



December 28, 2012

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 410, 414, 415, et al. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013; Final Rule

Dear Ms. Tavenner:

The American College of Physicians, the largest medical specialty organization and the second-largest physician group in the United States, wishes to reiterate that we are pleased CMS has shown its continued concern for improving payments for undervalued evaluation and management and care management services provided principally by internal medicine specialists in primary and comprehensive care of adults, internal medicine subspecialists, family physicians, and geriatricians, and that the new policies to improve payment for such services will not be restricted to a designated subset of specialties.

ACP members include 133,000 internal medicine 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.

Primary Care and Care Coordination

The proposed rule stated that CMS was continuing to monitor the progress of the AMA CPT/RUC Chronic Care Coordination Workgroup (C3W). The College was involved in the

efforts of this workgroup, and was pleased that CMS expressed serious interest in creating a pathway for care management in the fee schedule. ***ACP is grateful that CMS used the recommendations of the RUC and accepted most of the recommended values for the transitional care management codes.***

CMS proposed that the post-discharge transitional care management service (TCM) would be payable only once in the 30 days following a discharge, per patient per discharge, to a single community physician or qualified non-physician practitioner (or group practice) who assumes responsibility for the patient's post-discharge transitional care management. ***ACP agrees that this code should be billed at the end of the transition period, after the services have been provided.***

However, the College strongly requests that CMS provide physicians with clear and timely guidance on documenting and billing this code. There are already many questions arising about how internists can effectively use these innovative Evaluation and Management codes in their practices. ACP is eager to work with CMS to provide input and to disseminate the information to the ACP membership – ensuring that internists can take full advantage of the opportunities these transitional care management codes offer and that their patients can receive the full benefit of this type of care whenever possible.

The College also requests that CMS develop a method to monitor whether the physician or other qualified health care provider who provides these transitional care management services is the one reimbursed for the service. ACP asks that CMS make a careful examination of this provision, and consider ways to avoid the administrative burden of providing detailed documentation of non-face-to-face services that will meet physicians and qualified non-physician practitioners if more than one submits a claim for the post-discharge transitional care coordination code. We suggest that CMS consider other options, such as using a plurality of care—similar to that used in ACOs and the Innovation Center's CPC Initiative—to decide the payment in such cases.

The C3W also created three new codes to describe complex chronic care coordination (CCCC) services that are patient-centered management support services provided by physicians and other qualified health care professionals to an individual who resides at home, in a domiciliary rest home, or assisted living facility, billable per calendar month. CCCC services are provided to patients who typically have multiple comorbidities, and frequently have multiple medications requiring ongoing, non-face-to-face care coordination.

The choice of code is largely determined by the clinical staff time over the period of a calendar month. Unlike with the transitional care management services, a recent hospital discharge is not required, but the typical patient has several chronic conditions, sees multiple care providers, requires a variety of therapeutic and diagnostic services, and has a management plan that

requires frequent revisions. While the goal of TCM is to prevent re-hospitalization, the goal of CCCC is broader. The CCCC goals are to efficiently integrate care, maximize the patient's potential function and well-being and prevent hospitalization. CMS has postponed implementation of payment for these services, allowing for additional discussion regarding the appropriate application of the services. While ACP appreciates CMS publishing the RUC recommended relative values for these codes so that other payers could utilize them in 2013; we welcome the ability to work with CMS to address any remaining issues as the agency considers implementation of their own payment for the CCCC services.

Payment for New Preventive Service HCPCS G-Codes

ACP supports the agency's decision to add these newly created preventive services (HCPCS codes G0442 through G0447), representing alcohol misuse screening, depression screening, STI screening and counseling, intensive behavioral therapy for cardiovascular disease, and intensive behavioral therapy for obesity to the telehealth benefit, as Category 1 services. ACP also applauds CMS for expanding the telehealth benefit to alcohol and/or substance (other than tobacco) abuse structured assessment (HCPCS codes G0396 and G0397).

Potentially Misvalued Codes Under the Physician Fee Schedule

ACP is pleased that CMS has committed to considering ways to best measure the number and level of E/M visits that occur during a surgical global period – to assure that the Medicare program is paying appropriately for those services.

ACP continues to offer the following suggestions:

- 1) CMS should implement a requirement that each face-to-face visit provided within a global package be documented in the medical record. Accordingly, if the provided E/M services are not in accord with the service levels specified in the global package, the excess payment should be recouped by CMS and redistributed to the overall physician payment/RVU pool. This option would also provide CMS with data for its future reviews of global E/M services.
- 2) Alternatively, CMS should require that the surgeon report a HCPCS code (perhaps as part of a quality reporting measure) to indicate that the visit took place. The surgeon would not be held to the CMS E/M documentation standards for the E/M global visits.

For both of these suggested modifications, the face-to-face E/M visit could be provided by a physician or by a mid-level practitioner.

Medicare Coverage of Hepatitis B Vaccine

ACP commends CMS for adding coverage of the Hepatitis B vaccine for diabetic beneficiaries, for using the (ACIP) recommendation for hepatitis B vaccine, and for acknowledging the risk of infection to diabetic persons. ACP supports the expansion of coverage for hepatitis B vaccine and its administration to all individuals diagnosed with diabetes mellitus (not only those individuals with diabetes who are receiving glucose monitoring in facilities). With this decision, CMS demonstrates that it does not require a USPSTF Grade A or B designation of this service for reimbursement. For that reason, *ACP continues to recommend that CMS also consider including coverage for all ACIP-recommended vaccines to the preventive services benefit.*

Part B Drug Payment: Average Sales Price (ASP) Issues

The College is pleased that CMS chose to restrict the implementation of an "AMP Price Substitution" for a drug and dosage form that is represented by a HCPCS code reported on the FDA Current Drug Shortage list. Many of our members are in small practices, without the purchasing power of larger organizations. We believe that this change will make it more affordable for those physicians to purchase these limited-supply drugs and would improve beneficiary access to medications.

Physician Value-Based Payment Modifier (VBM) and the Physician Feedback Reporting Program

One of the most critical issues that should be addressed in the implementation of the VBM program is the use of timely data to calculate the modifier. In the final rule, CMS stated that it would use CY 2014 as the performance period for 2016 value-based modifier. *ACP continues to encourage CMS to examine ways to use more timely data to calculate the modifier for the participating physicians, in order to provide them with meaningful and actionable information that will enable them to improve the overall value of the care they furnish.*

ACP recognizes the importance of phasing in a program like this—and is therefore appreciative of the CMS decision to apply VBM only to practices of 100 or more eligible professionals in the first year. The College appreciates the educational efforts thus far and strongly encourages CMS to continue engaging in significant education and outreach efforts to those groups so that they:

- Are aware of the program;
- Understand what it involves and how it will have an effect on them;
- Feel they can make informed decisions about their participation in this initial year, as well as in future years; and
- Are able to provide meaningful feedback to CMS throughout the implementation of the VBM.

ACP understands that CMS will separate all groups of physicians with 100 or more eligible professionals into two categories based on PQRS participation, with the first category including groups of physicians that have reported PQRS quality measures or that have elected to report using the administrative claims-based reporting. This PQRS-reporting category will have its value-based payment modifier set at zero percent, which therefore would not affect their payment under the fee schedule.

The second category includes groups of physicians with 100 or more eligible professionals that have not elected a reporting method and did not report one measure. This second category's VBPM will be set at negative 1.0 percent—and will be in addition to the negative 1.5 percent payment adjustment assessed under the Act for failing to meet the satisfactory reporting criteria under PQRS.

The College reiterates its appreciation for the CMS efforts to align this program with the PQRS program to the extent possible. ACP also understands that the program, by law, must be implemented in a budget neutral manner. ***Therefore, the College strongly recommends that CMS ensure that there is timely, effective, and regular communication and data sharing between CMS and the groups that are to be included in the program—so that they clearly understand what the impact of their participation, or lack thereof, in PQRS will be on their practices, and have as many opportunities as possible to successfully participate.***

The College appreciates that CMS is seeking to reduce the administrative burden faced by eligible professionals trying to indicate their willingness to participate in the quality-tiering approach. ***ACP supports the agency's decision to use a web-based registration system that allows for ongoing registration by groups.*** However, we again note that there is a critical need for education and outreach by CMS, working collaboratively with the physician societies.

ACP supports the final decision that the VBM not apply to groups participating in the Medicare ACO or in the Medicare Shared Savings Program. The College agrees that it is preferable to wait until after the first year of the VBM program to apply the modifier to their payments. The College shares CMS' concerns about ensuring that the structure of the VBM program not conflict with the structures being established within the Medicare Shared Savings Program and other ACO initiatives. ACP views this as a beneficial delay that will allow both CMS and the ACO-participating practices to make decisions that are more informed and to understand better any potential conflicts in the designs of the programs.

ACP is encouraged to see that CMS continues to seek feedback on a proposal to develop a value-based modifier for hospital-based physicians. ACP cautions CMS to develop a value-based modifier option for hospital-based physicians that will not result in inaccurate measurement of hospitalists' performance. ACP remains concerned that the proposed method

attributes the total cost of the patients' stay at a hospital to the hospitalist, when the hospitalist may have only been responsible for discharging the patient.

Ordering Portable X-ray Services

ACP appreciates that CMS will revise its regulations, which limit ordering of portable x-ray services to only an MD or a DO, to allow other physicians and non-physician practitioners acting within the scope of their Medicare benefit and State law to order portable x-ray services.

Durable Medical Equipment (DME) Face-to-Face Encounters and Written Orders Prior to Delivery

The new provision for 2013 changes the timeframe for the written order and the face-to-face visit. CMS outlines that a physician must document and communicate to the DME supplier that the physician, a PA, an NP, or a CNS, has had a face-to-face encounter with the beneficiary no more than 90 days before the order is written or within 30 days after the order is written. The order itself must be relevant to the reason for the beneficiary's need for the item of DME; the face-to-face encounter would substantiate that the beneficiary's condition warrants the covered item of DME and be sufficient to meet the goals of this statutory requirement. *ACP commends CMS for making this change.*

Electronic Prescribing (eRx) Incentive Program

The College supports the provisions regarding the eRx Incentive Program included in the final rule. We particularly want to commend CMS for adding the two hardship exemption categories related to participation in the "meaningful use" electronic medical record (EHR) incentive program and the establishment of an informal review process for eRx program participants to request reconsideration by CMS regarding determination of successful reporting for the 2013 incentive and application of the 2014 payment adjustment.

Medicare Shared Savings Program

ACP applauds CMS for finalizing its decision to better align the program criteria with the PQRS criteria. The College agrees that CMS should incorporate the same PQRS GPRO under the Shared Savings Program that currently applies for purposes of the PQRS incentive under the Shared Savings Program. *We strongly support the alignment of quality assessment efforts used among the multiple quality initiatives currently being implemented within the public and private sectors.*

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

ACP strongly supports CMS' decision to initiate an administrative claims reporting mechanism for PQRS (as well as for the value-based modifier program) in 2015. The College agrees that this option provides a feasible alternative for physicians and groups to participate in the program, particularly if they have not yet been able to effectively use the traditional reporting mechanisms (claims, registries, or electronic health records EHRs) for this purpose or have otherwise not been able to meet the criteria for successful reporting for the 2013 and/or 2014 incentives. Further, the change to require that eligible professionals and groups elect to use that option by a pre-determined deadline is reasonable and ACP supports using a web-based and/or G-code approach for this purpose.

ACP is encouraged that the finalized alternative reporting criteria for registry-based reporting should prove to be better aligned with other quality improvement and reporting programs that are inclusive of 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 that approach and, when combined with the reduced number of required cohort patients, may increase the likelihood of more physicians being able to meet the PQRS reporting requirements.

While the effort to improve registry-based reporting criteria described above is encouraging, ACP recommends that CMS ensure that the measurement targets remain patient centered and reflect potential differences in risk/benefit for specific populations. For example, targets for the frail elderly frequently differ from younger patients. *ACP also recommends that CMS take these efforts further and make a reasonable assessment of their ability to align measures, accounting for risk adjustment, and then develop and publish a concrete plan to address that alignment.*

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,



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