August 30, 2011

Donald M. Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012; Proposed Rule; 76 *Fed. Reg.* 42,772 (July 19, 2011); CMS-1524-P

Dear Dr. Berwick:

The American College of Physicians (ACP) appreciates the opportunity to comment on the proposed rule: Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012. ACP represents 132,000 internal medicine physicians and medical student members. Internists specialize in primary and comprehensive care of adolescents and adults.

Identification of Mis-valued Services

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. ***In general, ACP commends CMS for its attention, especially in the past few years, to the issue of potentially misvalued service codes. However, the College takes notable exception to the proposal to review the entire family of evaluation and management codes.***

The proposed rule states that the Centers for Medicare and Medicaid Services (CMS) examined the claims data for the highest expenditure codes for each specialty and found that evaluation and management services were consistently among the most expensive (in

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terms of program expenditures, not by RVUs). Consequently, CMS proposes to request that the RUC do a comprehensive review of the 91 evaluation and management codes, including the two discharge day management codes which are discussed in a separate section of the proposed rule, because the agency believes that primary care has changed to meet the challenges of preventing and managing chronic disease since the Third Five-Year Review (2005-06) – ostensibly resulting in outdated code values. The rule explicitly states that CMS wants to address this change in medical practice and remedy the shortage of primary care physicians through changes in the Medicare fee schedule: ***"First, we are requesting that the AMA RUC conduct a comprehensive review of all E/M codes... During the intervening years, there has been significant interest in delivery system reform, such as patient-centered medical homes and making the primary care physician the focus of managing the patient's chronic conditions... as the focus of primary care has evolved from an episodic treatment-based orientation to a focus on comprehensive patient-centered care management in order to meet the challenges of preventing and managing chronic disease, we believe a more current review of E/M codes is warranted... Since we believe the focus of primary care has evolved to meet the challenges of preventing and managing chronic disease since the last comprehensive review of the E/M codes, we would like the AMA RUC to prioritize review of the E/M codes..."***

According to the proposed rule, CMS expects half of the evaluation and management codes to be RUC-reviewed by July 2012, with the balance reviewed by July 2013. The proposed rule for CY 2012 does not acknowledge that a significant portion of the evaluation and management codes were fully reviewed in the Third Five-Year Review and another nine evaluation and management codes are still in the rule-making stages of the Fourth Five-Year Review: the observation codes, which serve as comparison codes for many of the other CPT codes, will be examined by the Refinement Panel during the 2011 summer. The results of the Refinement Panel's deliberations will not be known until November 2011, making it extremely difficult to begin an evaluation of related codes in any meaningful way.

The Hospital Discharge Care Coordination discussion contained within the proposed rule, which relates back to the discussion of "Identification of Misvalued Services,' also references the re-development of the evaluation and management services codes: "We welcome comment on key physician activities associated with effective care coordination between the treating physician in the hospital and the beneficiary's primary physician in the community upon hospital discharge... We note that the Assistant Secretary of Planning and Evaluation (ASPE) in the Department of Health and Human Services hosted a technical expert panel in May 2011 identifying areas of additional research into equitable payment for services among specialties, with particular attention to valuing the resources required for primary care including generally identifying and valuing care coordination activities. We will consider the panel's discussion and any available analyses as we broadly consider physician payment for hospital discharge care coordination activities..."

Although ACP appreciates that the agency is paying attention to the valuation of the codes, we oppose the proposal to review all 91 evaluation and management codes, finding the idea to be unworkable and undesirable for these reasons:

- The evaluation and management codes were created 30 years ago, to describe medical practice as it existed in the 1980s. The codes no longer describe the depth and breadth of evaluation and management services, with its increasing focus on chronic disease management and care coordination. ***ACP recommends that CMS work with the medical community to develop evaluation and management codes that will appropriately describe the services, before undertaking another review.***

- The current medical service valuation system, set on the foundation of the legislated Resource Based Relative Value Scale (RBRVS), does not include metrics for the critical physician work that occurs outside of face-to-face contact with the patient. ***ACP does not feel that it is appropriate to subject the evaluation and management services to a valuation system that cannot fully measure those services.*** In the proposed rule, CMS states its desire to compensate the previously unaccounted physician work in comprehensive care and chronic disease management. The Relative Value Scale Update Committee (RUC) review process, based on the legislated concept and parameters of RBRVS, will not be able to capture the additional factors of comprehensive and chronic care.

- In the proposed rule, CMS reiterated its intent to bolster primary care. ***The College believes that a formal RUC review would be ineffective at achieving the agency's goals of compensating physicians for rendering comprehensive care and chronic disease management.***

- The proposed rule implies CMS's desire to address social issues such as the shortage of primary care physicians. ***ACP agrees that the shortage of internal medicine specialists and other primary care physicians is an issue that must be addressed in Medicare payment policies, including increases in payments under the existing Medicare fee schedule for evaluation and management services provided principally by primary care physicians, but that the RBRVS methodology alone is inadequate for achieving this goal.***

- Much of the proposed code valuation work has been completed recently. The evaluation and management codes were reviewed in the Third and Fourth Five-Year Reviews. ACP surveyed the following codes as part of the Fourth Five-Year Review:
    - 99218-220 (initial observation service),
    - 99224-226 (subsequent observation service),
    - 99234-236 (subsequent observation with same-day discharge),
    - 99385-387 and 99395-397 (adult preventive medicine services).

- ***ACP feels that another review of the codes – following so closely on the heels of the changes resulting from those previous reviews is unlikely to produce any meaningful changes in the distribution of relative value units.***

- The proposed rule offers a two-year period in which to complete the survey and review of the entire evaluation and management service code set. ***ACP and experts from a wide range of specialties agree that this brief timeframe would be unduly disruptive of the code review process, and would present an incredible administrative, financial, and staff resource burden for the involved specialties. Furthermore, because the evaluation and management codes underpin so many relative values of other codes, this proposed review has the potential to de-stabilize the entire fee schedule.***

<u>Alternatives to the CMS Proposal to Review evaluation and management Codes</u>
As a counter-proposal to the full evaluation and management review, ***ACP encourages CMS to work with the primary care community and the various task forces (the joint CPT/RUC Workgroup, the AAFP Task Force, etc.) to develop short-term, intermediate-term, and long-term changes to better reflect the primary care and chronic disease services. The College feels that evaluation and management services code descriptors need to become more reflective of the facets of medical care — non-face-to-face time, chronic disease management, care coordination — that are not currently encompassed in the existing codes.***

As an immediately achievable step towards the CMS goal of managing chronic disease, ***ACP recommends that CMS employ tools that already exist in CPT, by establishing Medicare payment for existing CPT codes that describe non-face-to-face evaluation and management services.*** ACP reiterates its previous comment on non-face-to-face 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 urges CMS to recognize non-face-to-face services that enable primary care physicians who provide chronic disease management and care coordination to provide valuable and timely care to their patients. The agency has declined to provide separate Medicare payment for these services—consistently considering them bundled into the payment made for E/M services or Medicare non-covered—despite the 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.

Existing non-face-to-face services which ACP feels should be paid by CMS are:

- Anticoagulant Management (99363 and 99364)
- Medical Team Conference (99366–99368)
- Care Plan Oversight (99339–99340 and 99374-99380)
- Counseling Services (99401–99420)
- Telephone Services (99441–99443; 98966–98968)
- On-line Medical Evaluation (99444 and 98969)
- Education and Training for Patient Self-Management (98960–98962, 99078)
- Review of Data/Preparation of Special Reports (99080, 99090, 99091)

ACP suggests these intermediate-range steps to rectifying the inadequate payment for evaluation and management services:

- ***CMS should continue the Medicare Primary Care Incentive Program.*** This program provides a 10 percent increase in payments for designated primary care services provided by internists, family physicians, geriatricians and pediatricians. ACP requests that CMS evaluate the program's effectiveness, to assure that the $240 million that was projected to be spent on the primary care bonus in the first nine months is being properly distributed.

- ***CMS should consider applying 0-day global periods to surgical codes, such that post-operative hospital and office visits meet the medical necessity and documentation requirements for evaluation and management coding.*** The global periods contain many evaluation and management codes, which every specialty agrees are equally subject to medical necessity and documentation requirements. ACP urges CMS to closely follow and enforce the evaluation and management documentation requirements for all specialties, to assure that Medicare funds are paying appropriately for services.

- ***ACP recommends a budget neutrality exemption for evaluation and management codes. In this exemption, CMS should require that any budget neutrality reductions resulting from RVU or volume increases in other non-evaluation and management categories of services be applied only to such non-evaluation and management HCPCS codes.*** Overall budget-neutrality within the Medicare physician fee schedule would be maintained. ACP recommends a budget neutrality exemption for the services described by CPT codes 99201 – 99205 (new patient office visits) and codes 99211 – 99215 (established patient office visits). These should be considered for exemption from budget neutrality because this has, to a significant degree, diluted the impact of the RUC-approved valuation over the last five years. In addition, undervalued evaluation and management services, consisting of office visits, nursing home visits, home visits, custodial care visits, prevention and wellness visits, emergency room visits, and hospital visits would receive higher payments and be protected from budget-neutrality cuts.

- ***ACP recommends that the RUC-approved Patient Care Medical Home values should be used to begin development of HCPCS G-codes to report chronic disease management.*** This could be considered, beginning in 2012 for implementation in the 2013 calendar year. Over the long term, this will allow the development of global/case management codes (monthly or 90-day) that capture the essential components of the non-face-to-face services — as well as the intensity of these encounters — with defined pre-service and post-service work outside of that associated with evaluation and management codes (more than seven days before or after an evaluation and management service). A well-designed chronic disease management initiative will result in savings to the Medicare trust fund as demonstrated by demonstration projects related to 1)

improved after-hour care and decreased emergency room utilization, and 2) the care coordination demonstration projects that have decreased hospital re-admission rates.

- ***CMS should collaborate with the primary care community to implement more descriptive evaluation and management codes for chronic disease management and care coordination.*** ACP regards the development of new CPT evaluation and management codes, descriptors, and documentation guidelines as the best long-range solution. With greater granularity, the codes would describe the distinctions between acute and chronic care, and would better acknowledge the widely varying levels of medical decision making. In brief, the new evaluation and management codes would need to be capable of better defining the work that is performed and the resources that are necessary to accomplish them.

Review Process for Misvalued Services

CMS proposes to eliminate the Five-Year Review, instead subjecting the physician work and practice expense (PE) relative value unit (RVU) reviews to annual updates. However, the malpractice RVUs would continue on a five-year review cycle. ***ACP feels that moving to annual code reviews would result in smaller, but more frequent, survey sets and would significantly increase the time commitments of volunteer physician advisors and expend a greater portion of specialty society resources.*** CMS also proposes to couple the physician work and practice expense reviews so that they happen simultaneously for any code. In the past, the physician work RVUs were reviewed separately from the PE RVUs. ***ACP predicts that this burdensome review of the practice expense inputs will be highly problematic, in that the current proportion of practice expense in evaluation and management codes may actually cause decreases in total RVU valuation due to the structure of the surveys that place great weight on practice expenses but virtually ignore the essential pre-service, post-service, and non-face-to-face time spent by primary care physicians. ACP feels that the PE review for evaluation and management codes should be reconsidered.***

ACP recommends that CMS offer more detail about its selection criteria for annual reviews and be more transparent in its requests. In order to respond appropriately, it will be important for the specialties to know which metrics have triggered the agency's interest in a code.

The rule proposes changes to the public nomination process for code reviews: beginning in 2012, code review nominations would be sought in the proposed rule, with final determinations announced in the final rule. A new provision is that nominations would need to be accompanied by documentation showing the code's inappropriate valuation (by physician times, RVUs, and/or direct PE inputs). ***ACP feels that presenting evidence along with a code nomination is appropriate, and encourages the agency to follow the same process when nominating codes for review. However, ACP does not agree with the once-a-year opportunity to nominate codes. The College recommends that there should be greater opportunity for public comment.***

Telehealth Services
ACP commends CMS on its proposal to add smoking cessation services (CPT codes 99406 and 99407, and HCPCS codes G0436 and G0437) to the telehealth benefit. ACP is a long-time advocate of efforts to reduce tobacco use in the United States and a strong supporter of physician engagement with patients regarding their tobacco use.

ACP is disappointed that CMS did not expand the telehealth benefit to include critical care services (CPT codes 99291, 99292), domiciliary or rest home evaluation and management, or online evaluation and management CPT code 99444 to the list of covered telehealth services. Inclusion of these services in a payable benefit would greatly aid the agency in meeting its goal of providing chronic disease management and care coordination. Incorporating these services into the fee schedule would be administratively simple: they have already been reviewed, and have relative value units assigned in the fee schedule.

Multiple Procedure Payment Reduction
The CMS proposal indicates that the agency will be focusing on expanding the multiple procedure payment reduction in future years, and looking for "efficiencies" in all sets of codes. To date, the MPPR has been targeted at surgical and imaging services. ***ACP supports CMS's encouragement of public comment regarding data sources and studies which could be used to validate estimates of physician time and intensity which could be factored into the physician work RVUs, especially for the services CMS views as "rapid growth" services.***

Practice Expense Relative Value Units
ACP supports the CMS proposal to update the cross-walked practice-expense relative value units for diabetic treatment and management HCPCS codes G0245- G0247, G0341-G0343, and G0365.

The Annual Wellness Visit
The proposed rule offers details about the contents of a health risk assessment (HRA) to be included in the annual wellness visits. The Agency for Healthcare Research and Quality describes the key features, associates them with successful HRAs, and discusses their applicability to the Medicare population. ***ACP commends CMS for including this guidance on the content and conduct of health risk assessments.***

ACP agrees that the standards outlined in the proposed definition of the term "health risk assessment" represent a minimum set of topics that need to be addressed as part of an HRA. They will allow the physician or provider the flexibility to evaluate additional topics as appropriate, and to provide a foundation for development of a personalized prevention plan.

ACP agrees with the CMS language that clarifies the definitions of the annual wellness visits; however, the College urges CMS to clearly define for physicians and their patients

what is and is not covered in the "free" preventive service visit that is part of the AWV. CMS proposes that the definitions of "first annual wellness visit providing personalized prevention plan services" and "subsequent annual wellness visit providing personalized prevention plan services" be revised to incorporate the use and results of an HRA (an integral part of the provision of personalized prevention plan services, consistent with section 1861(hhh) of the Act). The new definitions would read as: The newly re-designated paragraph (iii) would state "an update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first annual wellness visit providing personalized prevention plan services or the previous subsequent annual wellness visit providing personalized prevention plan services."

The newly re-designated paragraph (vi)(B), would state "the list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual as that list was developed at the first annual wellness visit providing personalized prevention plan services or the previous subsequent annual wellness visit providing personalized prevention plan services."

<u>Cross-walked Relative Values for the Annual Wellness Visits</u>
CMS proposes to maintain the current relative values for the AWVs, based on cross-walked values from the HCPCS G0438 and G0439 codes. In the CY 2011 PFS final rule CMS stated "that when the HRA is incorporated in the AWV, we will reevaluate the values for HCPCS codes G0438 and G0439". In the CY 2012 proposed rule, CMS goes on to assert that the services described by CPT codes 99204 and 99214 already include "preventive assessment" forms and that the current payment crosswalk for HCPCS codes G0438 and G0439 continue to be most accurately equivalent to a Level 4 evaluation and management new or established patient visit. ***On this point, ACP disagrees with CMS; the services described by 99204 and 99214 are not comparable to the Annual Wellness visit with a health risk assessment.*** The descriptors for 99204 and 99214 do not describe the work of obtaining information from the patient. While some of the data of an HRA is already incorporated into an AWV, the addition of the HRA, and of providing patients with a personalized written plan and checklist (as suggested in the rule) will add significant time to the visit -- certainly beyond what is currently performed as part of the AWV. ***The College strongly recommends that the HRA should receive additional RVUs because of the additional work and practice expense it will require. ACP recommends that CMS use the RVUs from CPT codes 99406 and 99407 (smoking cessation counseling) as building-block components for the HRA portion of the AWV. The College also recommends that the agency re-examine the code values in two more years (2013), after there is sufficient utilization and payment data on which to base the potential need for a further review.***

Geographic Practice Cost Indices (GPCIs)
ACP agrees with the CMS proposal to use wage data to update the GPCIs. However, the College urges the agency to continue to monitor the availability of more tailored data. For example, using the American Community Survey average rent for a 2-bedroom

apartment may be a reasonable proxy for now, but it would be better for CMS to obtain more specific rent data, including a survey of physicians regarding their office rent fees.

ACP suggests that CMS wait for the analysis in the referenced Institute of Medicine reports to become available before taking any action on the GPCI updates.

Physician Quality Reporting System (PQRS)

Core Measures

Calendar year 2012 physician reporting for the claims-based individual measures—applicable to internal medicine, cardiology, and family practice—is proposed to require at least one core measure plus no less than 50 percent of the eligible professional's Medicare Part B fee-for-service patients for whom services were furnished during the reporting period to which the measure applies. For the 2011 PQRS, the reporting threshold was 80 percent. ***ACP commends CMS on this part of the proposal, because it would reduce the reporting burden.***

However, CMS negates the above mentioned provision by proposing other specifics to the PQRS participation requirements—creating "core measurements" for internal medicine, cardiology, family practice, and general practice, because: "…[CMS believes] the PQRS core measures are most relevant to those specialties. Since we believe that eligible professionals in those specialties would likely report the proposed PQRS core measures regardless of the proposed requirement to report at least one PQRS core measure, we believe that the this requirement would not result in an increased burden to these specialties. In future years, we hope to develop a similar reporting requirement and core set of measures for other specialties." ***ACP disagrees with the CMS assessment of administrative burden. The College thinks it likely that the addition of mandatory reporting measures will have negative effects on the productivity of physician practices and may become a regulation that discourages participation in the program.***

PQRS Measure Clusters

Regarding claims-based reporting, CMS proposes that if a physician reports fewer than three measures in 2012 and reports on a measure that is part of an identified cluster of closely related measures, but does not report any other measures in the identified cluster, then the physician would not qualify as a satisfactory reporter in the 2012 PQRS or earn an incentive payment. This is a puzzling and vague requirement because CMS has never identified any "clusters of closely-related measures." It will certainly lead to significant confusion; physicians likely will have different views about what constitutes a "cluster of closely-related measures." Further, it would be extremely unfair for physicians to report data in good faith to the PQRS only to find out after-the-fact that they did not meet a requirement that was not specified up front. ***ACP urges CMS to identify these clusters before implementing the provision, so as not to leave physicians guessing about the specific requirements for successful participation in the PQRS.***

Definition of Group Practice

In 2012, "group practice" would be redefined to mean a group practice with one tax identification number (TIN), with 25 or more individual eligible professionals (or, as identified by National Provider Identifiers) who have reassigned their billing rights to the TIN. Previously, a group practice was defined as two or more individual eligible professionals. ***ACP supports the revised definition of group practice. The change reflects the agency's acknowledgement that high standards for the program should be maintained, and that the group practice category carries administrative burdens that are difficult for the individual provider to meet.***

The rule proposes to eliminate the six-month period for claims and registry based reporting of individual measures. ***ACP agrees that this will help align the PQRS reporting periods with the electronic health record (EHR) reporting mechanism. The proposal would also retain the claims-based, registry and EHR-based reporting mechanisms for 2012 and beyond.***

Also, CMS proposes various new requirements that physicians in internal medicine, general practice, and cardiology must satisfy for successful reporting of claims-based PQRS measures groups. One of these requirements is to report at least one PQRS measures group. If the measures group does not contain at least one Physician Quality core measure, physicians must report one Physician Quality core measure. ***ACP urges CMS to use the final rule to clearly identify which measures groups contain core measures. This will clarify when additional reporting is needed for a separate core measure.***

CMS states that it would post a list of qualified registries for the 2012 program year, but not before the start of 2012. ***ACP encourages CMS to publicize the list of qualified registries prior to the start of the 2012 reporting period, for the benefit of physicians who wish to participate at the beginning of the reporting period.***

EHR Reporting for PQRS

In the proposed rule, EHR reporting for PQRS would be maintained for 2012 and beyond. CMS notes that physicians and providers may have purchased Certified EHR Technology for purposes of reporting under the Medicare and Medicaid EHR Incentive Programs. Such Certified EHR Technology may or may not be qualified for purposes of the 2012 PQRS. Eligible professionals would need to ensure that their Certified EHR Technology is also qualified for purposes of the 2012 Physician Quality Reporting System, in order to participate in the PQRS via the EHR-based reporting mechanism for 2012. ***ACP encourages CMS to publicize the technology qualifications more widely, and to emphasize to the vendor community the importance of creating technology that satisfies the requirements of both programs.***

ACP opposes adoption of requirements that exceed the meaningful use certification. It is unreasonable for CMS to impose additional technical requirements for EHRs. For physicians in a small practice (which describes a significant portion of the ACP membership) who have installed an Office of the National Coordinator-certified EHR system to qualify for the meaningful use incentive, or to avoid the meaningful use

penalty, could still be penalized under the PQRS. ACP fears that CMS could unintentionally pressure practices to invest significant resources in unqualified EHRs, just to meet the deadline for avoiding the PQRS penalty.

CMS proposes that beginning in 2012, physicians who participate in the PQRS via the EHR-based reporting mechanism would have the option of submitting quality measure data obtained from their PQRS-qualified EHR to CMS either directly from the physician's qualified EHR or indirectly from a qualified EHR data submission vendor on the physician's behalf. Physicians would be required to have a separate PQRS-qualified EHR product, despite the fact that physicians may have already purchased Certified EHR Technology for purposes of reporting under the Medicare and Medicaid EHR Incentive Programs, i.e., meaningful use (MU) program. ***ACP urges CMS to immediately rectify these separate certification requirements.*** Physicians have invested significant amounts of money in purchasing Certified EHR Technology for the Medicare and Medicaid EHR Incentive Programs. Physicians should not have to face the additional burden of verifying whether their current EHR technology is also qualified for purposes of reporting under the 2012 PQRS. Moreover, they should not have to purchase additional technology to participate in the PQRS via EHR-based reporting simply because these programs have not been aligned.

ACP feels that it is critical that the measures and format for reporting measures under the PQRS and meaningful use programs are aligned. This requires:

- Establishing common program objectives;
- Aligning the measures and establishing a common format for reporting;
- Testing the common "measures" and "reporting format" to see if they can be implemented in an EHR system;
- Piloting the measures in an actual clinical environment once system testing is completed to provide real world results and feedback in a selected and controlled environment; and
- Evaluating results of pilot testing to determine that the results meet the original program objectives.

ACP stresses that alignment efforts must begin immediately, or physicians will have a definite incentive not to report under the PQRS program via the EHR-based reporting mechanism, resulting in a significant chilling effect on the progression of the PQRS program toward the more accurate and efficient EHR reporting.

In a further effort to align the PQRS and meaningful use programs, CMS proposes that physicians specializing in internal medicine, family medicine, general practice, and cardiology report: (i) all PQRS core measures (in the proposed rule); and (ii) report each measure for at least 80 percent of the physician's Medicare Part B fee-for-service patients for whom services were furnished during the reporting period to which the measure applies. Since not all of the proposed PQRS core measures will apply to all of these specialties, CMS proposes to allow the reporting of these proposed PQRS core measures with a zero percent performance rate. ***Although ACP favors meaningful use reporting, we support allowing reporting the zero-percent performances for these measures. It is equitable for these***

physicians to get credit if they are making an effort to meet the program reporting requirements, but barred from the current criteria for success when certain measures do not apply to their practice.

Maintenance of Certification Incentive and PQRS

The rule attempts a clarification of the requirement for participation under the Maintenance of Certification/Physician Quality Reporting System incentive program. Specifically, CMS proposes that in order to earn an additional 0.5 percent incentive for 2012 through 2014, a physician must participate more frequently than is required in at least one of the four parts of the Maintenance of Certification (MOC) Program, and must complete a practice assessment and improvement activity. CMS proposes to allow the specific Board certification requirements to decide whether a professional has completed one of the elements of a program "more frequently than is required." Rather than being required to meet all the MOC program elements as stated in the 2011 rule, the proposed rule for 2012 states that the physician would need to satisfy the practice assessment and participate in one additional MOC program element to qualify for the 0.5 percent additional PQRS incentive. ***ACP agrees with this proposal to take a more reasonable interpretation of "more frequently than is required."***

Electronic Prescribing

Definition of a Qualified System

CMS proposes a revised definition of a qualified electronic prescribing (E-Rx) system that includes Certified EHR technology: "A qualified electronic prescribing system, which we further propose to define as either a system with functionalities identified in the electronic prescribing measure specifications, *or* Certified EHR Technology as defined at 42 CFR 495.4 and 45 CFR 170.102. This proposal is consistent with our June 1, 2011 proposed rule for the 2012 E-Rx Incentive Program." ***ACP thanks CMS for revising and clarifying this language and aligning the system requirements for the E-Rx and Meaningful Use programs.***

E-Rx Group Practice Reporting Option (GPRO) Incentive Eligibility

CMS seeks to simplify the reporting criteria for group practices using the E-Rx GPRO, and proposes that for the 2012 and 2013 incentive payments and 2013 and 2014 payment adjustments, a group practice using the E-Rx GPRO must successfully report the electronic prescribing measure's numerator for at least 625 unique visits (for group practices comprised of 25-99 eligible professionals) or 2,500 unique visits (for group practices comprised of 100 or more eligible professionals. The College supports this effort at simplification.

2013 and 2014 Electronic Prescribing Penalty Programs

CMS proposes criteria for applying penalties in 2013 and 2014 for physicians and group practices who are eligible for E-Rx incentives but choose not to participate or do not successfully participate in the E-Rx program. The law that established the Medicare E-Rx incentive program, the "Medicare Improvements for Patients and Providers Act of 2008" (MIPPA) (P.L. 110-275), requires a penalty phase for eligible physicians who do not e-

prescribe during 2012 through 2014. According to MIPPA, physicians who are eligible but choose not to participate in the 2013 or 2014 Medicare E-Rx incentive program and do not qualify for a hardship exemption would be subject to penalties (one and a half percent payment reduction based on the 2013 Medicare fee schedule amounts during the year and two percent payment reduction in 2014). MIPPA also provides the Secretary of HHS with the authority to exempt physicians from penalties for hardship reasons.

CMS proposes that Physicians can avoid an E-Rx penalty in 2013 if they successfully participate in the 2011 E-Rx incentive program or e-prescribe and report at least 10 e-prescriptions during the first six months of calendar year 2012. To avoid the 2014 E-Rx penalties, physicians would have to successfully participate in the 2012 E-Rx incentive program or e-prescribe and report at least 10 e-prescriptions during the first six months of calendar year 2013. ***While ACP appreciates the additional six-month reporting periods to avoid the E-Rx penalty, we continue to adamantly object to levying financial penalties in 2013 and 2014 based on physicians' performance during 2012 and 2013, respectively.***

The law states that the penalty would apply "with respect to covered professional services furnished by an EP during 2012, 2013, or 2014." Congress clearly intended to provide CMS as much flexibility as possible to come up with a penalty program that is fair and reasonable. ***We strongly recommend that CMS revise the 2013 and 2014 penalty criteria by specifying the activity reporting periods for the same year that the penalty is applied.*** For example, physicians should be able to report 10 e-prescriptions during the first six months of 2013 to avoid the 2013 E-Rx penalty and report 10 e-prescriptions during the first six months of 2014 to avoid the 2014 E-Rx penalty. In addition, since CMS pays out E-Rx incentives following the conclusion of the reporting period, penalties should only be imposed after and not before the conclusion of the E-Rx penalty reporting period. In other words, a physician who does not successfully e-prescribe in 2013 and does not apply for an exemption should not be financially penalized until 2014.

The application of the E-Rx penalty is the first of several penalty programs (e.g., meaningful use of EHRs and PQRS programs include penalties), so this approach of back dating the reporting periods to the year prior to the penalty year will become even more confusing for physicians who may be subject to multiple, overlapping penalties. Multiple adjustments would have to be made to their claims payments and cost-sharing amounts would be fraught with errors causing confusion to physicians and their patients.

CMS proposes to allow several reporting mechanisms to report E-Rx activity in order to avoid a penalty; this is an expansion from the previous claims only limitation physicians may report HCPCS code G8553: (1) to CMS on their Medicare Part B claims; (2) to a qualified registry; or (3) to CMS via a qualified EHR product to avoid penalties. Physicians must select one mechanism and cannot report the E-Rx measure by using more than one reporting mechanism. ***ACP supports the CMS proposal to allow multiple mechanisms to report the E-Rx measure for the penalty program.*** It will be important to educate physicians on the different reporting periods associated with the use of a qualified registry or EHR.

The proposed rule states that physicians have only to report the E-Rx measure, G8553, 10 times during the specified six-month reporting periods (January 1, 2012 through June 30, 2012 to avoid the 2013 penalty and January 1, 2013 through June 30, 2013 to avoid the 2014 penalty), and that the 10 e-prescriptions do not need to be tied to a patient visit/service in order to be reported. ***ACP strongly supports the CMS proposal to only require the reporting of the HCPCS code G8553 at the most 10 times for the generation and transmission of 10 e-prescriptions during the reporting period and not tying the electronic prescription to a particular visit/service, given that physicians do not always e-prescribe on the day of a patient visit/service. We recognize that this change provides an increased capability for eligible professional to avoid the penalty.***

CMS proposes that the 2013 and 2014 penalties would not apply to the following individuals:

- An eligible provider (EP) who is not an MD, DO, podiatrist, nurse practitioner, or physician assistant as of June 30, 2012, for the purposes of the 2013 penalty and June 30, 2013, for the purposes of the 2014 penalty;
- An EP who does not have prescribing privileges and for the purposes of avoiding the 2013 penalty reports HCPCS code G8644, on at least one Medicare Part B claim with dates of service during the six month reporting period (January 1, 2012 through June 30, 2012) and for avoiding the 2014 penalty reports HCPCS code G8644, on at least one Medicare Part B claim with dates of service during the six month reporting period (January 1, 2013 through June 30, 2013);
- An EP's Medicare Part B allowed charges for covered services to which the E-Rx measure applies is less than 10 percent of the total Medicare Part B Physician Fee Schedule allowed charges for all covered services furnished by the EP during the 2013 or 2014 penalty reporting period;
- An EP who does not have at least 100 cases (that is Medicare Part B claims for patient services) containing an encounter code that falls within the E-Rx requirements during the January 1, 2012 through June 30, 2012 reporting period (to avoid the 2013 penalty) and during the January 1, 2013 through June 30, 2013 reporting period (to avoid the 2014 penalty).

ACP supports the above penalty exemptions for 2013 and 2014.

CMS proposes several additional categories for exempting eligible physicians from the E-Rx penalty: (1) physician or group practice in rural area without high-speed internet access; (2) physician or group practice in an area without a sufficient number of available pharmacies for E-Rx; (3) physicians who are unable to e-prescribe because of local, state, or federal law or regulation; and (4) physicians who write fewer than 100 prescriptions during the six month reporting period required to avoid the E-Rx penalty. ***ACP also supports these exemption categories, and recommends that CMS include the following clarification in the final rule:***

- Under the "Inability to electronically prescribe due to local, state, or federal law or regulation" exemption category, CMS should clarify that physicians who are unable to e-prescribe controlled substances because their E-Rx application/software is not yet compliant with the DEA and/or state requirements are eligible to apply for this exemption.

ACP strongly recommends that CMS also add more exemption categories. Specifically CMS should:

- Add an exemption category for physicians who are currently eligible for Social Security benefits or will be eligible for Social Security benefits by 2014. It will be economically burdensome for physicians who intend to retire in the next several years to install and utilize an E-Rx system. We are also concerned that many of these physicians may decide to close their Medicare fee-for-service panels or opt out of Medicare to avoid penalties during the end stage of their clinical careers, which would adversely affect access to care for our nation's elderly and disabled. Physicians who are currently eligible for Social Security retirement benefits or will be eligible for Social Security retirement benefits by 2014 should have the opportunity to apply for an exemption.
- Allow physicians the opportunity to apply for an exemption if they did e-prescribe at least 10 times in accordance with the program requirements but their claim submissions were missing the G8553 code due to administrative or system errors.
- Retain the 2012 exemption category in 2013 and 2014 for physicians who have registered to participate in the Medicare/Medicaid EHR incentive program and have adopted certified EHR technology. Physicians who are registered to participate in the Medicare/Medicaid EHR incentive program should be exempt from the 2013 and 2014 Medicare E-Rx penalties given that the EHR incentive program includes an E-Rx measure.
- Include an exemption category for physicians who were able to e-prescribe 10 times or more during the calendar year of 2012 and 2013 but were unable to issue all of the 10 e-prescriptions during the first six months of 2012 and/or 2013 in order to avoid a penalty.

CMS proposes allowing physicians to apply for an exemption request online during the relevant six month penalty reporting period (e.g., online request for an exemption from the 2013 penalty must be made between January 1, 2012 through June 30, 2012). We support the CMS decision to assess exemption requests on an individual basis, given that physicians have varying practices and must comply with varying state and local requirements. In addition, we support the use of a web-based tool or interface where physicians can log in to request an exemption and provide the reason(s) why a hardship exemption(s) should apply. ***Once CMS has completed its review of the physician's request for an exemption and made a decision, CMS should notify the physician or group practice within two weeks of the CMS decision to accept or reject the exemption request.***

Feedback Report on E-Prescribing Incentive Program and Appeals Process

We urge CMS to provide feedback reports as soon as practicable so that physicians have timely, actionable information on potential problems in their E-Rx reporting. We also recommend that CMS establish an appeals process, similar to what was established for the PQRS program, to allow physicians to appeal decisions that affect their eligibility to take part in the E-Rx program, that affect their ability to earn E-Rx incentives, and that physicians believe erroneously subject them to penalties. An appeals process is especially critical for

individual physicians and group practices whose request for a significant hardship exemption is denied. If CMS finds that it needs additional information from or about the physician to properly assess the physician's particular hardship, then CMS should request said information from or about the physician and not automatically deny the exemption request based on a technicality.

Reporting of Physicians Who Successfully Participate in the EHR Incentive Program
CMS is planning to publicly report the names of physicians who successfully who participate in the EHR Incentive Program on the Physician Compare website. ***ACP urges CMS to take appropriate measures to ensure the accuracy of the list of successful physicians participating in the EHR incentive program and to provide the appropriate disclaimers for the website listing.***

Physician Compare Website
CMS does not propose to ***post the measure performance rates*** of individual physicians in a group. However, the agency does propose to ***post the names*** of the physicians who were associated with the group practice during the reporting period. ACP is concerned that the Physician Compare website is not presenting up-to-date information. The College has received numerous reports of outdated or misleading data on the Physician Compare website. ***Before the agency proceeds with further additions to Physician Compare, ACP urges CMS to implement an efficient way for physicians to correct their online data. The College also recommends that the website's data be updated more frequently than it has been up to this time.***

Electronic Health Record (EHR) Incentive
In the proposed rule, CMS acknowledges that it is not prepared to accept electronic submission of Clinical Quality Measure (CQM) data in 2012; the agency proposes to continue using attestation for 2012.

In addition, CMS proposes a pilot program where participants in the EHR Incentive Program can use the PQRS EHR-based mechanisms to submit their Clinical Quality Measures data. Volunteers could submit their data through their approved EHR vendor or through the direct data submission supported for certain, approved EHR vendors. Volunteers would need to conform to all of the PQRS requirements, including submission of a full year's data. The advantage of this approach for Physicians would be that they would qualify for PQRS while meeting the CQM requirement for the EHR Incentive Program. ***ACP agrees with the proposed action, viewing this as a reasonable approach.***

CMS proposes to use the EHR program measures to move towards the integration of reporting on quality measures under the Physician Quality Reporting System with the reporting requirements of the Medicare EHR Incentive Program, as required by section 1848(m)(7) of the Act ("Integration of Physician Quality Reporting and EHR Reporting"). The rule proposes that participation in the Physician Quality Reporting

System-Medicare EHR Incentive Pilot would require Physicians to submit information on the same CQMs that were adopted for Physicians for the Medicare EHR Incentive Program. ***ACP supports the agency's attempt to better align the EHR and PQRS reporting requirements.***

Improvements to the Physician Feedback Reports

According to the proposed rule, in 2011, CMS plans to implement a number of improvements to the feedback reports: beginning to include the PQRS measures in the physician feedback reports, as part of the value based payment effort; expanding the physician feedback reports to identify "clear and consistent opportunities for improvement," with demonstrative data on how physicians' performance compares to their peers on the same quality measures; and increasing the production and distribution of the PQRS feedback reports in 2011, to 100,000 physicians nationwide. The agency also proposes to look at alternate methods of patient attribution, to more accurately assess the quality of care furnished and the associated resources, to use broader methods than those used in the 2011 program – which attributed patient care based on evaluation and management services and a minimum cost threshold, to separate the data by physician specialty and by the conditions they treat, which should give results that are more reflective of practice patterns, to examine whether to providing reports to groups of physicians who submit Medicare claims under a single tax identification number (TIN) will enable to the agency to provide feedback reports that cover more physicians. ***ACP supports these changes.***

The agency proposes to align the PQRS quality measures with the E-Rx incentive program quality measures. ***ACP supports the alignment, feeling that greater participation would be obtained if the reporting requirements and timeframes were less convoluted.***

Value Based Payment Modifier

CMS proposes to implement a budget-neutral, non-geographically determined, value-based payment modifier, as required by statute. The modifier is designed to "establish a payment modifier that provides for differential payment to a physician or a group of physicians" under the physician fee schedule "based upon the quality of care furnished compared to cost … during a performance period." The Act requires that "such payment modifier be separate from the geographic adjustment factors" established for the physician fee schedule.

ACP encourages the agency to incorporate fixed benchmarks for performance, and to make those transparently available to the public. We also encourage the agency to recognize not only those physicians with the highest performance rating, but also those whose performance has increased most dramatically.

Thank you for considering the ACP comments. Please contact Shari Erickson, Director, Regulatory and Insurer Affairs, by phone at (202) 261-4551 or e-mail at serickson@acponline.org if you have questions and/or need additional information.

Sincerely,

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