be NQF-endorsed for physicians or physician groups.
- All composite measures should be NQF-endorsed. The NQF Composite Framework discusses how composites need to be reviewed as a whole and not necessarily by its individual components.
- Measures should be reported on a private site for providers only, similar to what was in place for the development of Hospital Compare, for at least one year prior to the data results being posted on Physician Compare.
- Similar to Hospital Compare, Physician Compare should provide physicians and physician groups with the ability to review all data for accuracy and suppress inaccurate data prior to posting.

Certain Measures Should Not Be Publicly Reported

CMS states it will publicly report all measures from the 2012 GPRO web interface. The AAMC strongly disagrees with this decision. As described in the GPRO section earlier in this letter, logistical issues with data collection can influence performance results. In particular, inaccuracies in the patient attribution assignment may lead to gaps in the data record and technical issues, such as incorrect documentation, can prevent providers from receiving credit even if the service was completed. Finally, GPRO web interface reporting is unique compared to other PQRS reporting mechanisms in that providers do not have a choice of which measures to report. Given that the MAP has not reviewed the GPRO measures specifically, the AAMC believes that CMS should be flexible in determining which measures to publish and should NOT report the following measures in 2013

- **Measures new to GPRO in the 2012 reporting year.** Groups should have at least one year to identify and resolve logistics that can affect data collection.
- **Measures to be removed from the 2013 GPRO web interface.** If CMS finalizes the current list of measures for 2013, several measures from 2012 will no longer be required. The AAMC questions the value of reporting these measures.
- **Measures which are not NQF-endorsed for physicians or physician group practices.** These include the Ambulatory Care Sensitive Condition (ACSC) readmission composites and other outcome composite measures. The ACSC are community level measures (typically measured in terms of rates per 100,000 population). These are not endorsed for the physician level measurement and should not be publicly reported.

We also are concerned about measures with absolute thresholds. The targets may not be appropriate for a complex patient whose optimal range may be different from those of a non-complex patient. Without appropriate risk adjustment, providers taking care of these complex patients may have worse scores and incorrectly appear to be delivering poor quality care. Similarly, we are concerned about measures that do not allow a clinician to indicate that the patient has declined the service. Some participants in the GPRO Academic Network indicated that low performance was in part due to the inability to document these exclusions.

Finally, the AAMC believes that none of the measures should be reported if CMS encounters the technical issues that may affect data completeness (similar to what occurred during the 2011 reporting cycle.)

Reporting CG-CAHPS Data

CMS is offering to administer and pay for sections of the CG-CAHPS survey administration for all registered PQRS groups in 2013. CMS has proposed to publicly report the CG-CAHPS data starting in 2014, but is seeking comment on providing confidential feedback to providers in the first year.

The AAMC believes that patient experience data is valuable and supports CMS' proposal to invest in collecting this information in 2013. However, as stated above, the AAMC opposes any public reporting of any measure in its first year. This is particularly true for CG-CAHPS. It is unclear when providers will know the details of the data collection such as which patients are selected, how those patients are identified, and when the survey is administered. Those factors can influence results. After the methodology is finalized, providers will need time to understand the data and how to incorporate improvements into their practice. It may take a year or two before the rates reflect the true patient experience at a group practice.

Given these concerns, we recommend that CMS provide confidential reporting to providers at this time, or publish the results on a private website. Until the measure collection is validated and understood by providers, the CG-CAHPS should not be included on the main Physician Compare website nor included in any pay-for-performance program.

Minimum Sample Size, Validity, and Reliability Requirements

The AAMC does not support CMS' proposal to change the minimum number of observations for reportable measures from 25 to 20. While the slightly larger sample size may exclude more physicians from being measured, the AAMC does not believe CMS has provided sufficient reasons or adequate documentation to support this sample size reduction.

CMS indicates in the Value Modifier portion of the proposed rule that the Agency has done data reliability testing on claims-based measures from the 2010 individual quality resource use report (QRUR) reports. Their analysis concludes that there is not much difference in data reliability between 20 and 30 observations. However, CMS does not provide the necessary data to allow others to independently confirm that conclusion. In fact, language in the preamble leads to an inference that 20 may not be a sufficient sample size for certain measures: "Reliability was high for nine of the 15 administrative claims-based quality measures that we are proposing for purposes of the value-based payment modifier for the PQRS administrative claims-based reporting option when the minimum case size was 20 or greater." (77 Fed. Reg. at 45009) Unfortunately, CMS does not share the reliability for the other six measures.

The AAMC believes it is important that all measures meet a minimum reliability threshold and that a threshold should be calculated independently for each reported measure. Without a very strong rationale and supporting data, CMS should not lower the minimum sample size. In some cases, CMS should raise the sample size to ensure reliable testing.

Adequate Data Review

The AAMC believes that the performance data in Physician Compare requires a robust review process. Groups should have the opportunity to review not only their individual data, but also their comparative benchmarks, before the information is publicly reported. Sometimes it is only through review of data compared to a peer cohort that it is possible to detect problems with one's own data. 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.

Group practices should also have an opportunity to verify the data reported on Physician Compare, including which providers are included in the group, and the accuracy of basic contact information.

E-PRESCRIBING INCENTIVE PROGRAM (pp. 44983-44988)

The Association supports the CMS proposal to add two new hardship exemptions for EPs to avoid a 1.5 percent reduction in 2013 and 2.0 percent reduction in 2014 for the e-prescribing incentive program. Specifically, CMS is proposing the following new hardship exemptions;

- Eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting periods.
- Eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology.

The AAMC has long supported exemptions for those clinicians who have achieved or are attempting to achieve meaningful use. The AAMC is pleased that EPs would not have to individually request the hardship exemption in order to avoid the 2013 penalty. Instead, if technically feasible, CMS is proposing to mine an existing data source, the EHR Incentive Program registration and attestation database. The AAMC encourages CMS to ensure this mining occurs. We also request that CMS use this database to determine these hardship exemptions for the 2014 e-prescribing penalty. Clinicians should not have to separately request a hardship exemption if the data are available to CMS.

CMS has indicated that this proposal will be finalized by October 15 or by date of the final physician fee schedule. The AAMC asks CMS to extend the deadline by at least 30 days so that EPs have the opportunity to attest or register up to 30 days after the final rule is released. This extension ensures that CMS and the associations with which the Agency works have the

opportunity to communicate the final changes to affected clinicians and allows clinicians who may have postponed registration to register.

Finally, as CMS enters the final reporting periods for the e-prescribing incentive program, the AAMC asks the Agency to provide timely feedback to members on their e-prescribing status. It would be very helpful for practices to know when they have reported the minimum number of prescriptions needed to demonstrate that they have met the e-prescribing requirement.

POST-DISCHARGE CARE COORDINATION (pp. 44775 - 44780)

CMS is proposing the creation of a new HCPCS G-Code to reimburse for non-face-to-face care management services as patients transition from institutional care to community-based care. Specifically, the code would cover all activities for up to 30 days post discharge as a patient transitions from an inpatient acute care setting, psychiatric hospital, long-term care hospital, skilled nursing facility, and inpatient rehabilitation facility; hospital outpatient for observation services or partial hospitalization services; and a partial hospitalization program to community-based care. The proposal requires all activities to be performed under the supervision of a community physician or qualified nonphysician provider.

The AAMC applauds CMS for recognizing the care coordination efforts that occur outside of face-to-face encounters. The Association believes that care coordination may be provided by a variety of clinicians and supports a broad definition of community-based physician. We also support the inclusion of nurse practitioners and physician assistants as these clinicians increasingly play an important role in care coordination. However, we have some concerns about the proposed implementation which are discussed below.

CMS assumes that each patient will have only one primary physician coordinating care; therefore, the Agency proposes to pay for this service once per patient per discharge to the physician office that bills CMS first. The AAMC disagrees with this assumption. Complex patients often have to follow-up with more than one provider after a discharge. Each of these providers could be performing care coordination and should be compensated accordingly. If multiple practices are performing care coordination, but only one code is paid, then the offices will have to compete with each other to submit the bill first. In addition, practice offices will not be able to track whether or not they can get paid for the service. That type of uncertainty can undermine care coordination. We request that CMS allow multiple providers to bill for care coordination services.

CMS proposes that a provider must have had a face-to face E/M visit with the patient within 30 days prior to discharge or within 14 days post-discharge in the office/outpatient setting. The AAMC asks CMS to clarify which visits would be considered acceptable for the 30-days prior to the discharge date, particularly for patients who are in an acute or post-acute setting for more than 30 days. The AAMC also requests that CMS expand the definition of E/M visits in the post-14 day window to other outpatient settings such as home visits and domiciliary/rest home.

Finally, the AAMC wants to ensure that coordination is appropriately valued and that the budget neutrality (BN) assumptions are reasonable. CMS should refer the new code as well as other coordination services (such as discharge planning services) to be reviewed by a multi-stakeholder group such as the RVS Update Committee (RUC). In its budget neutrality assumptions, CMS estimated this care coordination code would be billed 10 million times in CY 2013, or once for each hospitalization. The AAMC believes this assumption is overly optimistic even if multiple physicians bill for the same hospitalization. The AAMC requests CMS reconsider its BN assumptions for this code.

Advanced Primary Care Practice

In anticipation of future payments, CMS is seeking comments on how to accredit the Advanced Primary Care Practice. The AAMC supports medical homes as a way to provide team-based integrated care. The AAMC encourages CMS to not develop its own accreditation criteria, but to instead recognize the accreditation from the four external organizations as it moves forward with the Advanced Primary Care Practice recognition. Organizations that have already invested in external accreditations should not be required to reapply for a separate certification.

MULTIPLE PROCEDURE PAYMENT REDUCTION (pp. 44745 – 44752)

CMS is enacting a provision from the 2012 Physician Fee Schedule Final Rule: to apply the multiple procedure payment reduction (MPPR) to the *professional* component of certain radiology procedures when multiple services are applied to the same person, the same day, by multiple physicians in the same practice. The AAMC opposes the expansion of the MPPR to multiple physicians within the same practice as the services may be unrelated to each other and each physician independently does the pre- and post-service work associated with the procedure.

The AAMC also encourages CMS to meet with specialty societies to determine which services are appropriately included in the MPPR moving forward.

EXPANSION OF TELEHEALTH SERVICES (pp. 44759-44762)

The AAMC supports CMS' proposal to expand the number of telehealth services to cover more preventative services. The AAMC encourages CMS' efforts to recognize the novel ways telehealth can improve access and care coordination and to cover all appropriate services.

NEW PREVENTIVE SERVICES (pp. 44797-44788)

The AAMC supports the expanded coverage of services defined by the US Preventive Task Force. To ensure the codes are properly valued, CMS should refer these new codes to the reviewed by a multistakeholder group such as the RUC.

Acting Administrator Tavenner

August 30, 2012

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SUSTAINABLE GROWTH RATE

Unless there is Congressional action, physician fees will decrease 27.0 percent on January 1, 2013. The AAMC remains concerned with the projected negative update and supports a full repeal of the SGR. We encourage CMS to work with Congress to revise the physician payment formula so that physicians will no longer face an annual negative update. We also encourage CMS to find ways of funding this repeal that does not harm other providers.

If you have any questions concerning these comments, please feel free to contact Mary Wheatley, Director, Physician Quality and Payment Policies, at mwheatley@aamc.org or 202-862-6297.

Sincerely,

A handwritten signature in black ink, appearing to read "J Conroy". The signature is fluid and cursive, with the first letter "J" being particularly large and stylized.

Joanne Conroy, M.D.
Chief Health Care Officer

cc: Mary Patton Wheatley, AAMC
Ivy Baer, AAMC