ACP
American College of Physicians
INTERNAL MEDICINE | *Doctors for Adults*

August 19, 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 130,000 internists and medical students, is pleased to comment on the Centers for Medicare and Medicaid Services (CMS) 2011 Medicare Physician Fee Schedule proposed rule, titled, "Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011." ACP is limiting its comments in this letter to the CMS proposed implementation of the Medicare Primary Care Incentive Payment (PCIP) program that was established by Affordable Care Act (ACA) Sec. 5501(a). While the College will submit an additional letter, also prior to the August 24 comment period deadline, on a wider range of issues addressed in the proposed rule, ACP views implementation of the PCIP program as a priority worthy of separate attention.

ACP strongly supported the inclusion of Sec. 5501(a) in the ACA and views it as a needed step toward increasing interest in the practice of general internal medicine and other primary care specialties. ACP is concerned that key aspects of the CMS proposed implementation of the PCIP program would unduly restrict the number of primary care general internists and other primary care physicians who will qualify and, thus, receive the incentive payment. ACP recommends numerous actions that CMS can take to promote broader, equitable incentive payments that are consistent with the law and its intent to increase access to primary care physicians and their services.

ACP believes that the fact that the Congressional Budget Office (CBO) estimate of the expenditures associated with Sec. 5501 exceeds the CMS estimate, stated in the financial impact portion of the proposed rule, supports the contention that Congress intended a more broad application of the incentive payment programs. The CMS Office of the Actuary (OACT) fiscal year 2011 estimate of $170 million is significantly lower than the CBO fiscal year 2011 $400 million estimate.[1] The estimate by OACT and CBO use the same parameters as they both

[1] Congressional Budget Office. Letter to the Honorable Harry Reid. March 11, 2010. Accessed at http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf.

include the combined cost of the PCIP program and the general surgery in a Health Professional Shortage Area incentive payment program and are based on the nine months that will remain in the government's 2011 fiscal year.

Need to Redefine the Allowed Charges Denominator as Physician Fee Schedule Professional Services

ACP urges CMS to modify its proposal to define the total amount of allowed charges out of which a minimum of 60% must be derived from specified primary care services—or the denominator amount—as allowed charges from professional services paid under the Medicare Physician Fee Schedule (PFS). ACP believes that the CMS interpretation that the language in Sec. 5501(a) of the law means that the allowed charges denominator be derived from all Part B-paid services is misguided. Our recommendation that the denominator be based on PFS professional service allowed charges is supported by: reasonable reading of the structure of ACA Sec. 5501(a); CMS implementation of other Medicare physician incentive payment programs; policy considerations; and the need to ensure fairness and avoid arbitrary qualification determinations.

Establishing Denominator as PFS Professional Services Allowed Charges Consistent with Reasonable Reading of the Structure of ACA Sec. 5501(a)

The language in subsection (x), which Sec. 5501(a) stipulates be added to Sec. 1833 of the Social Security Act, supports calculating the denominator from PFS-paid professional services. The "(1) In General—"statement stipulates that primary care services be paid 10% in addition to the amount otherwise paid under this part. As the primary care services defined in Sec. 5501(a) are all services paid under the PFS as professional services, it is logical to determine that the "part" referenced in the "primary care practitioner" definition in subsection (x) also refers to PFS professional services.

The use of the term "allowed charges" in Sec. 5501(a) also supports limiting the scope of the denominator to the PFS as it is our understanding that the term is primarily, if not exclusively, used in the PFS context.

Establishing Denominator as PFS Professional Services Allowed Charges Consistent with CMS Implementation of other Medicare Physician Incentive Payments Established by Legislation

Physician Scarcity Area Incentive Payment Program

In its implementation of the physician scarcity area incentive payment, established by Sec. 413 of the Medicare Modernization Act of 2003 (MMA), Public Law 108-173, available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_cong_public_laws&docid=f:publ173.108.pdf, CMS interpreted "under this part" to mean PFS professional services.

The relevant excerpt from Sec. 1833 of the Social Security Act that reflects the addition of the subsection established by MMA Sec. 413, as maintained in the "Compilation of the Social

Security Laws" on the Social Security Administration website, at http://www.ssa.gov/OP_Home/ssact/title18/1833.htm, is below.

> (u) Incentive Payments for Physician Scarcity Areas.—
>
> (1) In general.—In the case of physicians' services furnished on or after January 1, 2005, and before July 1, 2008—
>
> (A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or
>
> (B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),
>
> in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

The CMS-established regulatory text to implement MMA 413 at Code of Federal Regulations 414.66, titled, "Incentive payments for physician scarcity areas, shows the agency's implementation of "under this part." CMS determined that the MMA Sec. 413-established 5% incentive payment to eligible physicians for service furnished in scarcity areas was in addition to the "amount paid under the physician fee schedule for their professional services…" The CMS regulatory text, as it appears in the agency's 2005 Medicare PFS Final Rule published in the November 15, 2004 *Federal Register*, is below.

> § 414.66 Incentive payments for physician scarcity areas.
>
> (a) *Definition.* As used in this section, the following definitions apply.
>
> *Physician scarcity area* is defined as an area with a shortage of primary care physicians or specialty physicians to the Medicare population in that area.
>
> *Primary care physician* is defined as a general practitioner, family practice practitioner, general internist, obstetrician or gynecologist.
>
> (b) Physicians' services furnished to a beneficiary in a Physician Scarcity Area (PSA) for primary or specialist care are eligible for a 5 percent incentive payment.
>
> (c) Primary care physicians furnishing services in primary care PSAs are entitled to an additional 5 percent incentive payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.
>
> (d) Physicians, as defined in section 1861(r)(1) of the Act, furnishing services in specialist care PSAs are entitled to an additional 5 percent payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

We highlight that CMS went further than interpreting "under this part" as PFS-paid services by implementing it to mean PFS professional services. The agency described this implementation decision in a response to a comment in the 2005 Medicare PFS Final Rule published in the November 15, 2004 *Federal Register*, which is provided below.

> *Comment:* A commenter has questioned our proposal not to apply the new 5 percent physician incentive payment to the technical component of physicians' services. The commenter stated that extending the new bonus payment to both the professional and technical component of the physicians' services is consistent with Congressional intent and would simplify claims processing.
>
> *Response:* Section 1833(u) of the Act provides for incentive payments for physicians' services furnished in PSAs. We note that the statute contains two definitions of physicians' services. The first, which appears at section 1861(q) of the Act, defines physicians' services as ''professional services performed by physicians including surgery, consultation, and home, office, and institutional calls.'' The second, which refers to services paid under the physician fee schedule, is found at section 1848(j)(3) of the Act and contains a broader definition of physician services. However, that definition applies only for purposes of section 1848 of the Act. Since the incentive payment is not included in section 1848 of the Act, the definition of physicians' services specified in section 1861(q) of the Act is the definition that applies. Thus, we believe the best reading of the statute is that only *professional* services furnished by physicians are eligible for incentive payments.

While the physician scarcity area incentive payments have expired, the agency's implementation of MMA Sec. 413 indicates an interpretation inconsistent with its proposed interpretation of ACA Sec. 5501(a).

Health Professional Shortage Area Incentive Payment Program

The CMS decision that Health Professional Shortage Area (HPSA) incentive payments, which are still effective, be made in addition to only PFS professional services, a payment policy the agency alludes to at http://www.cms.gov/HPSAPSAPhysicianBonuses/, is contrary to the agency's proposed interpretation of ACA 5501(a). Social Security Act Sec. 1833(m)(1), which authorizes the HPSA incentive payment program, also uses the term "under this part." The excerpt as maintained in the "Compilation of the Social Security Laws" on the Social Security Administration website, at http://www.ssa.gov/OP_Home/ssact/title18/1833.htm, is below.

> (m)(1) In the case of physicians' services furnished in a year to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act)[72] as a health professional shortage area as identified by the Secretary prior to the beginning of such year, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.

Establishing Denominator as PFS Professional Services Allowed Charges Consistent with Policy Considerations

Need to Exclude Clinical Laboratory Fee Schedule Services from Denominator

While payments for most non-PFS Part B-paid services are minimal for most general internists, the inclusion of payments derived from Clinical Laboratory Fee Schedule (CLFS) services will preclude many general internists (and other primary care physicians)—who are in every respect primary care clinicians, by training and practice, and should accordingly qualify for the incentive payment—simply because they provide point-of-care laboratory services to their patients.

In-office laboratory testing is common as 65% of general internists work in an office in which lab testing is performed.[2] The percentage of revenue that internists' derived from in-office laboratory testing is stable, with the percentage of an internist's 2008 Medicare Part B revenue from ancillary services—including imaging, clinical laboratory tests, pathology services, outpatient therapy, and radiation therapy—unchanged from 2003.[3] ACP infers this finding to mean that internists are not increasing in-office laboratory testing.

Laboratory tests are integral to management of many chronic conditions. Primary care physicians commonly treat patients with chronic conditions. General internists report that an office visit often involves a patient with one or more chronic conditions, with 43% of visits furnished to patients with hypertension, 28% with hyperlipidemia, and 19% with diabetes.[4] The laboratory testing required to provide evidence-based care for diabetics illustrates the relevance of testing to proper management. The "Clinical Recommendations Statement" for Medicare Physician Quality Reporting Initiative (PQRI) Measure 1, Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus, states:

> Obtain a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals. (Level of Evidence: E) (ADA)[5]

Clinically appropriate care of beneficiaries who require long-term outpatient anticoagulation management provides another example. The routine venipuncture and the resulting prothrombin time test associated with anticoagulation management are two CLFS-paid services that are often

[2] ACP analysis of 2007 National Ambulatory Medical Care Survey data, using public data files accessed through http://www.cdc.gov/nchs/ahcd/about_ahcd.htm#NAMCS.
[3] Medicare Payment Advisory Commission. Report to Congress, Chapter 8, Addressing the Growth of Ancillary Services in Physician Offices. June 2010.
[4] ACP analysis of 2007 National Ambulatory Medical Care Survey data, using public data files accessed through http://www.cdc.gov/nchs/ahcd/about_ahcd.htm#NAMCS.
[5] CMS 2010 PQRI Measure Specifications Manual for Claims and Registry Reporting of Individual Measures document. Accessed on August 12, 2010, at http://www.cms.gov/PQRI/15_MeasuresCodes.asp#TopOfPage,

furnished in-office and whose high-volume is, in part, driven by the pursuit of optimal management of patients on warfarin, a dangerous drug that requires compulsive management.

Further, maintaining in-office testing capabilities promotes timely treatment and patient-convenience. That 44% of clinical lab and pathology services are performed on the same date as a related office visit demonstrates that physicians frequently order and provide timely lab testing.[6]

Establishing Denominator as PFS Professional Services Allowed Charges Consistent with the Need to Ensure Fairness and Avoid Arbitrary Qualification Determinations

Including CLFS-paid services in the allowed charges denominator injects unfairness in the incentive qualification determination as the administrative procedure that physician practices use to bill Medicare for in-office laboratory tests would result in arbitrary decisions under the CMS proposal. A primary care physician in a practice that bills laboratory tests using the primary care physician's identification number would face a higher hurdle in qualifying for the bonus than another primary care physician whose practice bills the laboratory test he or she orders using the group's identification number. This is because the denominator amount (as well as the numerator amount) is based on the allowed charges directly attributable to each individual physician. The contrasting billing approaches described in the scenarios below demonstrate how one primary care physician can fail to qualify despite providing the identical mix of services as a physician who does qualify.

> Scenario 1: A 50-physician group practice maintains a practice office laboratory. The group practice bills for the office visits and other professional services furnished by a general internist member in the name/National Provider Identifier number of that individual general internist. The group practice bills the in-office laboratory tests ordered by this same general internist in the name of the group/group identifier. The Medicare payment for these laboratory tests would not be included in allowed charges denominator when CMS assesses whether this individual physician meets the 60% allowed charges from primary care services threshold.
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> Scenario 2: A physician in solo practice maintains an in-office laboratory. The individual physician bills his office visit and other professional services—as well as the tests performed in his in-office laboratory—in his name/National Provider Identifier. CMS would include the laboratory charges in the allowed charges denominator when assessing whether this solo practice physician meets the 60% allowed charges from select primary care services threshold. This physician would be less likely to meet the threshold to receive the bonus.

This same dynamic described above may play out related to the individual physician's ordering of diagnostic tests that are performed on the group's premise, even though these services are paid under the PFS.

[6] Medicare Payment Advisory Commission. Report to Congress, Chapter 8, Addressing the Growth of Ancillary Services in Physician Offices. June 2010.

To conclude the portion of our comment on the need to redefine the allowed charges denominator as PFS professional services, ACP strongly supports such a modification for the reasons stated above. It would, however, be understandable if CMS took action to avoid holding physicians harmless for furnishing services that require significant equipment, and, thus, ACP would not object to the inclusion of PFS technical component payments in the allowed charges denominator. ACP remains firm is its position, though, that CMS should, at a minimum, define the denominator as PFS allowed charges. Expanding the scope of the denominator to non-PFS-paid Part B services, especially laboratory services, would result in an inappropriately narrow application of the PCIP program. Excluding physicians who truly furnish primary care and are in need of the added revenue will thwart the effort to expand access to primary care physicians and their services.

Need to Avoid Disproportionally Disadvantaging Rural Primary Care Physicians

A May 2009 paper by the American Academy of Family Physicians' Robert Graham Center titled, "Effects of Proposed Primary Care Incentive Payments on Average Physician Medicare Revenue and Total Medicare Allowed Charges," which used incentive payment qualification criteria similar to those included in ACA Sec. 5501(a), demonstrates that rural physicians will be less likely to qualify. Primary care physicians typically provide a broader array of services in rural areas. In addition to providing inpatient and emergency care, furnishing minor procedures such as aspiration, joint injections, and skin lesion removal is common. Accordingly, the incentive payment qualification threshold may have the unintended consequence of narrowing scope of practice for rural physicians and of limiting access for rural Medicare beneficiaries. ACP urges CMS to explore ways within its authority to avoid disadvantaging rural primary care physicians.

Steps to Hold Harmless Primary Care Physician who Follow Their Patients in the Hospital

CMS should exclude hospital evaluation and management (E/M) service-allowed charges from the denominator to hold harmless the physicians who furnish these services. This will avoid penalizing primary care physicians who treat hospitalized patients as following a patient in the hospital setting provides continuity of care and is a hallmark of traditional primary care practice. While the hospitalist movement has reduced the prevalence of primary care physician hospital visits, the number of primary care physicians making such visit remains significant. Approximately 61% of general internists report making hospital visits.[7] In survey of ACP members, 77% of general internists in active practice provide at least some inpatient care.[8] As beneficiaries in urban areas are more likely to receive care from a hospitalist,[9] rural primary care physicians are more likely to be harmed by criteria that associate hospital care as inconsistent with primary care. Excluding E/M hospital services would ensure that the PCIP program was neutral in that it would not discourage ambulatory-based physicians from making hospital visits

[7]ACP analysis of 2007 National Ambulatory Medical Care Survey data, using public data files accessed through http://www.cdc.gov/nchs/ahcd/about_ahcd.htm#NAMCS.
[8]ACP 2010 Member Profile. Philadelphia, PA.
[9] Kuo YF, Sharma G, Freeman JL, Goodwin JS. Growth in the Care of Older Patients by Hospitalists in the United States. New England Journal of Medicine. 2009 Mar 12; 360(11) 1102-12.

nor would it inherently alter the trajectory of the hospitalist movement. If CMS is concerned that primary care physicians may furnish visits to hospitalized patients with whom they do not have an established relationship, the agency could limit the exclusion to hospital E/M services to beneficiaries the same physician has provided outpatient E/M services.

Exercising Flexibility in Determination of "Prior Reporting Period"

ACP recommends that CMS run the calculation to determine whether an individual primary care physician qualifies for the incentive payment in the "prior reporting period" more frequently than for the entire year, e.g. quarterly or semi-annually. This would allow multiple opportunities to achieve the required 60% allowed charges threshold. We envision that a primary care physician who qualified in any quarter or half of the prior year would receive the incentive payment throughout the payment year. This approach would help to promote fairness especially if CMS determines that it lacks the authority to exclude hospital E/M services from the allowed charges denominator. The extent to which a primary care physician makes hospital visits can vary during the course of a year, especially for those involved in teaching residents as hospital visits can track with the education cycle. That Sec. 5501 stipulates that qualification during an incentive payment year be assessed during "a prior period as determined appropriate by the Secretary" provides CMS the needed discretion.

Establishing a Reasonable Pathway for Newly Enrolled Physicians

ACP urges CMS to establish a pathway that enables physicians new to Medicare to receive the incentive payment. The title Congress assigned to ACA Sec. 5501 "Expanding access to primary care services (and general surgery services)," inherently supports this contention and it is imperative that the agency take this step in the final rule. ACP provides the options below for CMS to consider in crafting a fair and viable new physician qualification pathway.

- Establish a rolling six-month "prior reporting period" for physicians who newly enroll in Medicare. Newly enrolled physicians would stay in this special category until they establish a claims history that enables their eligibility to be assessed in the same manner as all other physicians. Inferring that CMS would have the great majority of six months worth of claims within nine months (based on its statement that it has 99% of the history for a calendar year after 18 months), the agency could make an incentive payment qualification determination with limited lag time. To illustrate, CMS would make a determination on the eligibility of a general internist who enrolls in Medicare in July 2010 by March 2011. Assuming that the general internist qualifies, the agency could then make a semi-annual incentive payment for the six-month period April – October 2011. It could start each six-month incentive payment period to coincide with the beginning of the next coming quarter, i.e. starting April, July, October, or January, if a true rolling period is too challenging to administer.
- Make the physician incentive payment period nearly identical to the reporting period (the agency could vary it slightly, e.g. have the prior reporting period end a month before the payment period, if needed to comply with the law) for those who lack the claims history to be assessed in the same manner as other physicians. The physicians new to Medicare starting 2010 determined to be eligible would receive their payment after the conclusion

of the payment period. To illustrate, a physician who enrolled in Medicare January 2011 would lack the claims history to be determined in time for the 2011 payment year. However, CMS could use a portion of 2011 as the reporting period and then making a lump sum payment after the conclusion of the payment period as opposed to concurrent with it. A CMS determination in October 2011 that a physician who enrolled January 2011 is eligible would be paid for the 2011 payment period in a single lump sum in 2012.

The above options are also largely consistent with the ACP recommendation that CMS calculate incentive payment eligibility multiple times during a prior reporting period/reporting year. Regardless, ACP believes the language in Sec. 5501 provides no impediment to CMS using a different reporting period for newly-enrolled physicians.

Other Comments Specific to CMS Proposal

- ACP believes that the CMS proposal to make incentive payments quarterly is reasonable, though some variation may be necessary to fairly accommodate physicians newly enrolled in Medicare.
- ACP agrees with the CMS interpretation that the ACA's prohibition on administrative or judicial review does not preclude the agency from correcting "clerical or mathematical mistakes." ACP recommends that CMS provide the formula that it uses to calculate which primary care physicians earn the incentive payment in the final rule. Making the formula/step-by-step calculation instructions available to physicians will allow individuals to determine their own eligibility—enabling them to report contradictions consistent with the CMS statement that physicians have the opportunity to notify CMS of clerical or mathematical errors.
- ACP agrees that primary care physicians can receive the incentive payment independent of receipt of the Health Professional Shortage Area bonus payment.

Indicate CMS Number of Primary Care Physicians Estimated to Receive PCIP in 2011

CMS should indicate the number of primary care physicians (and other eligible practitioners) the OACT $170 million fiscal year 2011 cost estimate assumes will receive the PCIP in the final rule. While the agency could not reasonably be held to this estimate, making it available would promote more realistic physician expectations, which is especially needed if CMS declines to alter its proposed implementation plan.

Notification to Individuals who are Part of a Group Practice

ACP recommends that CMS provide notification to individual primary care physicians who qualify for the incentive payment even if the actual incentive payment is made to the group practice tax identification number under a reassignment arrangement. This would provide valuable information to individual, typically beleaguered primary care physicians.

In conclusion, excluding a large number of primary care physicians from receiving the PCIP is in conflict with Congress' intent to create incentives to support the very physicians that our nation is collectively relying on to serve as the foundation of the health care system. Not only would it

deprive them of needed financial resources, it would send a demoralizing message that their government fails to see them as part of the primary care solution.

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 if you have questions and/or need additional information.

Sincerely,

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