

September 4, 2012

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

RE: Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2013

Dear Administrator Tavenner:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the proposed rule entitled, "Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013," released on July 6, 2012. We look forward to continuing to collaborate with the Centers for Medicare & Medicaid Services (CMS) on the issues in this proposed rule, those associated with the Patient Protection and Affordable Care Act (ACA), and other administrative simplification issues that will increase practice efficiencies while improving patient care.

MGMA-ACMPE, founded in 1926, is the nation's principal voice for medical group practices. Our nearly 22,500 members manage and lead 13,200 organizations, in which 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States. The Association's core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them. Individual members, including practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently so that patient care remains the focus of physicians' time and resources.

MGMA offers detailed critiques and recommendations related to this rule on behalf of our members. Key points include:

- MGMA urges CMS to initially limit the value-based payment modifier (VBPM) to multi-specialty groups of 100 or more physicians as defined in section 1861(r) of the Social Security Act. Groups of fewer than 100 physicians should be given the opportunity to voluntarily participate in the quality tiering approach, if they successfully participate in the Physician Quality Reporting System (PQRS).
- MGMA is concerned that several technical issues related to the VBPM have yet to be appropriately addressed and question if it can be practically implemented under the proposed timeline and framework. We urge CMS to withdraw this proposal until the methodological and technical issues we outline are resolved. More time is needed to test valid measures of cost, outcomes and quality as well as mechanisms to accurately adjust for risk, before moving forward with a program that modifies physicians' payment based on CMS'

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definition of value.

- MGMA urges CMS to use its regulatory authority to deem all physicians that meet meaningful use requirements (and therefore electronically prescribe and report clinical quality measures under that program) as also successfully meeting all e-prescribing and PQRS requirements in each corresponding performance year. Eligible professionals (EPs) that successfully meet the meaningful use requirements should automatically earn the bonus for PQRS and avoid penalties for both e-prescribing and PQRS.
- MGMA objects to imposing financial penalties on physician practices for unsuccessfully participating in incentive or quality reporting programs, such as e-prescribing, PQRS and the value-based payment modifier. If penalties must exist, the government should only apply them after taking into account performance during the relevant year, rather than previous years.
- MGMA is pleased that CMS recognizes the importance of post-discharge care management, but is concerned that the agency plans to pay for this new service by decreasing reimbursement to specialties outside of primary care. Rather than penalizing many specialties under the Part B physician fee schedule, we encourage CMS to explore ways to pay for this service using the actual savings it will achieve under Part A.
- MGMA opposes CMS' proposal to expand the multiple procedure payment reduction to apply to the payment for the technical component of certain cardiovascular and ophthalmologic procedures when performed on the same patient on the same day and furnished by the same physician or another physician in the same group practice. MGMA is concerned that these cuts are arbitrary and not based on any actual reduction in clinical labor activities. We further object to any proposals that provide disincentives for forming and performing and billing through the same group practice.

Medicare Physician Reimbursement

CMS anticipates, barring changes to current law, an approximate 27 percent cut in physician payment rates for 2013 under the sustainable growth rate (SGR) methodology. The 27 percent rate cut is based on a March 2012 analysis from CMS. This massive cut will have catastrophic consequences on medical group practices and the patients they serve. Although Congress has repeatedly taken action to override most of the SGR's prescribed fee schedule reductions, these temporary "fixes" have increased both the size of future cuts and the cost of repealing the flawed payment system. As a consequence, the frequent need to override increasingly steeper cuts is undermining confidence in the Medicare program and jeopardizing the financial stability of medical practices. The current environment is forcing group practices to make operational changes that severely challenge their ability to provide quality care to Medicare beneficiaries.

MGMA will continue to work with congressional leaders, urging them to permanently address the broken Medicare physician payment system and replace it with a more stable and predictable update mechanism that accounts for the actual cost of providing care to Medicare beneficiaries.

Additional Multiple Procedure Payment Reduction for the Technical Component of Certain Cardiovascular and Ophthalmologic Procedures

MGMA opposes CMS' proposal to expand the multiple procedure payment reduction (MPPR) to the technical component of certain cardiovascular and ophthalmologic procedures when performed on the same patient on the same day and furnished by the same physician or another physician in the same group practice (defined by CMS as a physician who shares the same group practice national provider identifier [NPI]). CMS proposes these cuts, based on its assertion that certain clinical labor activities are not duplicated (and therefore should not be reimbursed) when two or more procedures are performed on the same day. It is notable that this proposal is a departure from previous CMS policy that applies the MPPR to services performed in the same session.

CMS asserts that certain activities are not duplicated when performed on the same patient on the same day. The list includes activities such as "preparing the room, equipment and supplies," "education and consent," "preparing charts," "monitoring the patient," and "cleaning the room." We disagree with CMS' assessment that these tasks would not necessarily be duplicated. The codes subject to this reduction vary significantly. In many instances, the services subject to the rule are performed on different equipment, which is supported by different skilled clinical staff. The staff will need to perform different quality assurance documentation for each procedure and will need to separately develop any necessary results. Where services are performed in different rooms, the patient will need to be prepared and positioned for each new test and each room will need to be cleaned. Where different subspecialists provide the test, each will need to review prior history and prepare charts. Given that CMS will apply this reduction for any duplicate test performed during the same day (rather than in the same session), the likelihood that this reduction will be applied is increased, given that patients requiring multiple tests are often scheduled on the same day for the convenience of the patient.

We also object to including add-on codes on this list, which are assumed to be performed with other codes and are priced accordingly, and other codes that call into question CMS' reasoning in compiling this list. In short, we are concerned that these code combinations performed on the same patient on the same day by the same physician (or another physician in the group practice) would not achieve the expected efficiencies that would warrant a payment reduction. We urge CMS not to adopt this policy and to instead work through the American Medical Association/Relative Value Update Committee process to address its concerns.

Expansion of cuts to physicians in the same group practice

In its proposal, CMS announces its intention to expand the MPPR to both the professional component and the technical component of certain services when they are performed by the same physician or another physician in the same group practice based on the group practice NPI. As noted above and in our previous comments on MPPR proposals, we disagree with CMS' assertion that the listed efficiencies exist in the technical component, especially where services are performed by different physicians in the same group practice. We also maintain our strong objection to the application of the MPPR to professional services. We do not believe CMS provided adequate rationale for this payment reduction when applied to the same physician. We renew our objection to the current policy and strongly object to its expansion to professional interpretations performed by multiple physicians in the same group practice. Where independent professionals in the same group practice interpret images on the same patient, each physician's professional responsibility requires him or her to perform a full and

complete review of each scan. We ask CMS not to adopt a policy that financially penalizes independent physicians for forming and billing through a group practice.

Moreover, it is unclear exactly how CMS plans to apply this policy, especially in situations where a radiologist in a group practice may also independently contract to perform outside interpretations for other groups. Reliance on the NPI in these cases may lead to confusion and potential compliance concerns, and we ask CMS how, if adopted, it would intend to apply this policy in such instances.

Part B Drug Payment

MGMA continues to have concerns with the Part B drug payment policy that substitutes 103 percent of the average manufacturer's price (AMP) for certain drugs currently paid at 106 percent of the manufacturer's average sales price (ASP). Reducing reimbursement by using this price substitution policy may jeopardize beneficiary access to critical drugs, including oncology treatments. We urge CMS to reconsider this approach. Absent this change, MGMA supports the exclusion of AMP price substitutions for those drugs identified by the Food and Drug Administration (FDA) to be in short supply at the time that ASP calculations are finalized to increase patient access to these life-saving therapeutics.

Value-Based Payment Modifier Program and Quality Resource Use Reports

Section 3007 of the Patient Protection and Affordable Care Act (ACA) requires the Secretary of the Department of Health and Human Services (HHS) "to establish a payment modifier that provides for differential payment to a physician or a group of physicians based upon the quality of care furnished compared to cost...during a performance period." The value-based payment modifier (VBPM) would apply to specific physicians and physician groups in 2015 and expand to all physicians by 2017. CMS proposes phasing in use of the modifier beginning in 2015 by applying the requirement only to physicians in groups of 25 or more eligible professionals (EPs).

The Secretary is required to provide confidential Quality Resource Use Reports (QRURs) to physicians that measure the resources used in providing care to Medicare beneficiaries. The Secretary is also authorized to include information on the quality of care furnished to Medicare beneficiaries in these reports.

While MGMA supports efforts to improve the efficiency and quality of care physicians provide to their patients, we are concerned that several technical issues related to the VBPM have yet to be appropriately addressed and question if it can be practically implemented under the proposed framework. We believe more time is needed to test valid measures of cost, outcomes and quality as well as mechanisms to accurately adjust for risk, before moving forward with a program that modifies physicians' payment based on CMS' definition of value. We urge CMS to withdraw its VBPM proposal until the methodological and technical issues outlined below are resolved.

Definition of a group

CMS proposes to apply the VBPM to "groups of physicians" with 25 or more EPs based on their performance in PQRS. CMS proposes to define a group of physicians for the purposes of the VBPM program, "as a single Tax Identification Number (TIN) with 25 or more EPs, as identified by their individual national provider identifier (NPI) who have reassigned their Medicare billing rights to the

TIN.” Physicians in these groups could avoid any negative adjustment in their payments if the group successfully participates in one of several PQRS group reporting options. For groups that are not successful PQRS participants, 2015 Medicare payment rates would be cut by 1 percent. Further, for groups that are successful PQRS participants, the group can choose to take a zero payment adjustment in 2015 or opt to be evaluated through a three-tiered system that would measure cost, outcomes and quality. In other words, low-tier participants would face a 1 percent payment cut, those in the middle would see no change in payment, and those in the high tier would receive an as-yet-undetermined payment increase.

CMS estimates that the value-based payment modifier will initially apply to between 4,000 and 6,000 group practices. The first measurement year would begin Jan. 1, 2013. The short time frame created by the proposed rule ignores the significant education and outreach efforts necessary to ensure that groups are aware that the modifier would apply to them. Further, there may be many groups that have few physicians but many EPs. The physicians in these groups may have successfully participated in PQRS in the past as individuals and therefore would not be aware that they are now considered a group that is required to self-nominate under the VBPM. For example, an individual physician in a group of 25 or more EPs could individually report and receive the 2013 PQRS upward payment adjustment but receive a downward payment adjustment under the VBPM in 2015 based on 2013 performance because they were unaware that they needed to self-nominate under the Group Practice Reporting Option (GPRO).

Given these concerns, MGMA urges CMS to initially limit the VBPM to multi-specialty groups of 100 or more physicians, as defined in section 1861(r) of the Social Security Act. We do not agree with CMS’ interpretation of the statute to include EPs as part of this definition. Groups of physicians under 100 should be given the opportunity to voluntarily participate in the quality tiering approach, if they successfully participate in PQRS.

To avoid a negative payment adjustment in 2015 under the VBPM, affected physicians would need to ensure that their group registered by Jan. 31, 2013 under the PQRS GPRO self-nomination process. Considering the outreach needed to educate physicians impacted by the VBPM coupled with concerns of untimely QRURs, the GPRO self-nomination process should be open throughout the year and not set at the Jan. 31 date currently applied to PQRS. An open GPRO self-nomination process may also further CMS’ aim to increase PQRS participation by fifty percent.

2015 payment adjustments based on 2013 performance

We continue to object to CMS’ basing a 2015 VBPM on what a provider does in 2013. The government should only apply payment adjustments that take into account performance during the relevant year, rather than previous years. This current method of imposing penalties is especially problematic given CMS will not finalize the program requirements until November of this year, two months before the modifier will be applied to a select group of physicians. Using 2013 as the initial performance period is not feasible and is not required by law.

As stated earlier, tremendous efforts will be needed to educate groups subject to the VBPM. The program is extremely complex and finalizing a 2013 performance period will establish an unworkable time frame to accomplish the goals of the program.

Quality reporting

The VBPM is based on performance in PQRS, which has only achieved minimal participation due to operational issues that continue to plague the program. There have been numerous problems in determining successful participation in PQRS, resulting in erroneous determination of successful or non-successful participation. Although we understand that CMS continues to address concerns with PQRS, problems remain which undermine the program and provide a disincentive for participation.

Furthermore, with respect to the PQRS program, MGMA continues to believe that the PQRS measures do not provide an accurate and reliable method for evaluating the quality of care performed by certain physicians. While a number of quality measures available are applicable to primary care physicians, there are fewer suitable measures for specialists. We urge CMS to continue to work with stakeholders to develop adequate quality measures that accurately reflect physicians' practices.

MGMA does not support the proposal to limit groups of 100 or more to the GPRO web interface reporting mechanism and urges CMS to allow groups of 100 or more to use all the GPRO reporting mechanisms. Many large group practices are diverse and therefore use multiple reporting modalities based on applicable measures. The CMS 2010 *PQRS and eRx Experience Report* indicated that 16,925 PQRS participants used more than one reporting mechanism. Additionally, it may not be possible for all physicians in the group (especially multi-specialty practices with a wide array of specialists) to report the same measures. It is therefore necessary for groups of 100 or more to be able to report across all GPRO reporting modalities.

Cost, quality and outcome measures

MGMA objects to CMS' proposal to calculate the VBPM based on reporting of measures on only 20 beneficiaries. We do not believe CMS has conducted the rigorous analysis it needs to fully understand the impact of its methodological decisions with respect to statistical validity. A 20 case threshold is much too low and likely will not be statistically reliable as noted in the Government Accountability Office (GAO) August 2011 report, Medicare Physician Feedback Program: CMS Faces Challenges with Methodology GAO Reports. Although CMS may believe a higher threshold undermines its alignment goals with other quality improvement programs (i.e., the PQRS 20 case minimum threshold of patients on which EPs are required to report using measure groups via the claims and registry reporting option), we believe the goal of alignment must be balanced against other important goals, such as statistical validity of the data. CMS must clearly demonstrate that its performance measures are reliable and robust. A higher minimum case size requirement increases the validity of the information in the reports.

We continue to have concerns that the outcome and cost measures will not apply to many practices, in particular single specialty practices. Not having applicable cost and outcome measures does not allow physicians to be compared on an "apples to apples" approach. Increasing the threshold to 100 physicians, will alleviate some of these concerns and address some of the ambiguity around measurement in the cost and outcome composites. It will also alleviate the challenges that smaller groups would face meeting a higher, more statistically reliable threshold for encounters.

MGMA recommends that when comparing performance scores, CMS score registry and data submission vendors separately from claims-based submissions. We believe that there are significant problems with comparing data that is submitted via claims-based CPT II codes and data gathered from

an EMR data submission vendor or a registry. Those who participate via registry must report on 80 percent of eligible patients but those who report via claims must only report on 50 percent. Those differing standards alone are reason enough to consider the data differently. As the *2010 PQRS and eRx Experience Report* illustrates, PQRS participants are often more successful when utilizing registry and EMR data submission than the claims-based reporting option.

Administrative claims option

If a group practice attempts to report under the PQRS, but fails to do so successfully, CMS proposes to allow the group to default to the administrative claims-based reporting option and the agency will determine from the group's claims whether it successfully reported under the PQRS. MGMA supports this proposal, and believes it is necessary to ensure physicians are not penalized under the VBPM (and PQRS).

The proposed rule lists measures to assess EP performance for the PQRS administrative claims-based reporting option. CMS states it selected these measures because they are clinically meaningful, focus on highly prevalent conditions among beneficiaries, have the potential to differentiate physicians and are reliable. MGMA urges CMS to include measures that apply to more specialties, as these are focused on primary care and preclude use of the administrative claims-based option for many specialty groups, especially single specialty groups for which these measures are not clinically relevant.

Risk adjustment

We are concerned that CMS has yet to fully determine and explain how it will implement effective strategies to risk adjust measures used to calculate the value-based payment modifier. Linking quality measurement and performance to payment adjustments without properly tested risk adjustment mechanisms would have a host of negative consequences. If CMS does not risk adjust adequately, it could discourage physicians from treating atypical or disadvantaged populations that may be more costly to treat. It is critical to account for risk adjustment to avoid potentially adverse effects to patient care. Lack of sufficient risk adjustment mechanisms is one of the greatest risks of the VBPM program. Adjusting for additional factors such as patient compliance and referrals could help address these concerns as well.

Quality resource use reports

MGMA has concerns about the dissemination of the quality resource use reports (QRURs) and the inability of the reports to reach their intended audience. Feedback from our members revealed that QRURs have not been made available to individual physicians or groups in a timely manner, and in the majority of cases there was no explanation given as to why the delay occurred. The GAO August 2011 report, *Medicare Physician Feedback Program: CMS Faces Challenges with Methodology* further supports our concerns about the QRURs and the need for more timely and actionable data.

Advisory committee

The statute does not allow for administrative or judicial review of the VBPM. However, many implementation issues will need to be addressed. Our members have experienced numerous difficulties receiving accurate information related to CMS quality programs. We urge CMS to create an advisory committee to serve as a resource for practical questions and concerns. This advisory committee should

include, at minimum, practice administrators and practicing physicians who can answer practical questions related to the VBPM and its application in real-world care delivery situations.

Attribution

MGMA has concerns about the attribution proposals outlined by CMS. As stated earlier, we urge CMS to withdraw its VBPM proposal until methodological and technical issues are resolved. Further refinement is needed before implementing any one of these largely untested rules to attribute Medicare costs to physician groups. It's critical that CMS invest in ensuring the accuracy of physician cost measurement in Medicare. The agency should share the results of its additional testing in future rulemaking to solicit stakeholder feedback.

Physician Quality Reporting System

MGMA is pleased to see the proposed modifications that reduce the administrative burden of participating in the physician quality reporting system (PQRS); however, we still have concerns regarding specific PQRS provisions in this proposed rule.

Proposed definition of a group practice

CMS proposes to modify the definition of group practice as “a single Tax Identification Number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider (NPI), who has reassigned their Medicare billing rights to the TIN.” CMS proposes to change the number of eligible professionals comprising a PQRS group practice from “25 or more” to “2 or more” to allow all groups of smaller sizes to participate in the GPRO. MGMA supports the new proposed definition of a group practice. This change allows for the elimination of redundant measure reporting by multiple providers in smaller group practices treating a single beneficiary.

2015 payment adjustments based on 2013 performance

We continue to object to CMS' basing a 2015 payment adjustment on what a provider does in 2013. The government should only apply payment adjustments that take into account performance during the relevant year, rather than previous years.

MGMA appreciates the new proposed reporting options for purposes of avoiding the PQRS penalties in 2015 and 2016. To avoid PQRS penalties in 2015 and 2016, CMS proposes two additional reporting options. These options include: i) reporting one PQRS measure or measure group using the claims, registry, or EHR-based reporting mechanisms during the 12-month reporting period (2013 and 2014, respectively); or ii) elect the proposed administrative claims-based measures. CMS will determine from a group's claims whether it successfully reported under the PQRS. To assure the administrative claims option aids in achieving CMS' goal to increase participation by fifty percent, MGMA urges CMS to include measures that apply to more specialties. The proposed measures are focused on primary care and therefore preclude use of administrative claims-based option for many other types of specialty groups, especially single specialty groups for which these measures are not clinically relevant.

PQRS group practice participation

MGMA opposes CMS' proposal to prohibit EPs in selected groups from participating in the PQRS as individuals. Individual reporting is critical for promoting alignment across the PQRS, VBPM and the

EHR Incentive Program. If EPs in a group practice (that participates through GRPO) cannot participate individually, the PQRS would not be aligned with Stage 1 of the Medicare EHR Incentive Program. Stage 1 does not have a GPRO, and therefore EPs have to report individually.

Removing the individual reporting option for EPs whose group participates through GRPO will also have a significant negative impact on registry reporting. Currently, when large groups participate as a GRPO, individual EPs in the group may continue to report to separate registries that are relevant to their practice. Registries are becoming increasingly popular among providers as a tool for ensuring adherence to clinical guidelines and assessing performance; therefore it is important that this data is collected.

MGMA also opposes the proposal that prohibits groups from continuing to report in the GPRO if the group practice changes its TIN within the reporting year due to reorganization or other factors. We urge CMS to continue to allow groups that change their TIN to participate in the PQRS. Otherwise, these groups could be penalized by both the PQRS program and the VBPM. CMS suggests that EPs in a group practice that has changed its TIN within a year may still participate as individuals; however, this may not be feasible or could be a rather large administrative burden depending on when the group changes its TIN during the year.

Reporting mechanisms

MGMA does not support the proposal to limit groups of 100 or more to the GPRO web interface reporting mechanism and urges CMS to allow groups of 100 or more to use all the GPRO reporting mechanisms. Many large group practices are diverse and therefore use multiple reporting modalities based on applicable measures. The *CMS 2010 PQRS and eRx Experience Report* indicated that 16,925 PQRS participants used more than one reporting mechanism. Additionally, it may not be possible for all physicians in the group (especially multi-specialty practices with a wide array of specialists) to report the same measures. It is therefore necessary for groups of 100 or more to be able to report across all GPRO reporting modalities.

E-prescribing Incentive Program

MGMA supports e-prescribing and other health information technology (HIT) that will improve clinical care and reduce administrative costs. However, it is our belief that the duplicative requirements of the e-prescribing incentive program unfairly penalize providers also participating in other federal quality reporting initiatives. CMS recognizes that this overlap exists and proposes additional hardship exemptions for certain providers also participating in the EHR Incentive Program. However, this proposal fails to eliminate the burden on providers to fulfill requirements in each separate program.

As proposed, these new exemptions will require providers to first determine if they are eligible to claim an exemption based on the registration and attestation criteria and time frames set forth in the proposed rule. We firmly believe CMS should bear the responsibility of determining which providers successfully participate in the EHR Incentive Program and automatically deem those providers as successful in other programs containing duplicative requirements such as e-prescribing. As stated in previous [letters](#) to the agency, we strongly encourage CMS to revisit this policy and develop the capability to harmonize the capturing and processing of provider information to and from multiple CMS-administered quality reporting programs. To further streamline these programs, we urge the agency to automatically deem those providers who are participating successfully in meaningful use to

have fulfilled both the e-prescribing and PQRS requirements rather than placing the burden on the provider to claim hardship exemptions to avoid duplicative penalties.

Should CMS finalize its additional proposed exemptions, we urge the agency to expand the exemptions to include any provider who has registered or attested in the EHR Incentive Program in 2011, 2012 or 2013. Additionally, providers wishing to claim these new exemptions to avoid a 2013 penalty should be given ample time to submit an exemption request. We believe providers should be given additional time to submit all hardship exemptions, and we urge CMS to revisit the current June 30 deadline, as well as the proposed Oct. 15, 2012 deadline for submitting these newly proposed hardship exemptions to avoid a 2013 penalty. Successful and widespread use of these new exemptions will depend on providers' awareness of this change. Granting additional time to educate providers regarding these new options will be critical to their success. We urge CMS to adopt a Dec. 31, 2012 deadline for submitting all hardship exemption requests to avoid a 2013 penalty. Similarly, we ask that the deadline for filing an exemption to avoid 2014 penalties be extended to Dec. 31, 2013.

Changes to the Group Practice Reporting Option

MGMA supports CMS' decision to change the definition of a group practice for the purposes of the Group Practice Reporting Option (GPRO) to include groups of 2 or more EPs. However, we urge CMS to reduce the reporting thresholds proposed for smaller groups within this category. CMS itself recognized the need for this distinction in 2011, the last iteration of the GPRO that included groups of 2-25 providers. The 2011 criteria recognized the need for different requirements for smaller groups within this category, and we ask CMS to reinstate the following 2011 reporting requirements to encourage greater participation in the GPRO among smaller practices:

- 2-10 NPIs: report a min of 75 denominator eligible patient encounters
- 11-25 NPIs: report a min of 225 denominator eligible patient encounters

Informal review

MGMA is pleased to see the addition of an informal review, or appeals process, for the e-prescribing program. We note that it is incumbent upon CMS to provide further guidance in this area, and request additional clarification regarding what situations will be considered in the informal review process. For providers to be sufficiently prepared to submit the necessary supporting information to accompany an informal review request, they must know the scenarios that would call for a review. MGMA requests that CMS review for appeal those cases in which a provider made a good faith effort to e-prescribe and report their eligible instances, but due to situations beyond their control (such as vendor problems, operational difficulties and/or technological problems), was penalized. We also ask that CMS expand the informal review process to accept requests for reviews of 2012 through 2014 determinations, including 2012 penalty determinations.

Further, the proposed deadline for submitting informal review requests should be extended. Absent some type of formal notification that a provider is being penalized, practices will need time to review remittance advice notices to identify that penalties exist, gather supporting documentation to include in the request for informal review and submit the request to CMS. For this reason, MGMA urges CMS to extend this deadline to provide practices with additional time to assess claims for penalties and account for discrepancies, should they exist.

Updates to e-prescribing standards

MGMA supports the proposed upgrades to existing e-prescribing standards and urges CMS to finalize an additional standard to address prior authorization. We recommend the HIPAA ASC X12 278 5010 standard transaction to be utilized as a single standard for all types of prior authorization.

Elimination of the Requirement for Termination of Non-random Prepayment Complex Medical Review

MGMA disagrees with CMS' decision to eliminate the regulations found at 42 C.F.R. part 421, subpart F. The agency intends to eliminate these regulations based on the removal of Section 1874A(h) of the Social Security Act, which placed limits on non-random prepayment review and directed CMS to develop regulations relating to the termination of prepayment review. In promulgating the regulations contained in 42 C.F.R. part 421, subpart F, CMS included several provisions to protect healthcare providers who have been placed on prepayment review, including limiting prepayment review to either one year or until a provider has reduced its error rate by 70 percent. The regulations also contain additional protections, including requiring contractors to, at a minimum, review the length of time a provider has been on prepayment review quarterly. Additionally, when a contractor determines that a provider should be removed from prepayment review, the regulations at issue require that the claims processing system be updated within five business days so that provider's claims will not continue to be suspended.

Prepayment review requires significant staff time and resources, disrupts revenue flow to providers and their group practices, and can jeopardize patient access to care. Providers can be subject to prepayment review for reasons unrelated to their billing practices. Particularly in the past year, we've seen a rise in physicians and other practitioners being targeted for prepayment and other controls based solely on location. We strongly disagree with CMS' proposal to eliminate all existing protections, instead leaving it to the discretion of each contractor to determine an acceptable error rate for eliminating non-random prepayment review. We urge CMS to rely on its rulemaking authority and maintain the protections for healthcare providers included in 42 C.F.R. part 421, subpart F. In addition, we urge CMS to take further steps to protect the interests of healthcare providers facing prepayment review. CMS could do so by including provisions in its agreements with Medicare contractors performing prepayment review to assess the contractor's activities and to evaluate the appropriateness of its use of prepayment review, including the effect it has had on the operations of affected healthcare providers in its jurisdiction.

Radiation Treatment Services – Potentially Misvalued Codes

As part of its efforts to identify and review potentially misvalued codes and make appropriate adjustments, CMS proposes to reduce the procedure time assumptions (thus reducing the payment amount) for two radiation treatment services – intensity modulated radiation therapy (IMRT) and stereotactic body radiation therapy (SBRT). The proposed reduction is based on discrepancies between the procedure time assumptions used to establish direct practice expense inputs for the codes and publicly available patient education and other materials that indicate a shorter length of time for sessions.

We urge CMS to be cautious in its modifications to the inputs used for individual codes, especially where, as here, the result is a steep payment cut that could dramatically affect patient access to

treatment. Relying on publicly available materials created for a specific purpose (e.g., patient education or marketing) may not provide a complete picture of time needed by clinicians performing these services. We urge CMS to use a more well-established and transparent approach to code modification – which should include an opportunity for the American Medical Association/Specialty Society Relative Value Update Committee to participate – rather than the proposed ad hoc approach.

Primary Care

Post-discharge care management

CMS proposes to create a HCPCS G-code for post-discharge transitional care management services related to the transition of a beneficiary from care furnished during a stay in a hospital (inpatient, outpatient observational services or outpatient partial hospitalization), Skilled Nursing Facility (SNF) or community mental health center (CMHC). This new code would provide reimbursement to a beneficiary's primary physician or qualified nonphysician practitioner (NPP) for non face-to-face post-discharge care management services furnished within 30 days of discharge.

MGMA supports CMS' proposed creation of this new G-code, which will help ensure beneficiaries receive the necessary support and care following a stay in one of these settings. Care coordination is essential for preventing adverse events such as unnecessary hospital readmissions. MGMA has pledged our support for HHS' Partnership for Patients and creating this code is a step in the right direction for preventing hospital readmissions. Many practices have been providing these care management services without receiving reimbursement. By recognizing and reimbursing for these services, it will allow practices to continue providing these services and enhance their focus on care transitions.

In the fee schedule, CMS states that the post-discharge transitional care management service would include care management services furnished by clinical staff member(s) or office-based case manager(s) under the supervision of the community physician or qualified NPP. CMS requests feedback about whether the agency should require these services to be furnished by only a physician, qualified NPP or other clinical staff in the practice who are qualified to assist beneficiaries in managing post-transition changes in conditions and treatments. We urge CMS to allow physicians and qualified NPPs to supervise a team of medical professionals to furnish this service. Team-based care under the supervision of a physician or qualified NPP will allow greater beneficiary access to this service. In addition to allowing teams of medical professionals to furnish this service, we encourage CMS to allow physicians of all specialties to do so, when appropriate. We appreciate that CMS does not propose a specialty requirement for this service, which we feel is appropriate since some beneficiaries go to a particular specialist more frequently and would thus consider that physician their "primary physician."

CMS requests feedback on requiring a face-to-face visit following discharge and whether that should occur on the same day as billing for the post-discharge transitional care management service. The agency correctly speculates that some beneficiaries may have trouble arranging an in-person visit following their discharge. We believe that requiring a face-to-face visit following discharge would be a barrier for some beneficiaries to receive the post-discharge care management service, and we encourage CMS to provide an exceptions process for beneficiaries who cannot arrange a face-to-face visit.

While we are pleased that CMS recognizes the importance of post-discharge care management, we are concerned that the agency plans to pay for this new service by decreasing reimbursement to specialties outside of primary care. We understand CMS' requirement to maintain budget neutrality, however, we

encourage the agency to consider alternatives to maintain reimbursement for other Part B physicians while also adding this new service. As cited in the proposed 2013 fee schedule, MedPAC found that in 2005, 17.6 percent of hospital admissions resulted in readmissions within 30 days of discharge, accounting for \$15 billion in spending. MedPAC estimated that 76 percent of the 30 day readmissions were potentially preventable, equating to \$12 billion in spending.

The proposed post-discharge care management service will help prevent billions of dollars in unnecessary hospital readmissions. While this savings will benefit the Medicare program overall, it represents a large cost savings under Part A and a smaller increase in Part B spending. Rather than penalizing many specialties under the Part B physician fee schedule, we encourage CMS to explore ways to pay for this service by using money that will be saved under Part A. For instance, in 2013 CMS must establish a Hospital Readmissions Reduction program focused on potentially preventable inpatient hospital readmissions for heart attack, pneumonia and congestive heart failure. Under this program, a portion of Medicare's payment amounts for inpatient services to certain hospitals will be reduced by an adjustment factor based on the hospital's excess Medicare readmissions. We urge CMS and Congress to consider utilizing funds from this program to offset new Part B initiatives, such as the post-discharge care management service, aimed at preventing costly hospitalizations. As providers work to enhance care coordination and decrease overall costs, it is essential that CMS and Congress also work to break down silos and coordinate payments between Medicare Part A and B.

Advanced primary care settings

Patient centered care is the principal concern for medical practices that work hard every day to improve care for Medicare beneficiaries. CMS discusses, but does not formally propose, establishing an enhanced payment for primary care services furnished to Medicare beneficiaries in advanced primary care practice environments. CMS considers how it would identify an advanced primary care practice environment. This could be done using existing accreditation for Primary Care Medical Homes (PCMHs) or by using criteria developed by CMS. There are four national models that provide accreditation for organizations wishing to become an advanced primary care practice: the Accreditation Association for Ambulatory Health, The Joint Commission, the National Committee for Quality Assurance and the Utilization Review Accreditation Commission. While the models differ in various capacities, they share a number of similarities and all meet the guidelines set forth by the four primary care physician societies: American Academy of Pediatrics, American College of Physicians, American Academy of Family Physicians and the American Osteopathic Association. Should CMS move forward to develop this enhanced payment, we urge the agency to use existing accreditation rather than create a duplicative set of CMS-specific criteria. The latter would result in unnecessary work for CMS and practices that have already undergone comprehensive PCMH accreditation.

Therapy Services

As required by the Middle Class Tax Relief and Job Creation Act of 2012, CMS proposes implementing a new claims-based data collection program for Medicare therapy services beginning in 2013. This reporting program will collect data on Medicare beneficiary status related to physical, occupational and speech language pathology therapy provided under Medicare Part B and Comprehensive Outpatient Rehabilitation Facilities (CORF) benefits. CMS will collect information on therapy services furnished, beneficiary function and condition. We understand that CMS is statutorily

obligated to create this program but have concerns about the onerous nature of the reporting and the administrative burden it places on therapists and practices.

CMS proposes a new set of G-codes and related modifiers to report on therapy claims. The G-codes would denote the functional limitations and modifiers would indicate the severity for these limitations. Beneficiaries may have multiple functional limitations to be reported, and G-codes and modifiers would be reported at the outset of a therapy episode, at established intervals during treatment and at discharge. Additionally, CMS proposes to require reporting a G-code in between the outset, established intervals and discharge. We strongly object to CMS requiring reporting in between the outset, established intervals and at discharge. This is unnecessary and onerous and would not provide any useful data. Requiring reporting on all therapy claims is a significant requirement, and we urge the agency to scale this back and only require reporting on a certain percentage of therapy claims. This would provide an adequate sample size and enough data for CMS to use as it considers other therapy payment options. We do not recommend the agency require reporting on more than one functional limitation.

The proposed 12-point severity scale does not come from existing therapy measurement tools, and therapists using existing tools would have to crosswalk scores from those to CMS' severity scale to determine the appropriate modifier. Given the varied nature of therapy services, progress benchmarks and conditions, there is not one standardized measurement tool that works for all therapy services. There are a wide variety of therapy measurement tools which are used to quantify patient function, and it will be very difficult to crosswalk some information from existing tools to the proposed 12-point severity scale. We recommend the agency work with stakeholders to consider alternatives for conditions and functions which do not adequately correspond to CMS' proposed 12-point scale.

CMS proposes to require reporting this information as a condition for payment for these therapy services. The agency proposes to implement the reporting requirements effective Jan. 1, 2013, but will have a six-month test period to allow providers to adjust to the new reporting requirements. Beginning July 1, 2013 claims without the required G-codes and modifiers will be returned unpaid. We appreciate CMS acknowledging that time is needed to educate providers on these new requirements, but six months is not nearly adequate. We urge CMS to make the reporting program optional for all of 2013 or until the provider community is fully prepared to meet these requirements. This will allow time for education and gradual implementation. Additionally, CMS is currently completing a five-year project exploring therapy payment alternatives, and this report is expected in the latter half of 2013. CMS should review these results before requiring an additional, burdensome reporting program as condition of payment for all therapy claims.

We have significant concerns about payment disruptions for therapy services. In addition to learning how to meet the new reporting requirements, practices will have to ensure that their clearinghouses and practice management systems are prepared to meet these requirements. As we have seen with other quality reporting programs, such as e-prescribing and PQRS, G-codes are sometimes stripped from claims by clearinghouses or practice management systems. Often providers do not realize this mistake until it is too late. It will take time for vendors to update their software and systems to prevent these codes from being removed. CMS proposes that claims without the required data will be returned unpaid. If CMS moves forward too quickly with these requirements, this will lead to a large number of returned claims. This is an administrative burden for practices and for contractors that have to deal with resubmitted claims. It may also result in a more wide scale contractor backlog, impacting claims other than those for therapy services. As CMS moves forward with this program, we caution the agency not

to compare providers of therapy services against one another based exclusively on this data. There are many other factors that contribute to a beneficiary's progress with different types of therapy, such as underlying health conditions and adequate access to therapy.

Physician Compare

The [Physician Compare website](#) was mandated by the ACA and CMS is required to add more information in the coming years. Many physicians have complained of inaccurate information on the site, which is difficult to correct and confuses beneficiaries. For instance, physicians practicing at multiple locations have had trouble when the website randomly and incorrectly selects a location as the physician's primary location. If a physician identifies inaccurate information, it often takes months for it to be corrected on the site. This is frustrating for beneficiaries who receive inaccurate information and for practices that must deal with the administrative hassles to correct this information.

In the proposed fee schedule, CMS states that in 2012 it intends to add providers' status of accepting new Medicare beneficiaries. This information would be taken from the Medicare enrollment system, PECOS. As we have commented to the agency previously, CMS should not collect this information through the enrollment process. A physician may frequently change his or her status on accepting new Medicare patients. This may fluctuate based on time of year, Medicare payment uncertainty stemming from the sustainable growth rate formula or patient demand. Especially considering the delays to correct information on Physician Compare, we urge CMS not to post this information, which will only lead to confusion for beneficiaries.

Before adding any new information to Physician Compare, CMS must address the basic issue of accuracy and the difficulty physicians face correcting information. It is imperative CMS address these problems before adding anything further to the site. In the fee schedule, CMS outlines plans for a full website redesign in 2013 to fix some deficiencies and add new capabilities to help prepare for future enhancements and reporting. We appreciate CMS recognizing existing flaws with the website, and urge the agency to address the issues we have outlined as part of its efforts. We also urge CMS to reach out to states that are successfully collecting, analyzing and reporting physician performance information to the public. CMS should consider ways to work in concert with successful state initiatives, allowing CMS to leverage existing programs and to minimize reporting burdens on physicians. Additionally, we would be pleased to work with CMS to help identify and address further concerns with the site.

CMS anticipates that beginning in 2013 it will post measure performance information for group practices participating in PQRS GPRO. The agency proposes reporting this information for practices that meet the measure minimum sample size, which the agency proposes to lower from 25 to 20 patients. We urge the agency not to post measure performance for GPRO. In order for CMS to meet the statutory requirements, we recommend the agency simply report groups that participate in GPRO. With implementation of the value-based payment modifier as proposed, all groups of 25 or more EPs would be required to participate in GPRO in 2013 or face a 1.0 percent penalty in 2015. Thus, it will be the first year of participation for many groups, which could lead to lower measure performance scores as these groups adjust to the new reporting requirements. Publicly reporting measure performance will be detrimental to practices new to the program and will mislead beneficiaries. As discussed in our comments on the value-based payment modifier, a patient threshold of 20 is much too low to be statistically reliable and we recommend a higher threshold to ensure validity. Further, prior experience with the PQRS has shown a myriad of problems in determining successful physician participation,

therefore “successful” or “non-successful” participation should not be reported on the site until these problems are resolved. Reporting success is not an accurate measure of quality.

Beginning as early as 2014, CMS proposes to publicly report 2013 patient experience data for group practices participating in the 2013 PQRS GPRO, or who are part of an ACO under the Medicare Shared Savings Program. We urge CMS to provide this information through confidential feedback to these groups, the majority of which will be new to PQRS GPRO. This information should be used to help groups identify ways to improve, not to publicly showcase results for new measures for which the practice has not had experience reporting. Prior to posting any information related to the measures in the value-based payment modifier, CMS must verify their accuracy through a thorough testing and analysis.

As we have previously requested, we urge CMS to add a review process prior to posting information on the site to assure accuracy. Practices and physicians should also have an option to include comments in the public report on the website, which would allow them to clarify information or explain why they may not have participated in a program like PQRS. Physician Compare will only be useful if beneficiaries, providers and CMS are confident in the information reported. We urge the agency to make these changes to increase that confidence.

DME face-to-face encounters and written orders prior to delivery

As included in the ACA, a physician must have a face-to-face encounter with a patient within the six-month period prior to certifying the need and writing an order for durable medical equipment (DME) under Medicare. The statute also allows a physician assistant, a nurse practitioner or clinical nurse specialist to perform the encounter, which may be performed through the use of telehealth. In its proposal, CMS intends to tighten the time frame surrounding the face-to-face encounter, requiring it to occur no more than 90 days before or within 30 days after an order is written. While MGMA understands the agency’s focus on eliminating fraud and abuse in the DME industry, we urge CMS to minimize the burden this requirement will have on physicians. One way to do so is to maintain the six-month window contemplated by the ACA while still allowing the face-to-face encounter to occur within 30 days after the order is written. In determining the requirements for physician documentation of face-to-face encounters, we urge CMS to be flexible and allow the physicians to choose the method of documentation that best fits within the physician’s existing processes. While physicians will maintain the needed documentation in their own records, once documentation is transmitted to the DME supplier, that supplier’s records should be the primary source of documentation needed for any post-payment audits. We further urge CMS to provide an exemption to these requirements for DME that is supplied by office-based physician suppliers.

We appreciate your consideration of these comments. If you have any questions, please contact Anders Gilberg, senior vice president for government affairs at (202) 293-3450.

Sincerely,



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