Charles N. Kahn III
President and CEO

September 4, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1590-P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face to Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013; Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Quality Improvement Organization Regulations; Proposed Rules (Vol. 77, No. 146), July 30, 2012

Dear Ms. Tavenner:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay, rehabilitation, and long-term care hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. The FAH appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services ("CMS") regarding the Notice of Proposed Rulemaking referenced above ("Proposed Rule" or "NPRM").

II. G. Therapy Services

The FAH shares CMS's goal of a reliable, accurate, predictable payment system for outpatient therapy services. Such a system should be evidence-based and derived from data that properly measures and distinguishes among multiple therapy disciplines, patient populations and diagnosis categories. The data should tie to patient functional status and

characteristics and enable valid comparisons. At the same time, the collection effort must be balanced and not impose unreasonable burdens on providers.

We are concerned, however, that the reporting requirements CMS has proposed, which includes a series of G codes and payment modifiers, could generate confusion, yield inconsistent results and fall short of these goals. The overall reporting structure imposes a broad new coding burden on therapists that would require extensive education and training, with little assurance that the data generated accurately and reliably measures clinical and functional status. At a minimum, the requirement to report secondary functional limitations should be optional.

The connection between G codes, modifiers, impairment metrics and functional performance is complicated and limited. The goal should be to capture a complete clinical picture of the patient's condition, yet the requirement that therapists choose one clinically relevant functional limitation could undermine that goal, especially for patients with neurological impairments, many of whom suffer from complex multiple functional limitations.

Moreover, the variation in therapists' practice patterns limits the utility of G codes and modifiers in comparing the outcomes among similarly-coded patients raising concerns about a payment system that is built on such subjective data, rather than objective data. Moving in the direction of more standardization of data that is collected, including through, among other means, tested, validated, and appropriate assessment tools, would help alleviate these concerns. In any event, coding and reporting should not interfere with or limit the therapist's ability to conduct a comprehensive assessment of her patient and to establish and carry-out treatment goals and protocols designed to address and restore a full range of functional limitations.

Regarding implementation, FAH supports the CMS concept of a transition period, though we believe a period longer than the six month period proposed, plus a phase-in of the data to be reported, is necessary to properly test, evaluate and, as warranted, make appropriate adjustments.

III. F. Physician Compare Web Site

CMS proposes to add patient experience survey-based measures, the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for group practices participating in the PQRS GPRO and Accountable Care Organizations on Physician Compare in 2013 and seeks comments on delaying this reporting until program year 2014. The FAH supports patients being able to view hospital and physician quality and performance data so that they may be better able to make well-informed decisions about their health care choices.

However, we encourage CMS to first confidentially share the experience of care information with providers for a year prior to making it public. This would permit physicians an opportunity to review the data for accuracy and to also improve their performance prior to its being publicly reported. In addition, waiting until 2015 would

provide CMS with an additional year of testing to ensure that its contractors are able to administer, collect and process the survey data timely and accurately. The FAH strongly encourages CMS to delay public reporting of the CG-CAHPS until 2015. As FAH has consistently commented on past CMS proposals related to public reporting, any new reporting program should be reported confidentially to the entity being measured for a year prior to public reporting.

III. G. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

For Group Reporting, CMS proposed to define a group practice as a single Tax Identification Number (TIN) with two or more eligible professionals as identified by their individual National Provider Identification number (NPI). FAH welcomes this proposed change in definition of a group from the previous definition of 25 or more eligible professionals. The smaller group definition permits greater numbers of physicians to report through the group practice reporting option (GPRO). The GPRO option is the most user friendly method of data submission, and it results in the fewest errors. FAH also urges CMS to not make any additional changes to the group practice size definition in the near future. Physicians need stability in the program to reduce the complexity, confusion and frustration many EPs have encountered when participating in the PQRS.

In general FAH is concerned that measures used for either the PQRS or VBM program be NQF-endorsed and tested for use in the setting in which they will be employed. In particular, the proposed rule addresses the use of composite measures in several different programs. The composite methodology and the composite measures themselves need to go through the NQF evaluation process and also through the Measure Application Partnership recommendation process for usability in specific payment programs.

III. K. Physician Value-Based Payment Modifier and the Physician Feedback Reporting Program

The ACA requires that CMS adopt a budget-neutral value-based modifier (VBM) for groups of physicians that begins in January 2015 and is to evaluate physicians' quality of care compared to cost. By January 2017, all physicians who bill under the Physician Fee Schedule (PFS) must participate in the VBM program in order to receive Medicare payment. CMS proposes in this rule to include only groups of physicians with 25 or more eligible professionals (EPs) in the CY 2015 VBM program. CMS is to finalize a list of measures it intends to use by January 1, 2012. CMS proposes that physician group practices which successfully participate in the CY 2013 physician quality reporting system will participate in the CY 2015 VBM program. Of those groups electing to participate in the CY 2015 VBM program, a maximum of one (1) percent of their Medicare PFS payment would be at risk. In addition, CMS proposes to penalize group practices which do not successfully participate in the PQRS program by imposing a maximum penalty of one (1) percent for the CY 2015 VBM program. This penalty would be additive to the 1.5 percent penalty that would be applied for failure to satisfactorily report quality measures

under PQRS. Consequently, it is possible that a physician group practice which does not successfully participate in the PQRS would suffer a 2.5 percent reduction in its payments.

The interface between the requirements for the PQRS, VBM, E-prescribing and EHR reporting programs is extremely complex and many requirements conflict. FAH members find it very difficult to advise their physicians on solutions or to assist in working through the intricacies of each of these programs. FAH encourages CMS to see synergies in the programs, to stream-line reporting and to maximize the ability of physicians to report either as part of a group or as individuals or as subgroups within a group depending on their specialty.

Hospital-based physician

CMS seeks comment on whether a VBM option specifically designed for hospital-based physicians should be developed. CMS suggests that these physicians could elect to be assessed based on the performance of the hospital at which they are based. The number of physicians employed by hospitals is growing annually. Hospitals directly employ some physicians and contract with a number of physicians either on a group or individual basis. Often emergency physicians, hospitalists, radiology and anesthesia services are contracted services. Greater physician integration represents the potential to better align goals and processes across the care continuum. However, numerous legal and regulatory barriers to clinical integration make it difficult to align hospital and physician incentives to improve quality and efficiency. The FAH is pleased that CMS is seeking comments on developing a VBM program for hospital-based physicians, and the FAH supports CMS in pursuing this type of program and encourages CMS to align the physician VBM program with the hospital value-based purchasing (VBP) program. As we have stated previously, such alignment will enhance the performance improvement of both physicians and hospitals.

CMS indicates that a VBM program for hospital-based physicians would include measures from both the inpatient and outpatient hospital quality reporting programs. While the inpatient quality reporting program has been in existence for a decade, the outpatient program is newer and issues with the measures are still being resolved. FAH encourages CMS to continue to explore the inclusion of both inpatient and outpatient quality measures but to delay implementation of a hospital-based physician VBM program until CY 2017 as is permitted by law. Having several years of experience with the initial implementation of the physician VBM program will inform the introduction of a hospital-based physician VBM program.

Collection of Information Requirements

The FAH is confused by the part of the Proposed Rule's "Collect of Information Requirements" section addressing necessary signatures to authenticate a laboratory requisition. During the MPFS rulemaking cycle for 2012, CMS proposed and finalized a policy that the signature of a physician or a non-physician practitioner ("NPP") is not required on a laboratory requisition. Thus, we ask whether there was a mistake made in the Proposed Rule indicating, for information collection purposes, that such a signature is required. The FAH urges CMS to address this inconsistency, to reaffirm its finalized

policy position from the 2012 rulemaking cycle, and to exclude laboratory requisitions from the list of documents for information collection purposes that require a signature of a physician or NPP.

The FAH appreciates the opportunity to submit these comments. If you have any questions, please contact me at 202-624-1534 or Steve Speil at 202-624-1529.

Sincerely,