



January 27, 2014

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, 414, 423, and 425
Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule,
Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014.**

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 its thoughtful consideration of our comments to the proposed rule for calendar year 2014.

Chronic Care Management (CCM) Services

CMS acknowledged the potential confusion stemming from the “complex” in the code title. In an attempt to avoid the confusion, the agency simplified the code title to “chronic care management.” *ACP agrees with the agency’s decision to eliminate “complex” from the code descriptor.*

Although the new CCM code is still in development, ACP is encouraged that CMS is moving forward with the code’s development and that the agency is interested in recognizing the full breadth of primary care and of chronic care management in particular. While ACP still sees room for improvements, it views the revised proposal as a positive development for improving care for patients with chronic conditions—and paying for that care, much of which is not provided within traditional face-to-face encounters.

In the rule, ACP appreciates that CMS made changes that ACP recommended in our comments with regard to the CCM code, including:

- Changing the reporting timeframe from 90 to 30 days, which brought it more into alignment with the existing CPT codes for complex chronic care management; and
- Changing the requirement for the CCM to be associated with an Annual Wellness Visit to a recommendation, given the recordkeeping burden this would have caused for physicians;

Additionally, the Agency kept a number of components of its proposed codes that ACP supports (and that were in line with the existing CPT codes), such as keeping the codes applicable to all specialties, and the requirement for a comprehensive care plan.

ACP appreciates CMS's receptiveness to ACP's recommendations. However, the College still has a few concerns about the proposed CCM code (GXXX1). Specifically:

- The proposed time required for CCM is 20 minutes, rather than the 30 minutes that is in the current CPT codes--this is important because it will likely impact the overall valuation (and payment amount) for the code, particularly when the practice expense involved in this code (independent of the time) is significant. The College recommends that CMS designate the 30-minute timeframe. This timeframe is important both to patient care and to providing an incentive for physicians. It is critical that the CCM code include a sufficient amount of physician work time (including non-face-to-face time) and clinical staff time in order to encourage its use.
- CMS proposes only one code, as opposed to three codes, as is currently in the CPT book—or even the agency's two-code proposal from July 2013. This is relevant again to the valuation; if significantly more non-face-to-face time than the specified 20 minutes is needed during the billing month, then there would be no means of billing for that time (and the related practice expense, i.e., overhead costs).
- ACP would prefer that this code (even if it is only one code) be a CPT code rather than a HCPCS G-code. This would allow for greater physician input into the valuation process and code description writing. Therefore, we appreciate that CMS indicated a willingness to consider a revised CPT code if it would meet their policy requirements.
- ACP raised a number of concerns about CMS' original proposal regarding the practice standards, particularly the EHR 24/7 requirements and the nurse practitioner (NP) hiring requirement—in the rule, CMS chose to allow more time for these standards to be

finalized through additional rulemaking over the coming year. ACP welcomes the opportunity to be actively engaged in providing input throughout that process.

- Patient Centered Medical Home (PCMH) - CMS did not make a final decision on this issue; it left the issue for future rulemaking. In response, ACP reiterates its feedback to CMS:
 - (1) Practices that have received independent certification or recognition as a PCMH or PCMH Specialty Practice should be recognized by CMS as able to bill and be reimbursed for this new CCM code, without having to provide additional documentation to demonstrate they satisfy the agency's criteria or standards, and
 - (2) CMS should establish a pathway for physicians, who are not in a certified PCMH or PCMH Specialty Practice, to demonstrate that the practices meet the reporting and reimbursement standards for the proposed new CCM code.

CMS expressed some concern about duplicative payments to physicians that are "participating in other programs and demonstrations." *ACP agrees that duplicative payments are not appropriate, but also recommends that CMS craft its regulations such that the CCM does not have any unintended negative effects on CMS and CMS Innovation Center programs that are determined to be working well.*

Resource Based Practice Expense (PE) Relative Value Units (RVUs)

CMS proposed an alternative to the current method of determining the practice expense of Medicare Physician Fee Schedule services. The alternative would have been to use the OPPS practice expense (PE) data or ambulatory surgical center (ASC) rates (whichever is less) as the baseline for pricing services that are rendered in the hospital outpatient, ASC, and office setting, rather than using the current, resource-based PE data for the Medicare physician fee schedule.

ACP and many other medical specialty societies made a strong case for CMS to withdraw its proposal, citing many instances where broad application of the proposed pricing criteria would result in unsound policy. In the final rule, CMS states that it will not finalize the OPPS data inputs for the physician fee schedule services. Rather, the agency expects that, after further consideration of all the received comments, it will revise its proposal and bring it back to the public through future rulemaking. *ACP agrees that the methodology would benefit from a thorough, overall review and further opportunity for public comment.*

Collecting Data on Services Furnished in Off-Campus Provider-Based Departments

In its July 2013 proposal, CMS stated, "[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 stated, "[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."

The College maintains its position of not supporting 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.

Although the agency has yet to make a decision on this issue, the College appreciates CMS's acknowledgement of ACP's comments as the agency continues to look at different approaches to collecting the data on services provided in off-campus provider-based settings.

Physician Compare Website

CMS continues 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, and finalized the expansion of quality measures posted on Physician Compare by publicly reporting CY 2015 performance on all measures collected through the GPRO web interface for groups of all sizes. In addition, for ACOs participating in the Medicare Shared Savings Program, performance on the ACO GPRO measures will be reported publicly on Physician Compare.

There will also be a 30-day preview period for confidential measure preview, and there will be public reporting of CG-CAHPS measures for groups of 100 or more eligible professionals (EPs) who participate in PQRS GPRO and, the Shared Savings Program ACOs reporting through the GPRO web interface or another CMS-approved tool or interface. *The College supports the overall goals of the Physician Compare Website and supports efforts to improve transparency in the health care system.*

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System (PQRS)

In the final rule, CMS made various updates to the PQRS program - adding 57 new individual measures and two measure groups to the PQRS program. CMS also changed the requirements for meeting satisfactory reporting requirements for the CY 2016 payment adjustment and the CY 2014 bonus. In addition, CMS finalized the alignment of measures under the PQRS and the EHR Incentive Program. *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 alignment of programs and quality improvement, both through quality measurement and reporting. ACP also supports the use of structure, process, and outcome measures in programs, and encourages their inclusion in the PQRS program.*

A single website will be used whereby group practices can make multiple elections for various CMS programs (such as PQRS and VBPM) and where a group practice of 25 or more EPs may register to participate in the PQRS GPRO and elect to be evaluated for the PQRS GPRO by reporting CG-CAHPS measures. In addition, CMS finalized a new reporting mechanism, the CMS-certified survey vendor to report the CG-CAHPS survey measures.

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.*** ACP also supports measuring patient care experiences through the finalized CG-CAHPS survey measures. Since the cost to do the survey will be at the practice's expense, the College appreciates that this will be optional for practices.

CMS finalized a new "quality clinical data registry" (QCDR) 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.

The College supports this new reporting method and specifically appreciates the policies aimed at increasing transparency and providing timely feedback to participating eligible professionals. ***ACP is slightly concerned that the less stringent time requirements on feedback reports will not result in timely educational feedback to physicians to promote quality improvement. CMS is urged to work with QCDRs to encourage them to provide these reports to EPs in a timely manner. While the College appreciates that the data submitted through the QCDRs be quality measure data on multiple payers (not just Medicare), it remains concerned about the lack of alignment among denominator populations within the PQRS program. To alleviate this problem, CMS should 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. ***ACP also urges CMS to monitor the data collected through the QCDRs 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).***

CMS eliminated claims-based measure group reporting and the administrative claims reporting option. Individual EPs can use claims-based reporting for individual measures for the 2014 PQRS Incentive and the 2016 PQRS Payment Adjustment requirements. *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. ACP is also concerned that many EPs may not be ready to collect PQRS data on January 1, 2014—due to vendors' difficulties delivering 2014 certified systems.*

Value Based Payment Modifier and Physician Feedback Program

In 2014, CMS continues to phase in the Value Based Payment (VBP) Modifier program as required by the ACA to apply to all physicians and groups of physicians by January 1, 2017. CMS further aligns the VBP and PQRS program through the final rule. The CY 2016 VBP will use all of the PQRS measures available to be reported under the various PQRS reporting mechanisms in CY 2014, including quality measures reported by individual EPs in a group through QCDRs, to calculate a group of physicians' VBP modifier in CY 2016. In addition, groups of 25 or more EPs can elect to have the patient experience of care measures collected through the PQRS CG-CAHPS survey included in their VBP calculation. CMS finalized CY 2015 as the performance period for the VBP modifier adjustments that will apply during CY 2017. *The College appreciates the continued alignment of the PQRS and VBP programs. In addition, ACP supports that the patient experience measures are being included in the programs and continues to urge CMS to close the gap between the performance period and the program year.*

CMS finalized a similar two-category approach for the CY 2016 VBP based on participation in PQRS. Category 1 includes groups of 10 or more EPs that meet the satisfactory reporting criteria through the PQRS GPRO to avoid the CY 2016 PQRS payment adjustment. Category 1 also includes groups that do not participate in the PQRS GPRO, but have at least 50 percent of the EPs billing under the group's TIN meeting the criteria for satisfactory PQRS reporting to avoid the CY 2016 payment adjustment as individuals. Groups of 10 or more EPs that do not meet the criteria for inclusion in Category 1 will be in Category 2 and be subject to an automatic downward 2% payment adjustment under the VBP modifier. *ACP does not support the finalized expansion of the VBP to groups of physicians with 10 or more eligible professionals. The College recommended that CMS more slowly implement the program and apply the VBP to groups of 25 or more EPs. Despite CMS finalizing its proposal, the College does appreciate that CMS will allow group practices to satisfy the VBP modifier requirement by having 50% of the group's EPs report PQRS individually.* We believe 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's goal of increasing quality reporting and without applying restrictions on how a group must report, allowing groups to choose an option that best fits their practice.

The College also appreciates CMS' policy to "hold harmless" groups of 10-99 EPs from any downward adjustment in the quality-tiering methodology. ACP does not support the finalized policy to increase the amount of payment at risk from 1.0 percent to 2.0 percent in CY 2016.

This 2% reduction will apply to groups that fall into Category 2 and be in addition to the PQRS 2% reduction. PQRS participation rates remain low and the College remains concerned about the combined 4.0% penalty that practices will face in CY 2016.

Medicare Telehealth Services for the Physician Fee Schedule

In July, CMS proposed to revise regulations regarding originating sites. The revision defines rural HPSAs as those located in rural census tracts as determined by the Office of Rural Health Policy (ORHP), stating that by defining "rural" to include geographic areas located in rural census tracts within MSAs, the agency would allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites. *ACP agrees that the more precise definition of "rural" may help to expand access to health care services for Medicare beneficiaries located in rural areas.*

Also proposed was a policy change establishing that geographic eligibility for an originating site would be established and maintained on an annual basis, consistent with other telehealth payment policies. Without this proposed change, the status of a geographic area's eligibility for telehealth originating site payment is concurrently effective with the effective date for changes in designations that are made outside of CMS. *ACP agrees that this move will reduce the confusion and disruption to patient care that can result from mid-year changes to geographic designations. ACP is also pleased that CMS finalized its plan to add TCM CPT codes 99495 and 99496 to the telehealth benefit.*

Medicare Shared Savings Program

The rule finalized changes within the Medicare Shared Savings program (MSSP) that better aligns quality-reporting requirements between the MSSP and the traditional Physician Quality Reporting Initiative (PQRI), and addressed changes in the establishment of the MSSP quality performance benchmarks, and finalized CMS's proposal to use national fee-for-service (FFS) data, including data submitted by Shared Savings Program and Pioneer ACOs, to set the performance benchmarks for the 2014 and subsequent reporting periods. *ACP welcomes both changes as important steps toward greater alignment of the MSSP and PQRI programs.*

The final rule requires 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. *ACP is pleased with the increased consistency of requirements for eligible professionals reporting under the traditional (non ACO-related) PQRS program.*

Updates to Standards for E-Prescribing Under Medicare Part D

The final rule updates one of the electronic communication standards with which Medicare Part D drug plans and electronic prescribers must comply: it finalizes the change from National Council for Prescription Drug Programs (NCPDP) Formulary and Benefit 1.0 standard to the NCPDP Formulary and Benefit 3.0 standard. *The College agrees, and views this as a uniform way 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.*

Misvalued Services

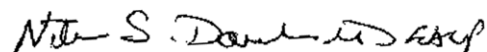
Consistent with amendments made by the Affordable Care Act, CMS, ACP, AMA, and other medical societies have been engaged in a vigorous effort over the past several years to identify and review potentially misvalued codes, and make adjustments where appropriate. *The College sees that CMS is continuing to make progress on that goal, and that the agency continues to work with the medical community to make appropriate changes to Medicare Physician Fee Schedule service values.*

Requirements for Billing “Incident To” Services

CMS will require as a condition of Medicare payment that “incident to” services be furnished in compliance with applicable state law. This policy strengthens program integrity by allowing Medicare to deny or recoup payments when services are not furnished in compliance with state law. The agency also eliminated redundant regulations for each type of practitioner by consolidating the “incident to” requirements for all practitioners that are permitted to bill Medicare directly for their services, reducing the regulatory burden and making it less difficult for practitioners to determine what is required in order to bill Medicare for “incident to” services. *ACP agrees with the change, as it will add consistency to the provision of medical services across local, state, and federal programs.*

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

Sincerely,



Nitin S. Damle, MD, FACP
Chair, Medical Practice and Quality Committee