



AMERICAN COLLEGE OF PHYSICIANS  
INTERNAL MEDICINE | *Doctors for Adults*

August 24, 2010

Donald M. Berwick, MD, MPP  
Administrator  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Attention: CMS-1503-P

Dear Dr. Berwick:

The American College of Physicians (ACP), representing over 130,000 internists and medical students, appreciates the opportunity to comment on: *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Proposed Rule*. This ACP comment letter supplements the letter the College previously submitted, dated August 19, 2010, that exclusively addressed the Centers for Medicare and Medicaid Services (CMS)-proposed implementation of the Medicare Primary Care Incentive Payment (PCIP) program that was established by the Affordable Care Act (ACA) Sec. 5501(a). In this letter, ACP provides comments on the following issues, which are listed in the order in which they appear in the proposed rule:

- Potentially Misvalued Codes Under the Physician Fee Schedule;
- Rebasing and Revising the Medicare Economic Index;
- Physician Feedback Program; Value-Based Payment Modifier Under the Physician Fee Schedule;
- Physician Quality Reporting Initiative;
- Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan; and
- Incentives for Electronic Prescribing—the Electronic Prescribing Incentive Program.

### **Potentially Misvalued Codes Under the Physician Fee Schedule**

#### *Introduction*

ACP believes that accurate valuation of Physician Fee Schedule (PFS) services is essential as the Medicare Payment Advisory Commission (MedPAC) and other researchers have described the effect of pricing on the availability and utilization of services. The College has long been concerned that inaccurate valuation of services is having an adverse impact on our health care

system, including undervaluing office visits and other cognitive-oriented services and discouraging interest in the practice of primary care and other specialties.

ACP commends CMS for its attention, especially in the past few years, to the issue of potentially misvalued service codes. The College appreciates the in-depth CMS discussion of its efforts related to potentially misvalued services, how those efforts relate to ACA Sec. 3134, and other activities the agency is considering to implement that section of the reform law. ACP provides comments on the CMS proposal/discussion pertaining to a few specific on-going activities. The majority of the College's comments, though, pertain to the need to improve our collective ability to accurately value services.

ACP believes that the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) plays an important role in the valuation of services and that it should be maintained. The RUC provides a venue for physicians to provide recommendations based on survey and other methodologies. It is distinct in that it includes participation from a vast array of physician specialties. The RUC has issued constructive recommendations, including those that have been beneficial to primary care and other cognitive-oriented physicians. Examples include: recommending the increase in the work relative value assigned to office visits and other common evaluation and management (E/M) services in the first and third "Five-Year Review"; and recommending that CMS increase the rate at which it assumes that advanced imaging equipment is used to bring it more in-line with actual usage and to adjust the per-unit payment. CMS has historically shown great confidence in the RUC by accepting around 90% of its recommendations since its 1992 inception.

As important as the RUC is in providing recommendations to CMS, it can be improved. ACP has long-standing policy calling on the RUC to change its composition. The College recommends a model that bases each specialty's representation on its proportionate contribution to providing care to Medicare beneficiaries. At a minimum, ACP has urged that the RUC add representation from primary care and internal medicine subspecialties that have particular expertise in the diagnosis, treatment, and management of chronic diseases. ACP is disappointed that the RUC has repeatedly declined to change its composition. While ACP recognizes that the RUC is taking steps to address potentially misvalued services, the College remains concerned that the RUC may be unable to take the comprehensive, prompt, and decisive action needed to sufficiently address misvalued services. The CMS description of status of its work with the RUC to address services for which there has been a shift in the typical site of service is illustrative. The agency remains troubled over the RUC's recommendations pertaining to these services and is again urging the RUC to reassess these services consistent with specific parameters.

Even if the RUC improves as ACP has recommended, CMS should diversify the information it uses in pursuit of optimal valuation of physician services. ACP strongly believes that CMS needs to take additional steps to fulfill its responsibility to maintain accurate relative value assignments and optimal methodologies. There is a need to more aggressively identify, access, analyze, and apply existing data. There is a need to investigate specific questions to facilitate the development of additional pertinent data sources. The Congressional requirements and direction contained in ACA Sec. 3134—for identifying and correcting misvalued codes and validating

relative value unit assignments—reinforce the need for strong, multi-faceted action to improving service valuation.

The College’s recommendations and options for consideration are described below. While a number of these recommended actions extend beyond the current CMS process for valuing services and would inherently supplement the RUC, it is possible that some actions could involve the RUC, either in a primary or secondary manner. Regardless, ACP believes the prudent next step is for CMS to establish a comprehensive plan of actions to improve the valuation of services. Accordingly, ACP urges CMS to follow the direction from Congress and use the discretion provided to it by ACA Sec. 3134, dedicating the operational budget and other funding needed to maximize its effort. As ACP supported the \$20 million annual funding for each-of-the-next-five-years that was dropped from the ACA before it became law, likely because of the expedient manner with which the final bill took shape, the College will work with Congress and the Administration to secure funding that CMS believes necessary.

### *Efforts Underway to Address Misvalued Services*

#### General Comment

ACP urges CMS to establish a “scorecard” that indicates the final action taken related to service codes that have been reviewed as part of a potentially misvalued activity. Examples of elements that CMS can represent for each procedure code are: whether the relative value(s) increased, stayed the same, or decreased; the most recent year’s utilization; and the year at which a relative value change was previous made, if applicable. CMS could maintain this resource on an on-going basis so that stakeholders can assess progress.

#### Codes (and families of codes as appropriate) with Substantial Practice Expense Changes

ACP appreciates that CMS works with the RUC to review direct practice expense inputs on an on-going basis, focusing on particularly high-volume codes where the payments have increased significantly, and commends the RUC’s diligence in this activity. The College, however, urges CMS to reassess the extent to which the direct practice expense equipment is dedicated to the service/procedure to which it is assigned.

#### High-Cost Supplies

ACP recommends that CMS propose a change in its methodology for establishing the price it assigns to high-cost supplies through future rulemaking. As the College had previously encouraged CMS to investigate the possibility of using the supply pricing methodology used by the Veterans Administration (VA), which conducts this activity under the auspices of the General Services Administration (GSA), it is generally supportive of GSA-based methodology that CMS is considering and on which it solicits comment. ACP urges CMS to clarify how it envisions the supply price will be established for items on the GSA medial supply schedule. The CMS explanation of its contractor-identified GSA schedule price for a jejunostomy tube, which ranged from \$60 - \$83, illustrates the need for clarification. Further, the agency should take into account the extent to which non-VA physicians can purchase supplies at the GSA prices. While

the College previously recommended updating high-cost supply prices annually, it views the CMS description of an every-two-years process as practical and reasonable. Overall, ACP agrees with the CMS aim of establishing a “predictable, public, and transparent methodology that would ensure that the prices in the PE database reflect typical market prices” and the College remains interested in working with the agency to make it a reality.

#### *Need to Better Identify, Access, Analyze, and Apply Data*

ACP notes the data sources listed below as those that CMS can investigate for applicability to valuing services. Investigating these sources would be consistent with the ACA Sec. 3134 requirement that the agency validate relative value unit assignments. It is also generally consistent with the Sec. 3134 direction related to methods that the agency can use to adjust the values identified as potentially misvalued using the law’s defined criteria.

#### Review of Articles in Literature and Their Underlying Methods

Cromwell, et. al. (Cromwell, Jerry, et. al., “Missing Productivity Gains in the Medicare Physician Fee Schedule: Where Are They?,” *Medical Care Research and Review*, published online June 16, 2010), present an empirical study showing more post-surgery handoffs by surgeons. That study suggests that surgeons are increasingly delegating postsurgical visits to other physicians, nurse practitioners, and physician assistants.

McCall, et. al. (McCall, Nancy, et. al., “Validation of Physician Survey Estimates of Surgical Time Using Operating Room Logs,” *Medical Care Research and Review*, December 2006) state that a review of hospital logs that document surgical procedures indicates that the amount of time recorded to perform many procedures is generally lower than the amount of time assigned to the procedures in the Resource-Based Relative Value Scale (RBRVS) methodology, which are typically established through survey responses reporting by a relatively small number of physicians.

#### Using Administrative Data to Further Assess the Extent to Which Service Relative Values are Misaligned

While CMS and the RUC have both established valuable, data-driven methods for identifying potentially misvalued services that trigger further investigation, ACP urges the agency to explore data analysis options for determining the extent to which misvalued services may be prevalent. Such analyses will be instructive for how much additional work needs to be done. If analyses show that misalignment is pervasive, the need for additional data and supplemental efforts may be heightened. ACP suggests some relatively straightforward data analysis options, which CMS could conduct itself or through a contractor, below. Outlier procedure codes could be identified using a standard deviation threshold if billing nuance prohibits a pure, direct comparison.

- Use the administrative data that pertains to Diagnosis Related Group (DRG) prospective payments for hospital inpatient stays to determine a weighted average hospital length of stay that can be mapped to a CPT code level procedure. That length of stay can be compared to the inpatient post-operative E/M hospital service visits assigned to that

procedure code. It would be problematic if the length of stay, in days, is shorter than the number of inpatient post-operative visits for a significant number of procedure codes.

- Compare the amount of anesthesia time billed for a procedure to the assigned intra-service time to that same procedure. It would be problematic if the average anesthesia time is less than the assigned intra-service time for a significant number of procedure codes.

#### Use of Electronic Health Record-maintained Data to Assess Relative Value Accuracy

CMS could enter into an agreement with large health systems that use an EHR to mine the extensive data they maintain to assess how the elements compare to relative value inputs for a variety of PFS services. The agency could engage in this project itself or through a contractor and approach systems such as Geisinger Health System, Kaiser Permanente, and the University of Pennsylvania. While the data maintained by large, especially integrated systems will not necessarily be representative of the entire physician community, analysis of data maintained by a few large systems under a cooperative agreement would be insightful.

#### Analysis of Quality Improvement Databases

Some physician specialty and other organizations maintain repositories of information pertaining to services/procedures furnished to patients. These organizations are to be commended for compiling and using these data for quality improvement. The RUC has used these data to some extent in determining relative value recommendations pertaining to certain services; however, application of such data in this context has been sporadic and selective. It may be possible to apply data from repositories that were collected for reasons unrelated to payment to improve service valuation.

#### *Investigating and Developing Additional, Pertinent Data Sources*

ACA Sec. 3134 provides CMS the discretion to adjust and/or validate service relative value unit assignments using a variety of methods, including the use of contractors and assessment of the elements of physician work and time. ACP recommends that CMS take the actions below to exercise that authority and direction. While the ACP does not intend for its recommended actions to comprise the full extent of CMS activities, it believes they will answer important questions and provide valuable source information for improving service valuation.

#### Facilitate Promising Research

ACP recommends that CMS identify and support promising research that can provide new data sources. Specifically, the College urges the agency to assess the University of Cincinnati research project to investigate physician work intensity using modern techniques. Newer methods for determining physician work intensity may allow refinement of relative values that are assigned to services. The College understands that two initial papers showing preliminary results have been accepted for publications in peer-reviewed journals. For more information, CMS may contact Ronnie D. Horner, PhD, Principal Investigator.

## Solicit Ideas from the Research Community

ACP recommends that CMS tap the research community by soliciting proposals on methods and ideas for improving valuation accuracy. Agency initiated request-for-proposal should be well funded, expansive, and include focus on how service valuation relates to achieving policy goals related to workforce, delivery system reform, and constraining the system-wide rate of cost growth. Information and data derived from these efforts may also be appropriate to share with the ACA-established Center for Medicare and Medicaid Innovation the agency is to launch for January 2011.

## Investigate Adequacy of Non Face-to-Face, Care Coordination Services

ACP recommends that CMS investigate the adequacy of payment for physician services that typically take place outside of a face-to-face patient encounter. The College continues to urge CMS to recognize non face-to-face services that provide valuable, timely services to patients that improve care coordination. The agency has declined to provide separate Medicare payment for these services—consistently considering them bundled into the payment made for E/M or Medicare non-covered services—despite the Current Procedural Terminology (CPT) Editorial Panel and the RUC taking extreme care to establish protections in the code description and the relative value recommendation that would prevent duplicate payment for the same work. The CMS decision to consider the bundle of work in the initial 90-day and subsequent 90-day period of outpatient anticoagulation management therapy for patients on long-term warfarin, CPT 99363 and 99364, respectively, provides an example.

While CMS has provided limited rationale for its decisions, ACP understands that a factor is the agency's concern about the potential for abuse in billing for non face-to-face services. ACP notes that the availability of information to validate that billing for these services is appropriate is more prevalent with the emergence of electronic health records (EHRs). While the overall percentage of physicians with EHRs is relatively low, the current percentage is significant and likely to increase, especially with the EHR Incentive Program established by the American Recovery and Reinvestment Act of 2009 that begins in 2011. Baron (Baron, Richard J., "What's Keeping Us So Busy in Primary Care? A Snapshot from One Practice," *New England Journal of Medicine*, April 29, 2010) illustrates the extent to which physicians can furnish non face-to-face work that exceeds the Medicare payment for associated services under the current system. The article also illustrates how EHR systems: enable physicians to ensure they are representing their work appropriately when billing for it; and provide CMS and other payers the opportunity to validate payments as needed.

An alternate approach, one that would be consistent with the agency's stated focus of including payment for component services into a larger bundle of services, would be to determine the appropriate bundled payment for non-face-to-face, care coordination-facilitating services. Such a bundled payment could be based on the monthly needs of beneficiaries and focused to physicians in Patient Centered Medical Home practices.

*Expert Panel*

ACP continues to recommend that CMS establish an expert panel that is supplemental to the RUC to assist the agency in improving the accuracy of service valuation. The College, which has called for an expert panel in 2006, believes that it would be especially valuable in advising the agency in its assessment of existing data sources and pursuit of additional data, including those the College recommends that CMS explore in this letter. An expert panel would help CMS address these labor-intensive, technical issues more thoroughly and promptly than possible under its current valuation process. ACP recommends that the expert panel include representatives without a direct financial stake in the fee-for-service payment system, including: physicians; experts in economics, technology, and physician payment from the private sector; and patient/consumer representatives. Physician representation should be sufficient, with an focus on adequate primary care representation.

### *Conclusion*

CMS discussion and proposals in numerous areas in this section of the rule illustrate the dearth of available data and the need to increase what available, accessible, analyzed, and applied. The RUC is integral to this effort. While ACP reiterates the need for it to improve its composition and processes, the RUC should be maintained. The RUC process, though, should be supplemented by CMS use of data and other expert sources. CMS is ultimately responsible for ensuring the accuracy of relative values and it needs to invest the required resources. Even at that \$20 million in each-of-the-next-five-years funding that Congress considered, the investment is relatively small compared to the potential reward associated with improving the accuracy of valuation of services for which there are roughly \$80 billion in annual allowed charges. Improved valuation will: promote more equitable payments to physicians of different specialties, especially important in Medicare's budget neutral system; promote the offering and provision of services consistent with only the needs of the patient, improve the physician workforce; and provide a more solid foundation for the development of payment systems that support innovative delivery system changes, e.g. the Patient Centered Medical Home, Accountable Care Organizations.

### **Rebasing and Revising of the Medicare Economic Index**

ACP supports the need to rebase the Medicare Economic Index (MEI) to use the most recent and best available data. It is important to ensure that the annual update as determined by the Sustainable Growth Rate (SGR) formula, albeit a flawed mechanism that needs to be replaced, be calculated correctly and that PFS payments, more broadly, are based on solid data.

ACP supports the proposed use of a technical advisory panel to review all aspects of the MEI, including the inherent productivity adjustment component, as College policy maintains that CMS consider whether the components of the MEI still represent an accurate indication of medical inflation.

ACP recommends that CMS refrain from making any MEI changes—rebasing or revising—until it has a chance to consider the technical advisory panel's recommendations. CMS states that the MEI in its current form, as detailed in 1992, is based, in part, on recommendations from a panel of experts. While CMS makes a point to distinguish between a “rebasing” and “revising”

activity early in its discussion, it is less clear as to the extent that revising occurred when the agency previously moved to use more recent data in 2003 (to use 2000 data). The extent of the proposed changes for 2011—which clearly involve rebasing and revising the MEI—seem similar to the scope of the changes implemented the last time an expert panel was included in the deliberations. Waiting for recommendations from the technical advisory panel would also enable CMS to make all changes through the rulemaking cycle for a single PFS year as opposed to making changes in 2011 and additional modifications shortly thereafter.

ACP is concerned that the agency's re-weighting proposal would increase payments for the practice expense and professional liability insurance components to the detriment of payments for the work component. While adjustments to keep aggregate payments consistent with the weight assigned to each component in the rebased/revised MEI are understandable, increasing payments for practice expense is contrary to other payment policy decisions and may harm the effort to refrain from over-recognizing investment in equipment and supplies. This is another reason to ensure as comprehensive a review as possible takes place before implementing MEI changes.

If CMS decides to go forward with rebasing and revising the MEI for 2011, ACP agrees that re-weighting of the three components be made through an adjustment to the conversion factor, as opposed to through a direct adjustment to the work relative values.

### **Physician Feedback Program; Value-Based Payment Modifier Under the Physician Fee Schedule**

ACP supports the discontinuation use of proprietary episode grouper software. The College believes that it is critical that the program software be capable of creating appropriate care episodes based on criteria that are reflective of Medicare populations, capability CMS found lacking in its evaluation of commercially-available products. Further, the College notes the ACA requirement that the details of the episode grouper software CMS uses must be public.

ACP commends CMS for its stated intention of using a variety of forums and mechanisms to engage stakeholders as its physician feedback report program evolves. Noting the agency's intent that the feedback report program serve as a foundational element of a value-based, budget-neutral modified payment system required by the ACA, ACP urges CMS to establish a structured timeline with a chronological listing of the key activities involved in establishing the high-impact value-based modifier system. The agency's timeline should indicate how it will work with stakeholders at each key stage. While use of modified system does not begin to take effect until 2015, ACA requires CMS to make a number of important decisions related to development of the system in the relative short term. The urgency to act is highlighted by challenges to which CMS alludes in its description of the feedback report program in the proposed rule, including: the agency must establish a workable, public episode grouper software program in less than 18 months; the fact the PQRI data is not currently available to factor into the quality component of the value equation because of the lag time of data and limited initial participation; and that the agency must designate the measures it will use in the next 18 months. The College is currently organizing expertise from its various internal components to assist in the full spectrum of



activities that will culminate in value-based modifier payment program. A comprehensive indication of the CMS plans would benefit ACP and other stakeholders.

### **Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan**

ACP supports the concept of establishing a wellness visit to discuss the needs of a Medicare beneficiary and plan for appropriate care and appreciates the CMS effort to implement the ACA-established benefit for 2011. In general, the wellness visit must be comprised of clinically-appropriate components, paid an adequate amount, and fit physician workflow.

ACP recognizes that the relative recent enactment of the ACA provided CMS little time to establish standard processes related to a health risk assessment (HRA). The College views the HRA as an essential component to the wellness visit as it will enable physicians to tailor prevention efforts to the needs of each beneficiary. Accordingly, the College urges CMS to act expeditiously to establish HRA standard processes and recommends that the agency engage directly with the most relevant stakeholders—including those representing the physicians who will use the tool to engage patients, such as the ACP—to ensure that the HRA fulfills the vital role of promoting optimal preventive care and related interventions envisioned by the ACA.

ACP believes that it is reasonable for CMS to propose to establish the value of the initial wellness visit service as equal to a level four, new patient office visit (CPT 99204) and the subsequent wellness visit service as equal to a level four, established patient office visit (CPT 99214). The College suggests that CMS revisit the payment values for these wellness visit services once it accrues sufficient experience related to the new benefit. For example, relative low utilization of the benefit may be an indication that the payment level is too low. CMS acted in this fashion by increasing the payment for the Initial Preventive Physical Examination (IPPE), or “Welcome to Medicare,” benefit in 2010 after early experience showed low utilization.

ACP appreciates that CMS will pay for a separate “medically necessary” visit service, e.g. CPT 99213, on the same date as the wellness visit service is furnished to a beneficiary. The College urges CMS to acknowledge in the final rule that it will be common—not rare, as presented in the proposed rule—for a wellness visit to be provided on the same day of service as a visit service to treat an acute condition or monitor a chronic condition. Most patients expect that their prevention planning discussion and medical concerns will be addressed in a single visit, rather than separated into administratively convenient distinct visits. Beneficiaries are likely to raise acute and chronic issues during a scheduled wellness visit and vice versa. In addition, CMS must ensure that physicians have needed flexibility in scheduling patients and providing the wellness visit in a manner that fits practice workflow. Physicians may interpret a continued belief by CMS that a two-service, same-day occurrence should be uncommon as a barrier to furnishing the wellness visit.

In addition, the College urges CMS to address the following issues that are related to the nuances of billing in the final rule:

- The College requests that CMS clarify whether it will inform beneficiaries that they will be responsible for paying for (non-covered) services that are preventive in nature that are

furnished as follow-up to the covered wellness visit. We expect that a follow-up office visit and an extensive phone call could logically flow from a wellness visit and that these services would be considered non-covered services.

- The College requests that CMS clarify whether a beneficiary could receive a wellness visit from two (or more) physicians in a single year. ACP envisions that the wellness visit will be furnished by the beneficiary's principle source of care, typically a primary care physician, but notes that one physician will not necessarily know if a beneficiary received the wellness visit from another physician.
- The College urges CMS to affirm that a physician continues to have the ability to furnish a Medicare non-covered Preventive Medicine Service, e.g. CPT 99387, 99397. These CPT-defined services are distinct from the wellness visit as they can involve patient-specific, age-appropriate physical examination. While the availability of the wellness visit is likely to diminish use of these non-covered services, physicians have the right to determine a preferred approach to prevention and wellness in conjunction with their patients.

CMS must minimize barriers that discourage physicians from furnishing the wellness visit as the physician-patient relationship and the effort to work collaboratively toward care goals can be harmed instead of helped if physicians find it impractical.

#### *Add Advance Care Planning as a Voluntary, Optional Element*

ACP urges CMS to make advance care planning a voluntary option under the wellness visit benefit. It is appropriate for physicians to engage competent adult patients in a discussion of their values and preferences and to establish and maintain advance care plans. Studies show that patients who engage a physician in advance care planning experience less anxiety and are more likely to continue the dialogue with family and other caregivers. Congress has recognized the appropriateness and value of these discussions by adding end-of-life care planning as a required component of the IPPE benefit through the Medicare Improvements for Patients and Providers Act of 2008. As CMS states that the wellness visit builds off the IPPE benefit, it is logical for the agency to also recognize advance care planning as an option under the wellness visit benefit. An advance care planning discussion could take place during an initial or subsequent wellness visit. Discussion during the initial visit would be especially prudent if the beneficiary never received the IPPE service, which must be received within 12 months of enrolling in Medicare Part B. As on-going discussion is appropriate as a patient's situation and preferences may change over time, it is also appropriate during a subsequent wellness visit.

The College recommends that the agency establish a billing modifier to be appended to the wellness visit service billing code that triggers a separate advance care planning payment. It is appropriate for CMS to recognize this valuable service when a patient chooses to engage in the discussion. Physicians should be adequately paid for this extended and complex counseling. Also, use of a modifier would provide CMS with insight into the prevalence with which these discussions take place.

Further, advance care planning discussions are consistent with emerging delivery models that aim to improve care such as the Patient Centered Medical Home. The Patient Centered Medical

Home is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with advanced care plans. This model is a valuable asset in advanced care planning since the physician would have the opportunity to maintain the personal relationship with patients and their families needed to implement an end of life care plan.

### **Physician Quality Reporting Initiative**

In general, ACP welcomes the improvements that CMS has proposed to the Physician Quality Reporting Initiative (PQRI). The College finds that the proposal includes a number of program components that are favorable to internists and their practices.

#### *Claims-based Individual Measures Reporting Option*

ACP supports the CMS proposal to lower the threshold required for reporting the percentage of encounters to which an individual measure applies from 80% to 50%. The College agrees that the lower threshold is more achievable while also high enough to preclude a physician from receiving successful reporting credit without a diligent effort. We question retaining the 80% of eligible encounters threshold for registry-based and EHR-based reporting options. Despite the fact that CMS states that lowering the threshold would have limited impact as the percentage of physicians who qualify under those options is already high, CMS should maintain the same threshold across reporting options for consistency unless there is a compelling reason beyond the generally-stated notion that the impact would be minimal.

#### *Group Practice Reporting Options*

ACP supports the CMS proposal to expand its definition of "group practice" relevant to PQRI. ACP agrees with CMS that changing the minimum group size from 200 to two will greatly expand the opportunities for participation in the 2011 modified group practice reporting option (GPRO II). ACP agrees with the eligibility-defining criteria of a single tax identification number (TIN) with two or more eligible providers who have reassigned their billing rights to the TIN.

ACP supports the CMS proposal to calculate whether individual members of the group qualify to receive the incentive payment if the group collectively fails to qualify. This is an appropriate recognition of the effort of individual members of the group.

#### *Registry-based Reporting*

ACP supports the CMS proposal to eliminate the requirement for reporting on consecutive patients in the registry-based reporting option. We also support that this reporting option will now allow for inclusion of non-Medicare patients.

ACP believes that having eligible registries report discrete patient data to CMS for the agency to calculate the physician's results is a viable option. The College believes that any privacy concerns can be addressed through a carefully designed and secure reporting mechanism. While

such an action would further the CMS goal of improving uniformity in the calculation of results, it may be prudent for the agency to first receive discrete data from some eligible registries to test the option and compare it further against the current method of registries reporting their calculation of physician results.

#### *Simplifying Notice of Eligible Registries and EHR Product Options*

ACP recommends that CMS publish notice of registries and EHR products that the agency designates as eligible to submit quality data on behalf of physicians prior to the beginning of a reporting year. The agency can note that it is still accepting self-nominations through a longer period and that the list of eligible registries and products may/is likely to expand before the final cutoff date. Providing notice before the beginning of the reporting year would be less confusing for physicians assessing their reporting options, without constraining the ability of registries and EHR products to continue to engage CMS. Registries and products would still be able to be added into the reporting year and physicians would still have the ability to work with a registry and EHR vendor that is seeking to be designated as eligible.

#### *Other Reporting Method-related Comment*

ACP credits CMS for expanding the number of individual quality measures and measures groups but urges the agency to continually explore ways to make the greatest number of reporting options available to the largest number of physicians. ACP remains firm in its view that all quality measures must be evidence-based. The College believes that CMS should consider whether more measures groups can be created, consistent with the evidence and through a multi-stakeholder validation process. We specifically recommend that the agency determine whether asthma measures can be expanded to cover the typical Medicare aged population.

#### *Implementation of ACA Components*

##### Timely Feedback

ACP believes that timely, actionable, PQRI feedback reports are essential and it urges the agency to do more to meet this goal. The agency should strive to promptly provide physicians with real-time access to data on file and start with concise quarterly status/feedback reports. The reports should also include summary information such as participation rates among specialties, successful reporting rates among specialties, practice types, and practice sizes.

Further, ACP requests that CMS review the methods through which physicians are expected to obtain their reports to improve ease of access. While the College appreciates the significant steps the agency has taken to simplify the process, many individual physicians and small practices still have difficulty obtaining their reports.

##### Appeals Process

ACP recommends that CMS institute a more structured and transparent appeals process, so that physicians have an avenue to quickly remedy erroneous determinations. The current process

available to physicians to investigate discrepancies—relying on “help desks” and finding personal contacts within the agency and its contractors—is inefficient for CMS as well as for physicians.

### Maintenance of Certification Program Option

ACP supports participation in a Maintenance of Certification Program (MOCP) as a pathway to PQRI credit. While the College would have preferred that Congress craft the ACA provision in a manner that reduces redundancy across quality improvement efforts, ACP provides the comments below on the CMS proposed implementation of the law.

ACP urges CMS to limit the application of its stated requirement that a physician must “more frequently” participate in an MOCP than is otherwise required to maintain certification to an MOCP practice assessment. Applying a “more frequent” standard to other parts of an MOCP is impractical and inconsistent with the intent of the ACA. Further, ACP recommends that the “more frequently” standard apply uniformly, a more equitable approach than the standard varying according to the unique requirements of each specialty Board as CMS proposes. A uniform standard will also enable CMS to specify exactly how the 0.5% incentive payment will be attached to successful participation under this option, e.g. payment for a single year or for multiple years.

ACP believes that the CMS proposal to require a patient experience of care survey as part of a practice assessment is premature. The College recognizes the importance of capturing patient experience, including supporting it as a measurement inherent to the evaluation of the Patient Centered Medical Home model, but understands that this requirement cannot be practically met at this time. Considering that the American Board of Medical Specialties (ABMS) and the specialty Boards are working toward the incorporation of a patient experience survey into MOC, ACP urges CMS to work with the ABMS/specialty Boards to incorporate this component in a reasonable manner.

ACP understand that the ABMS and specialty Boards will be challenged to meet the proposal that MOCP-sponsoring organizations report specific information by the end of the first quarter of 2012 and urges the agency to work with ABMS/specialty Boards to achieve a reasonable resolution.

ACP asks CMS to clarify whether the 0.5% payment for successful participation using the MOCP option is a stand-alone incentive payment opportunity or one that can only be realized if a physician first qualifies using a quality measure reporting option, e.g. individual measures, measures groups. The College requests clarification in response to the frequent CMS reference to an “additional” 0.5% incentive payment.

ACP notes that the 0.5% incentive payment associated with successful participation in this option provides minimal revenue to the average internist. Using our standard assumption that the typical internist receives approximately \$200,000 in Medicare PFS allowed charges in a year, the average internist would receive about \$1,000 per year for meeting the CMS MOCP PQRI requirements (we are unclear if a single qualification would trigger the payment in multiple

years). While ACP supports the notion that internists continually strive to improve, the College urges CMS to avoid establishing requirements that involve high participation costs, especially those imposed beyond the costs that are already associated with physician participation in an MOCP.

The ACA-mandated timely feedback and appeals processes, in addition to other CMS improvement efforts, provide CMS an important opportunity to engender greater physician confidence in the PQRI program. Increasing physician confidence is even more crucial as perception of the PQRI program has the potential to serve as the basis of the level of confidence physicians have in the government to administer the EHR Incentive Program established by the American Recovery and Reinvestment Act of 2009.

### **Incentives for Electronic Prescribing—the Electronic Prescribing Incentive Program**

ACP continues to support the efforts of the federal government to facilitate the implementation of electronic prescribing (eRx). The effective use of eRx will promote increased quality, efficiency and safety of the care provided to Medicare beneficiaries. The College's specific comments in response to the changes outlined in the proposed rule are below.

#### *Relationship with Medicare EHR Incentive Program*

There should be increased alignment between the EHR and eRx incentive programs. As proposed, a physician (or group practice) who earns an incentive payment under the Medicare EHR incentive program cannot qualify for the eRx incentive bonus payment; but that physician is still at risk for a penalty under the eRx incentive program. The College recommends this be changed such that earning the EHR Incentive precludes inclusion under the eRx penalty. The EHR incentive program, beginning in 2011, already includes an eRx requirement, so the continued vulnerability of practices to the eRx incentive program penalty is redundant, and will add unnecessary confusion.

#### *Reporting Mechanisms*

The College supports the concept of the availability of multiple reporting mechanisms to individual physicians to report their eRx measures. This flexibility is appreciated by our members, and facilitates their participation in the incentive program. We particularly commend CMS for the inclusion of an EHR-based reporting mechanism for 2011.

#### *Statutory Limitation*

The College recommends that the submission processes for self-nominations letters required by group practices to participate in the 2011 eRx incentive program (and the 2011 PQRI program) include regular mail, as well as online submission and by e-mail.

#### *Penalty-Payment Adjustment*

ACP policy supports positive incentives to encourage physicians to engage in specific activities, such as eRx, to achieve policy goals and opposes punitive payment penalties. Employing positive incentives attached to well-designed programs is a more appropriate and effective way to prompt physicians to implement quality improvement activities. While ACP recognizes that CMS must implement a penalty-payment adjustment consistent with the law, reasonable implementation of the penalty portion—including judicious application of the hardship exemption—is essential. Unfair, or unnecessarily harsh, implementation of the penalty will foster physician skepticism of the government’s ability to administer not only the eRx incentive program but the PQRI and EHR incentive programs. Early physician success is integral to achieving the momentum needed to realize the policy goals associated with all of these incentive programs. The window of time available to generate momentum to go beyond the tipping point is short. Therefore, it is essential that CMS revise its proposed eRx penalty-payment adjustment approach consistent with the ACP recommendations below.

### 2012 Penalty

The College strongly opposes the proposed methodology to implement a penalty-payment adjustment in 2012 that is based on activities during the first six months of 2011. Many willing practices will not have enough time to implement eRx within the specified time period, particularly given that the final rule will not be released until late 2010. In addition, this methodology appears inconsistent with the Congressional intent as the law indicates that the penalty begin in 2012. As proposed, the penalty is actually accrued in 2011. The College requests that the penalty be based on activities in 2012, and be paid through adjustments to 2013 payments.

### 2013 Penalty

The College strongly opposes the proposed methodology to implement a penalty-payment adjustment in 2013 that is also based on activities during the first six months of 2011. This proposal is unnecessarily punitive in that it qualifies a physician for a penalty both in 2012 and 2013, based on activities in the first half of 2011. Consistent with our above recommendations regarding the 2012 penalty, the College requests that the penalty for 2013 be based on activities in 2013, and be paid through adjustments to 2014 payments.

### *Significant Hardship Exemption*

The College appreciates the recognition that various groups of practices may have difficulty meeting the requirements of the eRx incentive program, and that there is a proposed procedure to exempt specific practice classifications from the required payment adjustment penalty. Currently, only physicians or group practices in a rural area with limited high speed internet access or in an area with limited available pharmacies for electronic prescribing can request such an exemption. The College believes that these exemption categories are too limited, and should be expanded to at least include small practices (1-2 physicians) and practices located in Health Professional Shortage Areas.

Thank you for considering the ACP comments. Please contact Brett Baker, Director, Regulatory and Insurer Affairs, by phone at 202-261-4533 or e-mail at [bbaker@acponline.org](mailto:bbaker@acponline.org) if you have questions and/or need additional information.

Sincerely,

A handwritten signature in black ink that reads "Donald W. Hatton MD FACP". The signature is written in a cursive style with some capital letters.

Donald W. Hatton, MD, FACP  
Chair, Medical Services Committee