ACP
American College of Physicians
Internal Medicine | Doctors for Adults®

September 6, 2013

Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P. O. Box 8013
Baltimore, MD 21244-8013

Re**: 42 CFR Parts 405, 410, 411, et al. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule**

Dear Ms. Tavenner:

The American College of Physicians (ACP) is the largest physician medical specialty society, and the second largest physician membership organization, in the United States. ACP members include 137,000 internal medical physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. The College thanks the Centers for Medicare and Medicaid Services (CMS) for this opportunity to address the notice of proposed rulemaking for the Calendar Year 2014 Medicare Physician Fee Schedule publicly.

In the Medicare Physician Fee Schedule notice of proposed rulemaking for 2014, CMS proposes a number of changes to its physician fee schedule rules, including adding coverage for complex chronic care management, updating standards for e-prescribing under the Part D program, and making changes to reporting requirements for the Medicare Shared Savings Program. ACP appreciates the effort that CMS is making to reform the Medicare Physician Fee Schedule, for the better capture of the wide breadth of care while keeping care quality in consideration. However, the College believes that some of the specific requirements proposed by CMS, especially related to the proposed new codes for complex chronic care management, may not be workable for some smaller practices and internal medicine subspecialists. In such instances, we have proposed alternatives.

Complex Chronic Care Management (CCCM) Proposal

ACP has been working, through the Current Procedural Terminology (CPT) and Relative Value System Update Committee (RUC) processes, to develop billing codes that would account for the non-face-to-face care that internists provide to their patients; the College also wants those codes to be recognized by payers. ACP is very pleased to see CMS continue to recognize the full

breadth of primary care and of complex chronic care management in particular. This follows the path of the agency's other initiatives for primary care, such as the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) model, the Advance Payment ACO model, and the Primary Care Incentive Payment Program.

The new proposal from CMS is an important and welcome step in reaching those goals. ACP views this proposal as a positive development for improving the care of patients with complex chronic diseases, many of whom get their care from internal medicine specialists and subspecialists. It signifies the importance that the agency places on primary care and cognitive services.

We note, however, that this proposal differs in detail from the existing CPT codes for CCCM (99487-99489), although the scope of the proposed codes retains overall similarity to the CPT codes. ACP applauds CMS for <u>not</u> making the CCCM proposal specialty-specific, instead choosing to focus on a practice's ability to provide the required services.
The code definitions that CMS proposes are:

> Complex chronic care management services furnished to patients with multiple (two or more) complex chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
>
> - GXXX1, initial services; one or more hours; initial 90 days
> - GXXX2, subsequent services; one or more hours; subsequent 90 days

Also included in CMS' CCCM proposal are: care transitions, including referrals to other clinicians, visits that follow an emergency room visit, and visits following discharge from hospitals and skilled nursing facilities; coordination with home and community based clinical services; and enhanced opportunities for the patient to communicate with the provider, including via the telephone, secure messaging, internet communication, or other same-time consultation methods.

CMS further specifies that the 90-day service period for CCCM services would include a systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.

***ACP Comment*:**
The College has concerns that 90-day codes may not be workable: a three-month period is likely too long for meaningful documentation, especially if most of the care is rendered within the first 4-6 weeks. **Therefore, ACP recommends that the CCCM codes be written for reporting periods of <u>one calendar month each</u>, which is similar to the existing CPT codes for complex chronic care management.**

ACP also notes that neither of the proposed codes references a face-to-face visit with the patient. **The College asks that CMS consider greater alignment of its codes with the existing CPT codes for CCCM with regard to a face-to-face visit, which is included in code 99488**.

CCCM Practice Characteristics

According to the proposed rule, in order to bill for the CCCM services, a practice would need to possess the following characteristics:

- Ensure that physicians are available to provide care on a 24 hour a day, 7 day a week basis to address a patient's acute complex chronic care needs. The practice would have to provide the patient with the means to contact the practice's health care clinicians in a timely manner. Members of the complex chronic care team would be required to have access to the patient's full electronic health record (EHR), even when the office itself is closed.

  ***ACP comment*:** ACP agrees with the goal of having EHRs available with total interoperability for all clinicians 24 hours a day, 7 days a week but this is not currently possible for many physicians and their EHRs. The College also agrees with the goal of providing patients with timely access to physicians and other health professionals in a team-based, patient-centered practice, with immediate access when a patient's medical condition or needs require it. However, it will not always be feasible, especially in smaller practices, for a patient's personal physician or another clinical team member to be available on a 24/7 basis for every patient who may have a non-urgent concern that could appropriately be handled within usual office hours. (This can be challenging even for mid-size and larger practices that do not have the capability to be open on a 24/7 basis). While it is getting easier to log into some EHRs at any time from almost anywhere, this is not a requirement for 2014 EHR certification. Many practices will be using systems that qualify for Meaningful Use Stage 2, but that do not support 24/7 remote access. Practices should not be required to change from one certified system to another just to gain this feature.

  The agency should revise this requirement to provide more flexibility for practices to demonstrate that they have their own protocols to ensure that patients with complex chronic diseases have timely access to physicians and other team members within a realistic timeframe. Practices could be required to demonstrate that their patients have same or next day access—by phone, email, telemedicine, or in person (including same day open scheduling to the extent possible)—to the physicians in their practice, to other physicians via coverage arrangements, and/or to other health professionals that have arrangements with the patients' personal physicians (and that can provide immediate access to a physician when necessitated by a patient's condition). We note that providing such flexibility is consistent with the Joint Principles of the Patient-Centered Medical Home (PCMH), which state, "Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff."

- A practice would need to use a certified, practice-integrated EHR that meets current HHS meaningful use standards. However, the agency also states that it is aware that not all physicians and qualified practitioners will be fully capable of meeting the practice requirements of the CCCM codes, without making additional investments in technology, staff training, and in the development and maintenance of systems and processes to furnish the services.

  ACP comment: ACP understands the need for certified EHR adoption and its role in achieving meaningful use. At the same time, ACP appreciates that CMS is considering the fact that many practices would not be able to meet the CCCM requirements immediately; the College is hopeful that CMS will offer interim opportunities for such practices to develop their capabilities.

- "The practice must employ one or more advanced practice registered nurses or physicians assistants whose written job descriptions indicate that their job roles include and are appropriately scaled to meet the needs for beneficiaries receiving services in the practice who require complex chronic care management services provided by the practice." (78FR43338)

  ACP comment: This part of the proposed rule would make it impossible for a physician who does not employ an advanced practice nurse (APN) or PA to provide the CCCM; yet an APN–as an independent, billing provider— could provide the CCCM without the involvement of a physician. **ACP recommends that CMS not prescribe the hiring decisions that practices need to make to be eligible for the CCCM codes. Instead, we recommend that the agency provide greater flexibility for practices to demonstrate that they have the structural capabilities, personnel, and systems to coordinate care effectively, through their own engagement with patients, as well as by having other qualified health care professionals available, either within the practice itself or through external arrangements, to provide complex care management services.** For instance, physician practices may employ registered nurses who do not have additional training as an APN to ensure effective care management services provided by the practice. Other practices may have formal relationships with APNs, PAs, RNs, nurse-educators, clinical pharmacists, social workers, and/or other health professionals who, although not directly employed by the practice, are available to the practice. In some cases, third party payers or hospitals have arranged to fund and/or provide such services at little or no cost to practices. Practices might also pool their resources— such as through an independent practice association (IPA) model—to provide all practices in the IPA with access to such health professionals to ensure effective care management, without necessitating that any one practice by itself bears the full cost of employing them. This option has been examined in an article from the *American Medical News*: [1]

  > Researchers surveyed a nationwide sample of 1,164 physician practices with fewer than 20 doctors and found that 24% took part in an

[1] *American Medical News* article is accessible at: http://www.amednews.com/article/20130819/profession/130819952/4/.

> independent practice association or physician-hospital organization. In these arrangements, individual physician groups maintain separate ownership, but they can join with perhaps 150 to 300 other doctors to negotiate health plan contracts and jointly spend on health information technology and other infrastructure that can improve care… The 24% of practices involved in an IPA or PHO offered an average total of 10.4 care-management processes to patients with asthma, depression, diabetes or heart failure, nearly triple the 3.8 services that the remainder of practices were able to provide.

We note that the concept of providing smaller primary care practices with access to other health professionals, funded not by the practice itself but by another payer, is enshrined in Section 5405 of the *Patient Protection and Affordable Care Act*. This section authorizes the Secretary to fund the creation of Primary Care Extension Agencies to support and educate primary care clinicians about preventive medicine, health promotion, *chronic disease management*, mental health services, and evidence-based therapies. Primary care clinicians would work with local, community-based health connectors, referred to as Health Extension Agents, who provide assistance in implementing quality improvement or system redesign that incorporates the principles of the PCMH and links practices to diverse health system resources. Unfortunately, this section of the law has not received funding from Congress. Nonetheless, it shows that Congress intended for HHS to support models where practices may have access to community-based health professionals to assist them in providing chronic disease management services without the practice having to employ them directly.

We also note that some solo physician practices and many small group practices have achieved Level 3 NCQA PCMH certification or comparable certification by URAC or the Joint Commission, without employing APNs or PAs within the practice itself. To illustrate, the NCQA reports as of May 30, 2013, 1,557 solo physician practices have achieved Level 3 PCMH certification, and 1,998 practices of three to seven physicians have achieved such certification. In fact, more than three quarters of the 4,341 practices that have achieved NQCQ Level 3 PCMH certification are in practices of 1 to 7 physicians; only eight are in practices of 50 or more physicians.[2]

CMS's proposed rule to require that practices hire APNs or PAs would inappropriately disqualify many, if not most of the practices that have achieved Level 3 NCQA certification, or comparable certification from other accreditation entities, from billing for the complex chronic care management codes.

Recommendations for Care Management Accreditation Sources

The proposed rule states, "We understand there are differences among the approaches taken by national organizations that formally recognize medical homes and therefore, we seek comment on these and other potential care coordination standards, and the potential for CMS recognizing a

[2] NCQA, letter to the House Energy and Commerce Committee, July 10, 2013, accessed at http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH/NCQA%20Energy%20&%20Commerce%20SGR%20Comments%206-10-13.pdf

formal patient-centered medical home designation as one means for a practice to demonstrate it has met any final care coordination standards for furnishing complex chronic care management services." (78FR43339)

ACP Comment:
The establishment of these codes has been a top priority of the College for several years — and we believe that they are an important and welcome step in recognizing the full breadth of primary care through the fee for service payment system. This section of the proposed rule suggests that CMS is open to recognizing the ability of a physician who has achieved formal recognition as a patient centered medical home (PCMH) by the National Committee for Quality Assurance (NCQA), an NCQA Patient-Centered Specialty Practice (i.e., a PCMH neighborhood practice, or PCMH-N), or has otherwise received equivalent certification or met other comparable qualifications.

ACP believes that CMS should make it a priority to accelerate widespread adoption of the PCMH and PCMH-N models throughout the Medicare program. Therefore, making such practices eligible to bill and be reimbursed for the CCCM codes would be an important step toward furthering this goal. **ACP strongly supports allowing practices that have received independent certification or recognition as a PCMH or PCMH-N (specialty practice) to be recognized by CMS as satisfying the requirements to bill and be reimbursed for the CCCM codes without necessitating that they provide additional documentation to CMS that they satisfy the criteria established by the rule.** We specifically recommend that CMS "deem" PCMH and PCMH-N recognition programs that provide independent certification of practices as being equivalent to satisfying the final practice capability standards that CMS establishes for the CCCM codes.

The College further recommends that CMS allow for multiple pathways for accreditation, recognition, and/or certification of PCMHs and PCMH-N practices, noting other entities offer these programs, such as URAC and The Joint Commission. We also recommend that CMS include other approaches to recognizing medical homes as developed by private health plans and within CMS via its Innovation Center Comprehensive Primary Care Initiative, some of which may not have been formally certified by an accreditation entity.

ACP specifically encourages CMS to pursue the PCMH-N: specialty practice recognition as a pathway to the CCCM codes, since this would make it possible for internal medicine subspecialists to qualify if they otherwise meet the requirements.

ACP also recommends that CMS establish a pathway that would allow physicians who are <u>not</u> in a PCMH-certified practice to demonstrate that they meet the standards to bill and to be paid for the proposed new codes. This will provide these physicians and practices an avenue via Medicare fee for service payment to achieve PCMH status. At the same time, ACP strongly agrees that if a practice is already a formally certified PCMH, then they have demonstrated that the practice capabilities needed to use the codes and should be able to do so.

Patient Notification and Consent

The proposed rule would require that a patient be notified and informed of the scope of CCCM services before a physician can bill for the service. As evidence of the consent, the physician must note it in the patient's medical record and the patient must be given a copy (printed or electronic) of the care plan. Consent must be reaffirmed at least once every 12 months. The patient may revoke consent at any time.

ACP Comment: ACP appreciates the inclusion of this proviso, since in the potential absence of a face-to-face visit; it alerts both the patient and the physician that the CCCM service will be provided.

CCCM Relationship to Annual Wellness Visit and Initial Preventive Physical Examination

ACP Comment: **The College disagrees with the idea of tying the CCCM to either the Initial Preventive Physical Examination (IPPE) or the Annual Wellness Visit, as proposed by CMS.** Requiring an IPPE/AWV as a criterion for the CCCM codes presents an additional record-keeping burden to physicians. In many cases, the same physician will provide the AWV or IPPE and the CCCM. However, there are likely to be a substantial number of cases where the patient has seen a different doctor for the AWV/IPPE – but the would-be CCCM physician has no effective way to know whether or when the patient received the preventive visit.

Determination of Relative Values

CMS proposes that the codes be considered for the 2015 calendar year, in order to give the agency sufficient time to develop and obtain public input on the care standards. Consequently, there are no proposed relative values for GXXX1 and GXXX2.

ACP Comment: **ACP recommends that, for these proposed codes, CMS work with the medical community and the RUC to develop the relative values for these codes. Additionally, ACP is supportive of implementation of the codes in the 2015 calendar year, in order to allow CMS and physicians the time needed to improve the codes and better prepare for their use.**

ACP Overall Recommendation for the CCCM Codes

ACP recommends that CMS implement coverage for the complex chronic care management services, under the existing CPT codes 99487-99489, or as consistent with these codes as possible. The College suggests that CMS work with the medical specialties, the CPT Editorial Panel, and the RUC to revise the existing CCCM code descriptors, structure, and valuation to resolve differences between the CPT codes and the proposed G-codes.

Regarding the extensive list of items that would need to be documented for each patient, it is unfortunate that CMS, in its effort to build a bridge between traditional fee-for-service billing and payment, offers a proposal that would perpetuate the already outdated Evaluation and Management documentation system of bullet lists to prove medical necessity. ACP anticipates that the CCCM proposal, as written, could result in codes that are administratively difficult to use. Physicians would be challenged by the CCCM codes, due to the number and burden of the proposed requirements. While ACP agrees that the complexity of these codes necessitates challenging changes and new approaches for physicians and their practices, ACP is concerned

that if the entry requirements for practices are set too high—as it appears to be in this proposal—then the agency's goal of reforming the health care system will be compromised.

Ongoing Issue of Transitional Care Management Services

Although there are no new proposals for the transitional care management (TCM) services policy, ACP would like to note an issue that may have an effect on future care management policies. **The College notes that CMS has yet to resolve the administrative problems that are caused by its care management policy for TCM (CPT codes 99495 and 99496). Physician claims are denied if the discharging facility has not submitted its claim (a matter over which the physician has no control)—causing a financial hardship to physician offices who depend on timely payment of their claims.** ACP notes that CMS does not deny physicians' claims for inpatient visits, on the sole basis that the facility claim has not been received. ACP recommends that CMS eliminate the requirement for receipt of the facility claim as a requirement for adjudication of the TCM claim.

Misvalued Codes

In this proposed rule, CMS continues to examine the relativity of all services in the physician fee schedule. In particular, the agency expressed concern about the relativity of facility-based versus non-facility-based services.

CMS establishes practice expense (PE) relative value units (RVUs) for procedures that can be furnished in either a non-facility setting or facility setting.

In the proposed rule, the agency contends that for some services, the non-facility Medicare Physician Fee Schedule (MPFS) payment rates for procedures exceed those for the same procedure when furnished in an outpatient department (OPD) or an ambulatory surgical center (ASC). CMS believes this is <u>not</u> the result of appropriate payment differentials between the services furnished in different settings, but rather that it is due to anomalies in the data used under the fee schedule and in the application of the resource-based PE methodology to the particular services. This methodology relies largely on voluntarily submitted price information from individuals and groups who provide the services. CMS indicates that it is becoming skeptical of these data, if only because they have no way to effectively verify the price information.

Believing that the Hospital Outpatient Prospective Payment System (OPPS) data inputs are more accurate and valid because they are updated every year (as opposed to the fee schedule inputs that are updated, on a rotating basis, every few years), CMS proposes an alternative. The alternative would be to use the OPPS practice expense data or ASC rates (whichever is less) as the baseline for pricing services that are rendered in the hospital outpatient, ASC, and office setting, rather than the resource-based PE data used for the Medicare physician fee schedule.

ACP Comment:

The most common unit of payment under OPPS, the ambulatory payment classification (APC), is determined by hospital cost reports. However, it is not entirely clear what the actual inputs are for the APCs. In each payment classification, there are underpaid and overpaid services. Looking at the reported cost of providing care in some of the APC groups, there is no rationale

for the differences in the reported costs, yet CMS depends heavily on those reported costs. Alternatively, the RUC PE process (used for the fee schedule) reviewed the actual inputs with a great deal of scrutiny. Each medical service review in the RUC process includes not only a review of the physician work, but also a close and specific review of every item claimed for practice expense—the APC inputs are not so transparent.

Therefore, ACP recommends that CMS employ greater transparency before proceeding to any implementation of this proposal in its current form. The agency must share, for public feedback, the direct PE inputs that it compared across settings. The public should have the opportunity to review the OPPS and ASC direct PE data inputs, and to view the calculations related to the identification services for which the PE value would be reduced.

We understand CMS' attention to potentially anomalous site-of-service payment differentials that may result from inaccurate resource input data used to establish rates under the MPFS. However, we disagree with CMS' proposed approach of identifying and automatically adjusting non-facility PE RVUs for certain codes through this process, without providing a mechanism for validating both the CMS facility and non-facility resource-use data. **Rather, ACP recommends that CMS use the mechanisms created in this proposal as <u>a screening tool</u> for potentially identifying codes in which the non-facility payment appears to be higher than the facility payment—without automatically adjusting the non-facility PE RVUs.**

Additionally, before adjusting the non-facility PE RVUs for identified codes, CMS must provide a mechanism for determining whether there are statistical anomalies or other data issues that would create a rationale for excluding a code from the proposal. Therefore, when a code is identified for adjustment under this proposal, entities should have the opportunity to provide updated resource use data to the agency. The Relative Value Update Committee (RUC) also should be provided the opportunity to evaluate the resource use data associated with the codes identified in this proposal to determine if there are statistical anomalies in the data.

Our recommendations are based on several, specific weaknesses in the CMS assumptions that ACP has identified:

- Fee schedules changes can unintentionally re-align practice choices, by providing financial incentive for change—without an accompanying improvement in patient care. As an example, in 2012 and 2013, CMS re-priced renal vascular access interventional procedures that contributed to an increased rate of fistula success and progress toward achievement of the CMS Fistula First Breakthrough Initiative goals. Interventional nephrologists, vascular surgeons or radiologists were paid for their services in the physician office (place of service code 11), but ASC/outpatient hospitals were paid at a lower rate. Subsequently, the reduced payments for renal services to ASCs and outpatient departments have led to many centers potentially needing to close because their actual costs are not covered by the Medicare payment, thus resulting in a loss of patient access to these services.

- CMS presumes that the OPPS data are more accurate than are the MPFS data. However, other than the fact that the hospital OPPS data are "auditable" and "updated annually,"

CMS provides no evidence that such data are more accurate for all codes paid for under the MPFS in all circumstances. Additionally, as discussed above, ACP questions how the APCs are built and whether each APC groups similar-cost services. Therefore, ACP requests that CMS explain how it will keep the MPFS and OPPS/ASC schedules aligned with each other as the current proposal relies on outdated data for some services whose APCs were changed in 2014. For example, CMS has proposed, in the hospital OPPS proposed rule for CY 2014, to revise the assignment of CPT code 53855 (*Insertion of a temporary prostatic urethral stent, including urethral measurement)* to a new APC (APC 0160), yet CMS proposes to use the APC 0164 from CY 2013 to establish a price for the 2014 MPFS.

- CMS' assumption that hospital OPPS data are more reliable when a service is significantly and disproportionately physician office-based is also problematic. In such cases, we believe that information from non-facility data resources is more accurate than the facility data that CMS has published in the Supplies Public Use Table. Accordingly, ACP strongly suggests that CMS should have a mechanism for excluding codes from the proposal to adjust non-facility PE RVUs if CMS is presented with data that is more reliable than the hospital OPPS data.

- In the OPPS Proposed Rule, CMS proposes conditional packaging of numerous diagnostic studies performed in conjunction with a physician office encounter. While this reduction in payment would affect facilities, it will primarily have adverse effects on patients. Our members report that the facilities in which they practice will not allow performance of such diagnostic testing on the same day as an office visit, and require patients to return on a separate day. Such barriers currently exist for many bundled, but concurrently ordered, diagnostic tests; and such barriers will be expanded by this proposal, thereby inconveniencing patients, adding inefficiencies (such as multiple claims production and adjudication), and producing delays and fragmentation instead of coordination between patients and their physicians.

Upper Payment Limits for Office-Based Procedures

In the CY 2014 MPFS proposed rule, CMS states that, "[g]iven the differences in the validity of the data used to calculate payments under the MPFS and OPPS, we believe that the non-facility MPFS payment rates for procedures that exceed those for the same procedure when in a facility result from inadequate or inaccurate direct PE inputs, especially in price or time assumptions, as compared to the more accurate OPPS data" (78FR43296). Accordingly, CMS states, "this proposal provides a reliable means for Medicare to set upper payment limits for office-based procedures when furnished in a facility setting where the cost structure would be expected to be somewhat, if not significantly, higher than the office setting" (78FR43297-98).

ACP Comment:

ACP questions whether CMS has the specific statutory authority to permit CMS to use payment rates established under one regulatory scheme (hospital OPPS) to create an absolute upper payment limit on payment amounts under another regulatory scheme (the MPFS). CMS could use such OPPS payment rates to establish a guideline for determining potential payment limits under the MPFS, but then needs to establish reasonable criteria for the presumption to be

reviewed by outside entities. Additionally, as noted earlier, other than the fact that the hospital OPPS data are "auditable" and "updated annually," CMS provides no evidence that such data are more accurate for all codes paid for under the MPFS in all circumstances.

Exclusion of Certain CPT codes

In the CY 2014 MPFS proposed rule, CMS states that, "[t]he MPFS PE RVUs rely heavily on the voluntary submission of information by individuals furnishing the service and who are paid at least in part based on the data provided. Currently, we have little means to validate whether the information is accurate or reflects typical resource costs" (78FR43296). As discussed earlier, to circumvent the perceived unreliability of the non-facility data, CMS proposes to use facility data instead to determine MPFS PE RVUs for certain codes. However, CMS also acknowledges that data distortions can occur even in the OPPS setting when the relevant volume of data being relied upon is low. Accordingly, CMS proposes to "exclude any service for which 5% percent [sic] or less of the total number of services are furnished in the OPPS setting relative to the total number of MPFS/OPPS allowed services" (78FR43297).

ACP Comment:

CMS does not provide a rationale for why the threshold for the exception is 5%, and not some other percent or absolute number. Further, CMS does not contemplate the use of other types of thresholds for circumstances in which the 5% threshold may cause statistical anomalies, either in addition to or in lieu of the percent threshold. CMS' proposal also fails to take into account that there may be other circumstances, besides the volume of services furnished in the OPPS setting being below 5%, wherein the non-facility data may be more accurate than the OPPS setting facility data (for example, when services are rarely performed in the ASC). Accordingly, there needs to be a mechanism outside of the 5% threshold to rebut the presumption that the OPPS data will always be more reliable than the non-facility data.

In the August 29, 2013 letter submitted to the Secretary by the American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC)—on which ACP was a signatory—it was noted that “78 of the 211 services for which CMS proposes to reduce payments to the ASC level are already paid less under the PFS than the OPPS rate, meaning that Medicare and patients will actually pay more, not less, if these services are driven out of physician offices and into hospital outpatient departments.”

Use of Single Price Quotes for PE RVUs

CMS states that, "[i]n some cases the PE RVUs are based upon single price quotes or one paid invoice. Such incomplete, small sample, potentially biased or inaccurate resource input costs may distort the resources used to develop non-facility PE RVUs used in calculating MPFS payment rates for individual services" (78FR43296). CMS assumes that PE RVUs based upon resource input costs using a single price quote must be distorted, because such information is biased or inaccurate.

ACP Comment: CMS fails to consider situations where market competition affects the pricing of a product, even when that product is the only product billed under a particular CPT code and there is only one supplier for the product. In such a situation, the availability of substitutable products creates a competitive marketplace. If there are substitutable products available in the

market, the pricing of the single product captured in the CPT code must remain competitive with those other products. CMS should consider that the existence of a competitive market serves as a checks and balances system when the resource input costs for certain PE RVUs are based upon a single price quote, and that pricing is not necessarily arbitrary just because a single price quote or one paid invoice is used to establish the PE RVUs.

Services Furnished in Off-Campus Hospital Provider-Based Departments

In its proposal, CMS states, "[w]hen services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting" (78FR43296). Further, CMS states, "[w]e believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings" (78FR43296).

ACP Comment:

The Medicare Payment Advisory Commission (MedPAC) reports that about a quarter of the increase in volume in outpatient departments is due to a shift in the site of physician office visits from freestanding offices to physician offices that are owned by the hospital or deemed part of that outpatient department. When patients visit a physician office that is part of a hospital's outpatient department, Medicare pays a facility fee to the hospital and a reduced fee for the physician's services. The combined fees paid by Medicare for visits to hospital-based practices are often more than 50 percent greater than rates paid to freestanding practice.[3] In 2009, the volume of visits to the higher paid outpatient-based practices owned by hospitals grew by 9 percent, while visits to freestanding practices grew by less than 1 percent. Patients also often end up paying more for certain outpatient services and procedures at provider based/hospital outpatient locations than at freestanding sites. This higher cost sharing can be due to increased out-of-pocket costs and premium increases.[4] For example, patients with insurance will often have a typical co-payment of $25 for the doctor visit and a co-insurance payment that is approximately 20-30% of the facility fee.[5]

ACP recognizes the importance of balancing the needs of the community and the unintended consequences of abolishing this approach, often referred to as provider-based billing. In many rural areas, hospitals and patients rely on the care provided in these settings. In addition, abolishing provider-based billing could have an effect on salaries of physicians employed by such entities, an effect on medical education programs at such entities, and an effect on availability of services provided to uninsured patients at such entities. The ACP believes that care should be provided in the most efficient setting possible, while maintaining quality of care.

[3] Medicare Payment Policy – Report to the Congress March 2011. Medicare Payment Advisory Commission. Accessed online at http://medpac.gov/documents/Mar11_EntireReport.pdf

[4] Medicare Payment Policy – Report to the Congress March 2012. Medicare Payment Advisory Commission. Accessed online at http://www.medpac.gov/documents/Mar12_EntireReport.pdf

[5] Ostrom, Carol. *Why you might pay twice for one visit to doctor*. The Seattle Times. November 5, 2012. Accessed online at http://mobile.seattletimes.com/story/today/2019600338/track-.-.-./

Therefore, the College does not support provider based billing for care delivered in an outpatient, hospital-system owned practice when that care is not dependent on the hospital facility and its associated technologies. Rather, in line with the College's high value care initiative, the College supports delivery of care in the most efficient setting, while maintaining quality of care.

While there are certainly instances where the additional technology and other services of a hospital facility are necessary to a physician office visit, many visits to internal medicine specialists, including most standard evaluation and management (E&M) office visits (e.g., CPT code 99213) do not require the availability of those additional services. However, according to MedPAC, there was a 6.7 percent increase in the number of these 99213 office visits furnished in outpatient departments from 2009 to 2010—likely resulting in an increase in Medicare expenditures and beneficiary cost sharing without any difference in patient care. Moreover, if the percentage of all E&M office visits that are provided in hospital-owned practices continues at its 2010 growth rate of 12.9 percent over 10 years, then about 24.5 percent of E&M office visits will occur in hospital-owned practices in 2020. This shift would ultimately increase Medicare program spending by $2.0 billion per year and beneficiary cost sharing by $500 million per year—all without any discernable difference in patient care. Therefore, in line with the College's high value care initiative, the College supports delivery of care in the most efficient setting, while maintaining quality of care. It is simply not appropriate for payers and patients to be subjected to increased costs for the same level and quality of care because the physical location and/or the business arrangement of the practice are different from a freestanding physician office.

Updating Existing Standards for E-Prescribing under Medicare Part D

The proposal in this section of the rule updates one of the electronic communication standards with which Medicare Part D drug plans and electronic prescribers must comply. It proposes a change from the National Council for Prescription Drug Programs (NCPDP) Formulary and Benefit 1.0 to NCPDP Formulary and Benefit 3.0. This standard provides a uniform means for pharmacy benefit payers (including health plans and pharmacy benefit managers) to communicate a range of formulary and benefit information to prescribers via point-of-care (POC) systems. The proposal would consider both standards in compliance from January 1 through June 30, 2014 and then specifically require only the NCPDP Formulary and Benefit 3.0 standard effective July 1, 2014.

ACP Comment: The College agrees with the proposed changes; these updates are routine and reflect improvements.

Medicare Shared Savings Program

The proposals address both increased alignment between PQRS and quality reporting within the Medicare Shared Savings Program.

Under current regulations, accountable care organizations (ACOs), on behalf of their eligible professionals who are ACO providers/suppliers, must successfully report only one ACO group practice reporting option (GPRO) measure in 2013 to avoid the penalty in 2015. This proposed rule will require ACOs, on behalf of their ACO providers and suppliers who are eligible

professionals, to satisfactorily report the 22 ACO GPRO measures during the 2014 and subsequent reporting periods to avoid the PQRS penalty for 2016 and subsequent payment years. This is consistent with the requirement for eligible professionals reporting under the traditional (non ACO-related) PQRS program. Furthermore, this proposed rule continues the current requirement finalized in the FY 2013 rule that providers/suppliers who are eligible professionals may only participate under their ACO participant TIN for purposes of the penalty in 2016 and subsequent years. ACO participant providers who also bill services under a non-ACO TIN will be required to report quality data related to those services through the traditional PQRS program.

Regulatory language currently requires data reported under the traditional PQRS GPRO option to be delivered through a CMS web interface, but the Shared Savings regulations reference the use of a GPRO interface to deliver quality-reporting data. The proposed rule amends these regulations to replace all references to GPRO web interface with CMS web interface.

Current regulations only permit CMS to establish quality benchmarks for the Shared Savings program based on national Medicare fee-for-service performance rates, national Medicare Advantage (MA) quality measure rates, or a national flat percentage. The proposed rule would expand data sources for the performance benchmarks for 2014 to include data submitted by Shared Savings Program and Pioneer ACOs. While the College understands this change as a means of improving the validity of the quality benchmarks, we encourage CMS to monitor closely the future effects of an expanding proportion of the database used to set these quality benchmarks coming from programs (e.g., the Shared Savings and Pioneer programs) with a strong incentive to improve quality. Over time, as the proportion of such programs increase, there is a potential for the quality benchmarks to be raised to such a point by these programs' positive results as to have the adverse effect of limiting the incentive for further improvement by many Shared Saving program participants.

The rule proposes a standardized method for calculating benchmark rates when a measure's performance rates are tightly clustered. This should allow for the determination of more meaningful differences in performance rates. The application of this proposed methodology to reduce measure clustering would only apply to quality measures whose performance rates are calculated as percentiles.

The rule proposes to change the weighting used for the seven "patient experience of care" measures within the Patient Experience of Care Quality domain so all are equally weighted. There is no change in the weight given to the overall domain.

ACP Comment: ACP generally agrees with the Medicare Shared Savings Program proposed changes, while noting the concern regarding the possible adverse future effects of including Shared Saving and Pioneer program data within the quality benchmarks.

Physician Compare Website

CMS is continuing to institute the plan for a phased approach to public reporting of performance information on Physician Compare that was finalized in the 2012 MPFS final rule. In 2014, CMS will publicly report PQRS GPRO measures (specifically Diabetes Mellitus (MD) and Coronary Artery Disease (CAD) PQRS GPRO measures) collected through the GPRO web interface

during 2012. Additionally, the 2014 Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) data for group practices of 100 or more eligible professionals reporting data in 2013 under the GPRO and for ACOs in the Shared Savings Program will be posted to Physician Compare as early as 2014.

ACP Comment:
The College supports the overall goals of the Physician Compare Website and supports efforts to improve transparency in the health care system. Transparent healthcare information is useful for a wide range of stakeholders, and can help a patient and their families make more informed health care choices. **ACP recommends that evaluation of physician performance be based on a number of important criteria including information being reliable and valid; transparent in its development; open to prior review and appeal by the physicians and other health care professionals referenced; minimally burdensome to the reporting physician and other healthcare professionals; and comprehensible and useful to its intended audience including a clear statement of its limitations. The College emphasizes the importance of physicians and other health care professionals having timely access to performance information prior to public reporting and a fair chance to examine and appeal potential inaccuracies.**

Therefore, the College supports using nationally recognized performance measures and data collection methodology in the Physician Compare Website. The College supports the PQRS and alignment among various CMS programs to reduce the reporting burden on physicians**. The College recommends that CMS ensure that the measurement targets remain patient centered and reflect potential differences in risk/benefit for specific populations.** In addition, ACP supports the proposed 30-day preview period prior to publication of quality data on Physician Compare so groups and ACOs can review their data prior to public reporting.

ACP is also generally supportive of CMS' proposed display of GPRO and patient experience measures, in that it focuses on context, discussion of data limitations, and guidance on how to consider other factors in choosing a physician. The rationale and methodologies supporting the unit of analysis reported should be clearly articulated. The College also supports increased efforts to determine and employ the most effective means of presenting performance information to patients/consumers and to educate these information users on the meaning of performance differences among clinicians, and on how to use this information effectively in making informed healthcare choices. In addition, the College is supportive of the public reporting of initiatives such as ACP's High Value Care initiative or the *Choosing Wisely* campaign, with a clear explanation of the specific initiative included in such a display. These initiatives should encourage high value patient centered care—and could even be considered for incentive payment through approaches (such as code modifiers) outlined by ACP in our July 9, 2013 letter to the House Energy & Commerce Committee.[6] .

In future designs of the physician compare website the College recommends that the search function include a way to identify various practice models such as ACOs or PCMHs. The College supports the newly designed Intelligent Search Functionality debuted in July 2013 on the

[6] The full text of this letter can be accessed at: http://www.acponline.org/acp_policy/letters/acp_response_e_and_c_june_28_leg_language_sgr_2013.pdf.

Physician Compare Website. However, in reviewing the search results staff often found the results were too broad and were not actionable for patients. The College suggests developing reasonable criteria for inclusion in the webpage search results, to help consumers/patients more appropriately identify the needed physician.

Physician Quality Reporting System -- Physician Payment, Efficiency, and Quality Improvements

CMS proposes changes to the criteria for satisfactory reporting for PQRS based on reporting method and group size. Proposed changes mostly include increasing the number of measures required, covering National Quality Strategy domains, and the inclusion of outcome-based measures (for the clinical quality data registry).

ACP Comment:

ACP agrees with CMS that alignment of its quality improvement programs, reporting systems, and quality measures will decrease the burden of participation on physicians, thus allowing them more time and resources to use caring for patients. The College has long supported quality improvement, both through quality measurement and reporting. ACP supports the use of structure, process, and outcome measures in programs and is encouraged by their inclusion in the PQRS program.

ACP supports providing a single website whereby group practices may make multiple elections for various CMS programs (such as PQRS and VBPM). This will ease the burden on physicians and practices and will simplify the registration process for these programs. However, the College remains concerned that the measures and reporting periods within the PQRS program continue to be unaligned with other reporting programs such as meaningful use and maintenance of certification (MOC) requirements. The College continues to encourage CMS to improve alignment among quality improvement programs and reporting systems to decrease burden on physician practices.

Clinical Data Registries

CMS also proposes to define a "quality clinical data registry" for purposes of the PQRS as a CMS-approved entity that collects medical and/or clinical data for the purposes of patient and disease tracking to foster improvement in the quality of care furnished to patients.

ACP Comment:

The College supports this new reporting method and specifically appreciates the proposals for these registries to be transparent and provide timely feedback to participating eligible professionals. The College encourages CMS to require qualified clinical data registries to provide timely educational feedback to physicians to promote quality improvement. The College supports the proposal that the data submitted to CMS through the clinical data registries for purposes of demonstrating satisfactory participation be quality measure data on multiple payers, not just Medicare patients. However, the College continues to be concerned about the lack of alignment among denominator populations within the PQRS program.

Further, the College encourages CMS to allow other methods of reporting to include non-Medicare patients. The inclusion of non-Medicare patients in the denominator may also provide

more accurate overall assessments of the quality of care provided by physicians and may increase the likelihood of more physicians being able to meet the PQRS reporting requirements. Such measures would help to more appropriately capture a practice's true performance and better assist practices in quality improvement. The College also encourages CMS to ensure that unintended consequences do not result from expanding the denominator population to include all patients (i.e. in quality measurement and performance measurement).

Claims-Based Measure Groups

In an effort to encourage registry and EHR reporting, CMS is proposing to eliminate claims-based measure groups.

ACP Comment:
The College supports the use of more advanced reporting methods, such as registries and EHRs; however, it remains concerned that by eliminating the administrative claims option and reducing claims-based options many practices will not be able to successfully report PQRS in 2014. Also, the College is concerned that many EPs may not be ready to collect PQRS data on January 1, 2014 due to vendors' difficulties delivering 2014 certified systems.

In 2011, claims based reporting was the most common method used for reporting PQRS measures. Although data are not available for more recent years, it is likely that claims-based reporting is still a common choice among those reporting PQRS measures. Registry and EHR reporting both have a financial implication for practices (either paying for the registry or having an EHR in their practice). CMS' proposal to remove both claims-based reporting for measure groups and the administrative claims options could put undue stress on practices both financially and practically to be successful in meeting the PQRS reporting requirements. Furthermore, the low rates of PQRS reporting overall indicate the need for CMS to continue to allow groups options and flexibility in meeting the PQRS requirements. **The College recommends that CMS extend the claims based reporting and the administrative claims reporting mechanism for PQRS as they provide a feasible alternative for physicians and groups to participate in the program, particularly if they have not yet been able to effectively use the traditional reporting mechanisms.**

Reporting of CAHPS Survey Measures

CMS is also proposing to allow group practices comprised of 25 or more eligible professionals to report Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures. These measures would be collected through a certified vendor.

ACP Comment: ACP supports measuring patient care experiences. Since the cost to do the survey will be at the practice's expense, ACP appreciates CMS' proposal to make this optional for practices.

Value-Based Payment Modifier (VBPM)

CMS is proposing to apply the VBPM to groups of physicians with 10 or more eligible professionals in CY2016.

ACP Comment:
ACP does not support CMS' proposal to apply the VBPM to groups of physicians with 10 or more eligible professionals in CY2016. Rather, the College recommends that CMS apply the VBPM to groups of physicians with 25 or more eligible professionals in CY2016.

The College understands that applying the VBPM to groups of 10 or more eligible professionals would cause approximately 17,000 TIN-defined groups and nearly 60 percent of physicians to be affected by the VBPM in CY2016. Whereas the alternative proposed by ACP, to apply the VBPM to 25 or more eligible professionals would cause nearly 45% of physicians to be impacted by the VBPM. The College believes applying the VBPM to group practices of 25 or more eligible professionals is a reasonable expansion of the program and will engage more physicians in the VBPM as CMS is required to implement the program to all physicians in performance year 2015. This would allow CMS to study, improve the methods, and learn about the implementation of the VBPM program before expanding it to a larger group of eligible professionals.

The College has two specific reasons for requesting this change:

- First, the low participation rates in the PQRS program—in the 2011 PQRS Experience Report, CMS found that only 29.1% of eligible professionals (27% of internal medicine physicians) participated in the PQRS program.[7] CMS does not break this down into practice size, however feedback from our members suggests that the larger groups have better infrastructure for quality improvement and have higher rates of PQRS participation than smaller groups.

- Second, groups of 10-24 eligible professionals will not have access to the 2012 QRURs (compared to their colleagues in groups of 25–99 eligible professionals) and will not know how their practice compares to the national benchmark.

ACP strongly recommends that CMS use the next year to engage in outreach to all practices (especially smaller practices) to encourage them to participate in the PQRS program and work to increase PQRS participation rates. In addition, CMS needs to ensure that these practices are:

- Aware of the VBPM program;
- Aware of the alignment of the VBPM with PQRS reporting;
- Able to understand what the VBPM program involves and how it will impact them; and
- Able to provide meaningful feedback to CMS throughout the implementation of the VBPM program.

Criteria Change for Category 1

ACP understands that CMS proposes to use a similar 2-category approach for the CY2016 VBPM based on physicians' participation in the PQRS, but to change the criteria for Category 1.

[7] Available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/

CMS' proposal for Category 1 would include groups of physicians that meet the criteria for satisfactory reporting of data of PQRS via the GPRO (through web-interface, EHR, or qualified registry reporting mechanisms) or groups of physicians that do not self-nominate to participate in the PQRS as a group, and who have at least 70% of the group's eligible professionals meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals or satisfactorily participate in a PQRS-qualified clinical data registry for the CY 2016 PQRS payment. Category 2 would include groups that do not fall into Category 1.

ACP Comment:
The College appreciates the proposal to allow group practices to satisfy the VBPM requirement by having 70% of the group's eligible professionals report individually. This will especially be helpful to smaller groups that do not have experience with or have not used the group reporting option for PQRS. This approach continues CMS' goal of increasing quality reporting and does not apply restrictions on how a group must report, allowing groups to choose an option that best fits their practice.

Quality-Tiering
CMS has proposed to make quality-tiering mandatory for groups with Category 1 for the CY 2016 VBPM. Furthermore, groups of physicians with 10–99 eligible professionals would be subject only to any upward or neutral adjustment determined under the quality-tiering methodology, and groups with 100 or more eligible professionals would be subject to upward, neutral, or downward adjustments under the quality-tiering.

Further CMS has proposed to increase the amount of payment at risk for Category 2 groups from 1.0 percent to 2.0 percent in CY2016.

ACP Comment:
The College believes this is a reasonable approach for CMS to pursue and appreciates the proposal for only upward or neutral adjustment for those groups that are new to the VBPM program. Allowing groups of 10–99 eligible professionals (or groups of 25–99 under ACP's alternative proposal) to avoid risk for a downward adjustment is an appropriate extension of implementing the VBPM program and will allow these groups to gain experience before being at risk for a downward adjustment. It will also allow CMS to gain experience in analyzing and improving the accuracy of the VBPM program before applying a penalty to a larger group of practices.

However, the College is not supportive of the proposal to increase the amount of payment at risk from 1.0 percent to 2.0 percent in CY 2016. As proposed, a 2% reduction would be applied to groups that fall into Category 2. This would be in addition to the PQRS 2% reduction and would likely have a significant impact on all practices, especially small ones. As noted earlier, the 2011 PQRS participation rates remain low and the College is concerned about the combined 4.0% penalty that practices would face in CY 2016. The College believes that CMS needs to gather and analyze data from the first year of the program to ensure the program is being appropriately designed and implemented before increasing the amount of payment at risk.

Performance Period Change

CMS proposes to use CY 2015 as the performance period for the VBPM modifier adjustments that will apply during CY 2017. CMS notes that a closer performance year would require moving the deadline for submitting quality information to the end of the performance period. CMS notes that there would be a shortened review period for physicians to review the calculation of the VBPM modifier.

ACP Comment: The College understands CMS' challenges in closing the gap between the performance period and the VBPM adjustments. The College continues to encourage timely feedback for physicians to be able to make meaningful changes in their practice to improve quality. The College encourages CMS to look to other payers and the Centers for Medicare and Medicaid Innovation (CMMI) for ways to turn data around faster and more efficiently in order to close the gap between the performance period and the VBPM adjustment.

Quality Measures - Alignment

CMS proposes to align the quality measures and quality reporting mechanisms for the VBPM modifier with those available to groups of physicians under the PQRS during the CY 2014 performance period.

ACP Comment: The College supports further aligning the PQRS and VBPM programs in an effort to reduce reporting burdens for practices. The College appreciates including all of the PQRS GPRO reporting mechanisms and all of the individual PQRS reporting mechanisms as a means to fulfill the VBPM requirement and allow eligible professionals to avoid the VBPM penalty.

Quality Measures – Use of CAHPS

CMS proposes that groups of physicians with 25 or more eligible professionals will be able to elect to have included in their VBPM modifier for CY 2016 the patient experience of care measures collected through the PQRS CAHPS survey for CY 2014.

ACP Comment: The College supports the CG CAHPS measures included in the VBPM as long as the surveys are appropriately validated and risk adjusted. The College supports high value patient-centered care and is encouraged by the inclusion of the patient survey data in the VBPM program.

Quality Measures – Calculation of Group Performance Rates

CMS proposes for those groups of physicians subject to the VBPM in 2016 whose eligible professionals participate in the PQRS as individuals (i.e., 70% threshold VBPM requirement), CMS would calculate the group's performance rate for each measure reported by at least one EP in the group of physicians by combining the weighted average of the performance rates of those eligible professionals reporting the measure. Individuals that PQRS report via the "qualified clinical data registry" method will report on all patients, while individuals reporting using other methods would report only on Medicare patients. CMS also proposes that if it were unable to calculate the quality data for those individuals using the clinical data registry for PQRS reporting, these individuals would be considered average for quality in VBPM.

ACP Comment: **Overall, the College is supportive of phasing in the clinical quality data registry reporting method. However, ACP is concerned that the measure groups using the 70% individual reporters, which would likely include non-Medicare patients, could skew the composite/benchmarks in the quality-tiering system. The College urges CMS to appropriately adjust and compare the physicians in the quality-tiering system, especially when comparing the 70% individual reporters.**

Quality Measures – Cost

CMS submitted two cost measures—the total per capita costs for all attributed beneficiaries measure and the "Medicare Spending per Beneficiary" measure—to the National Quality Forum (NQF) for endorsement.

Further, CMS proposes to change the specialty adjustment to account for the specialty composition of the group prior to computing the standardized score for each cost measure.

ACP Comment: The College appreciates that CMS is taking this thoughtful approach to the implementation of its cost measures, as we support measures that are evaluated through and collected in a consistent, reliable, feasible, and transparent manner; thoroughly tested prior to full implementation to the extent possible; and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care. Additionally, ACP supports NQF as a multi-stakeholder, consensus-based process for developing, evaluation, and endorsing performance measures.

The College supports the intent of the proposed specialty adjustment methodology to better standardize the cost measures.

Physician Feedback Program

In September 2013, CMS will provide QRURs at the TIN level to all groups of physicians with 25 or more eligible professionals, based on 2012 data. These reports will include an initial look at the VBPM methodologies using the group's PQRS measures, outcome measures, and cost measures. In late summer of 2014, CMS plans to disseminate the QRURs based on CY 2013 data to all physicians (that is, TINs of any size).

ACP Comment:

The College urges CMS to continue to work with medical specialty societies to improve the QRURs and make them meaningful and actionable for physicians. CMS should continue to work on efforts to increase the download/open rate of the QRURs. As discussed earlier, the College is concerned about groups of 10–24 eligible professionals that will not receive a QRUR in September 2013, but would be subject to the VBPM in 2014. If finalized, ACP encourages CMS to work with these groups in particular to make sure they are aware of and can access PQRS reports that would help indicate how they compare to their peers. ACP understands that these reports have been available for the past few years and encourages practices to access and review these reports. ACP appreciates that CMS plans to send the QRUR reports to all physicians in 2014 to allow them to prepare for the mandatory VBPM in 2015.

In future reports, ACP encourages CMS to explore ways to provide physicians with accurate data on the quality and total cost of care provided by other clinicians and hospitals within their geographic communities to enable them to make informed referral decisions. These data should include the total cost of care and outcomes associated with each clinician and hospital in their community. This approach would not only be informative to specialists and subspecialists, but would also help primary care physicians to make informed referral and hospital selection decisions and potentially reduce cost by providing them with transparent and ongoing data on the types of tests and procedures their subspecialists colleagues are ordering.

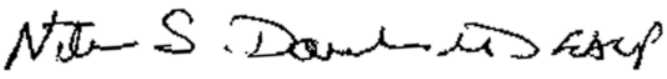
EHR Incentive Program

The HHS Secretary is required to develop a plan to integrate reporting on quality measures under the PQRS with reporting requirements related to meaningful use under the EHR Incentive Program. The PQRS and EHR Incentive Program in particular have taken steps to align their respective quality measures reporting criteria.

For purposes of meeting the CQM reporting component of meaningful use for the Medicare EHR Incentive Program in 2014 and subsequent years, CMS proposes to allow eligible professionals to submit CQM information using qualified clinical data registries. If the criteria established for satisfactory participation in a qualified clinical data registry under PQRS in the final rule are different from the proposed criteria, CMS intends to adopt the criteria that are finalized for PQRS to the extent feasible for the Medicare EHR Incentive Program.

ACP Comment: **The College has consistently argued in favor of alignment. However, ACP is concerned that due to expected delivery and implementation problems with 2014 certified EHR systems, EPs hoping to qualify for EHR Incentive and PQRS will be unable to begin data collection on January 1, 2014.**

Thank you for considering ACP's comments. Please contact Shari Erickson, Vice President, Governmental and Regulatory Affairs, by telephone at 202-261-4551 or e-mail to serickson@acponline.org if you have questions or need additional assistance.
Sincerely,



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