



December 23, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: **42 CFR Parts 403, 405, 410, et al.
Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule with Comment Period**

Dear Ms. Tavenner:

On behalf of the American College of Physicians, I am writing to share our comments on the final rule for the Calendar Year (CY) 2015 Medicare Physician Fee Schedule (PFS). ACP is the largest physician medical specialty society, and the second largest physician membership organization, in the United States. ACP members include 141,000 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. The College thanks the Centers for Medicare and Medicaid Services (CMS) for this opportunity to address this final rule with comment period publicly.

ACP appreciates the effort that CMS is making to reform the Medicare Physician Fee Schedule, for the better capture of the wide breadth of care while keeping care quality in consideration. ***However, we continue to urge CMS to step back and review the physician fee schedule as a whole rather than just as individual components. Physicians in all settings, but particularly in small practices, have to digest all of this information, determine which elements apply to them, and then figure out the changes they have to make in their practices to comply with all of the relevant components.*** This is on top of all the other constantly changing requirements that CMS and other payers ask of these practices. It is tremendously difficult for physicians to know what exactly to do—and if they determine what to do, then they must find the time to carry it out while still providing high quality care to their patients and managing the other day-to-day activities and business aspects of their practice.

Chronic Care Management (CCM)

In this final rule, CMS continues to emphasize primary care by creating payments for chronic care management (CCM) services—non-face-to-face services to Medicare beneficiaries who have multiple, significant, chronic conditions (two or more)—beginning in 2015. Chronic care management services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management.

The College is appreciative of a number of changes CMS made with regards to this code, including:

- Finalizing the Agency’s plan to provide payment to clinicians for the critically important non-face-to-face work involved in helping patients manage multiple chronic conditions—something the College has been calling on CMS to pay for over a number of years.
- Finalizing the proposal to allow greater flexibility in the supervision of clinical staff providing CCM services. The proposed application of the “incident to” supervision rules were widely supported by the ACP and several other commenters.
- Adopting a CPT code (99490) rather than a G code for the chronic care management services, which is something ACP had asked for and expects will allow for broader adoption of this code by clinicians and payers.
- Making some improvements in the requirements for electronic health records (EHRs) by not requiring a 2014 certified EHR system but rather allowing the use of a 2011 or 2014 certified system.
- Making some moderate improvements to the electronic care plan requirements, and while these did not go as far as ACP would have liked—the details of our concerns are outlined below.

While the College appreciates CMS’ receptiveness to ACP’s recommendations as outlined above, the College still has several concerns about the CCM code, specifically:

- 1. The payment amount for the CCM code of \$42.60, which is well below the Relative Value Scale Update Committee (RUC) recommended value.***

The RUC recommended a work RVU value of 1.0 for CPT code 99490, which would have resulted in a payment rate of nearly \$80. ***While the College recognizes that the payment rate established by CMS may reduce expenditure growth, we remain concerned about whether it will encourage long-term investments in the care management services for patients with multiple chronic conditions.***

- 2. The use of care plans according to the rule may require some practices to invest in additional health information technology (HIT) to ensure that they will have the needed care plan management and communication capabilities.***

This investment in additional HIT could be a significant expense for practices. Further, the care plan requirements as outlined by CMS may result in some clinicians having to both enter and maintain duplicative information in multiple systems, or split what should be a single clinical data repository into multiple disconnected systems. ACP’s specific concerns with the CCM electronic care plan requirements that still have not been addressed in this final rule include:

- Care plan data requirements, as laid out by CMS, are not fully supported by any currently existing EHRs. These include the following:
 - CMS notes that a full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care—and therefore the rule calls for structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology. However, there is no document type or section within existing EHRs that supports the functions needed to manage a care plan. There is a Plan of Care

section, but it does not support the elements that CMS calls for, let alone all of the elements that current care management processes require.

- The clinician must at least electronically capture care plan information—as noted above, current EHRs are not well designed to capture this information; therefore, it is likely that a parallel data capture system will be needed.
- Care plan availability requirements call for practices to make information available on a 24/7 basis to all clinicians and staff within the practice whose time counts towards the time requirement for the practice to bill the CCM code. However, ACP remains concerned that practices using locally hosted EHR systems may be unable to support 24/7 remote access, or they may have to invest in such capabilities if they are available from their vendor.
- Care plan sharing requirements call for practices to be able to share the care plan electronically (other than by fax) with other clinicians involved in the care of their patients. ACP remains concerned that, depending on location, there may be many options available for electronic exchange of clinical information, and a practice cannot be expected to invest in interfaces needed to connect to all communication options used by all external practitioners and providers with whom they must communicate. Additionally, since there are no requirements placed by this rule on external practitioners and providers, and since many of them will not be Eligible Providers in the Meaningful Use program, it is likely that many external clinicians and provider organizations will not have the capability to receive, view, edit, create, or send electronic care plans or care summaries in any form at all. Therefore, again, it is likely that practices will need to invest in supplemental HIT systems that can more effectively and efficiently share the care plan information. Fortunately, CMS is not requiring the use of a specific tool or service (such as an EHR) to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax).

3. *The requirement for patients to pay the \$8 estimated coinsurance amount could potentially hinder beneficiary access and/or make it challenging to reach the 20 minutes required for billing, because beneficiaries may delay care until a face-to-face visit becomes necessary.*

ACP understands that CCM services do not fall into any of the statutory preventive services benefit categories of the Affordable Care Act. The College also understands that CMS does not have the statutory authority that would allow them to waive the applicable coinsurance for CCM services. However, ***ACP urges CMS to continue to explore different options regarding this coinsurance payment to ensure that access to these services is not hindered.***

4. *The participants in the Multi-Payer Advanced Primary Care Demonstration and the Comprehensive Primary Care Initiative could potentially be put at a disadvantage compared to their colleagues that are not participating in these models, but who will be able to bill for the CCM code.*

ACP understands that duplicative payments would be inappropriate and respects that CMS acknowledges there may be appropriate opportunities for clinicians participating in the demonstration models to use the chronic care management code, even though this may be a limited number. However, ACP does not agree that the services provided in CMS Innovation Center projects are necessarily duplicative of those provided under the CCM code. Additionally, ACP is concerned that this exclusion may be discouraging to those participating in the Innovation Center models, particularly as these models do still involve a strong fee-for-service payment component. ***Therefore, the College continues to recommend that CMS carefully analyze this policy decision to determine if the Multi-Payer Advanced Primary Care Demonstration and the Comprehensive Primary Care Initiative***

participants are put at a disadvantage compared to their colleagues that are not participating in these models, but who will be able to bill for the CCM code (i.e., will those nonparticipating practices be able to obtain a higher reimbursement overall by billing the CCM code than their colleagues engaged in the Innovation Center alternative payment model programs, particularly when the Innovation Center participants are required to meet significantly higher practice standards).

Resource-Based Practice Expense (PE) Relative Value Units (RVUs) Relevant to Site of Service

In line with the ACP's high value care initiative, the College supports delivery of care in the most efficient setting, while maintaining quality of care. Therefore, we are appreciative of CMS' efforts to begin collecting data using an additional Healthcare Common Procedure Coding System (HCPCS) modifier and Place of Service (POS) code as finalized in this rule. We agree that these data can serve as an important tool in furthering the analysis of outpatient services furnished off of the hospital's main campus and off of any of the hospital's other campuses. ***However, ACP recommends that CMS work closely with the College and other stakeholders to evaluate the data collected on services furnished in an off-campus provider-based department (PBD) prior to proposing any policy changes to ensure that patient access to cost-effective, clinically effective, quality care in an appropriate setting is preserved.***

Complex Advance Care Planning Services

The College is disappointed with the Agency's decision not to cover complex advance care planning services in 2015. Specifically, CMS states that "For CY 2015, we are assigning a PFS status indicator of "1" (Not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services) to CPT codes 99497 and 99498 for CY 2015. However, we will consider whether to pay for CPT codes 99497 and 99498 after we have had the opportunity to go through notice and comment rulemaking."

ACP strongly urges CMS to make complex advance care planning a covered medical service and provide adequate reimbursement to physicians and other clinicians for these consultations (using the RUC recommend RVUs for CPT codes 99497 and 99498) due to the significant amount of time and documentation involved in developing an end of life care plan. Although a significant body of evidence exists that shows that advance planning consultations will significantly improve care at the end of life, a 2013 U.S. survey of nearly 2,100 adults showed that while 90 percent believed having family conversations about wishes at the end of life is important, less than 30 percent had done so (The Conversation Project, 2013). This reluctance sometimes originates from patient belief that clinicians should initiate the conversation. Thus, removing an opportunity for physicians to have advance care planning discussions by withholding reimbursement presents a real barrier for patients who may be fearful of discussing the topic. In fact, a recent Institute of Medicine report on *Dying in America* recommended support for the time required to have advance care planning conversations between physicians, patients and families, stating time constraints presented a significant barrier to effective clinician-patient communication. Providing Medicare coverage for the physician time required to support patients and families in their end-of-life choices eliminates a barrier to these much-needed discussions.

Potentially Misvalued Services under the Physician Fee Schedule—Obesity Behavioral Group Counseling

CMS finalized the work RVU of 0.25 and the work time of 10 minutes to a single new G-code for group obesity counseling, G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes). The Agency noted that it is reasonable to create a single code for group obesity counseling and crosswalk the work RVU and work time from the MNT group code. The individual code for intensive

obesity behavioral therapy and the individual MNT code are valued the same, so in the absence of evidence that group composition is different, CMS believes it makes sense to use the same values.

ACP appreciates CMS' consideration of comments on the proposed group obesity counseling coding and supports the Agency's decision to revise policy to create only one code (G0473) for group counseling (2-10), valued at 30 minutes.

Improving the Valuation and Coding of the Surgical Global Package

CMS finalized its proposal to retain global bundles for surgical services, but the Agency will refine bundles by transforming over several years all 10- and 90-day global codes to 0-day global codes. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. CMS will make this transition for current 10-day global codes in CY 2017 and for the current 90-day global codes in CY 2018, pending the availability of data on which to base updated values for the global codes.

ACP appreciates that CMS finalized its proposal to transition 10- and 90-day global codes to 0-day codes. The College would like to work with CMS and other stakeholders to map out a process for implementation of this transition. ***ACP recommends that CMS work collaboratively with the RUC to explore the appropriate group practice data and CMS data to validate the actual number of post-operative visits. CMS, along with the RUC, should consider reviewing the Medicare Part A claims data to determine the length of stay of surgical services performed in the hospital facility setting.*** Matching the average length of stay with the post-operative visits in the physician time file would provide the opportunity to identify anomalies within the data set that could be further reviewed. The RUC, working along with CMS, could review post-operative visit length of stay data for outliers.

ACP recognizes that the codes with very low and negative intra-service work per unit of time (IWPUTs) would have to be surveyed as directed by CMS instruction to the RUC that this be performed. [Rasch](#) pairings¹ would be an acceptable methodology for surveying large numbers of codes in a family, perhaps supplemented by a standard survey of several "anchor" codes, to establish the work RVUs.

Overall, ACP believes that this policy was finalized in an appropriate manner that is consistent with the CMS rulemaking process that included a proposed rule with an adequate comment period. The College understands that some have expressed concern about the policy changes, and ACP would like to reiterate the College's commitment to working with CMS and all stakeholders to ensure that patient access to quality care is not impacted and undue burdens on physicians and CMS are avoided.

Valuing New, Revised, and Potentially Misvalued Codes

CMS finalized that beginning with the PFS proposed rule for CY 2016, CMS will include the proposed values for all new, revised and potentially misvalued codes for which CMS has complete RUC recommendations by February 10 of the preceding year (this is a change from January 10). For RUC recommendations received after February 10, CMS will delay revaluing the code for one year and include proposed values in the following year's rule.

For a revised or misvalued CPT code received after February 10, CMS will create a G code for the next year to describe the predecessor code—since it will no longer be listed in the CPT manual—and pay at the old rate until it is revalued. For wholly new CPT codes received after February 10 for which CMS

¹ Additional information available at: <http://www.rasch.org/florin.htm>

decides it is in the best interest to establish values for the following year on an interim final basis, CMS would contractor price (individual Medicare Administrative Contractors set their own reimbursement value) the code for the initial year.

CMS is delaying the complete implementation of this process so that those who have requested new codes and modifications in existing codes with the expectation that they would be valued under the PFS for CY 2016 will not be negatively affected by the timing of this change. CMS will use CY 2016 as a transition year, for the CY 2016 proposed rule CMS will include values for new, revised, and misvalued codes for which they receive the RUC recommendations in time for inclusion in CY 2016 proposed rule, February 10, 2015. For those codes received after February 10, 2015, CMS anticipates establishing interim final values for them for CY 2016, consistent with the current process. Beginning with valuations for CY 2017, the new process will be applicable to all codes.

ACP applauds CMS for their policy changes to provide additional transparency and comment opportunity in the valuation of physician and other healthcare professional services. The College appreciates the Agency's decision to push back the deadline for the submission of RUC recommendations to February 10 for inclusion in the following year's Medicare Physician Fee Schedule. However, ACP notes that February 10 still imposes a tight timeline for finalizing recommendations following the RUC meeting in late January. ACP also had called on CMS to delay implementation of this new approach until CY 2017 and therefore is pleased that the Agency chose a phased approach rather than full implementation in CY 2016, as was originally proposed.

Additionally, ACP appreciates CMS' decision to not finalize a proposal that would have eliminated the Multi-Specialty Refinement Panel process currently used to consider comments on interim relative values. ACP expressed concerns with CMS' proposal to eliminate the panel and solely rely on agency staff to determine if the comment is persuasive in modifying a proposed rule. ACP physician members have historically served in an advisory capacity on this panel, and retaining it is important in providing an independent and unbiased primary care provider voice to the process.

Medicare Telehealth Services

CMS finalized four services which will be eligible for telehealth payment. These services are:

- Medicare's annual wellness visit (coded with HCPCS G0438 and G0439)
- Prolonged evaluation and management services (reported with CPT codes 99354 and 99355)
- Family psychotherapy (CPT codes 90846 and 90847)
- Psychoanalysis (CPT code 90845)

ACP supports the expanded use of telehealth services as an important element in comprehensive patient care and urges CMS to continue exploring options to expand access to health care services for beneficiaries in rural and underserved areas.

Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models

CMS finalized a proposal to use its authority under the Innovation Center legislation and regulations to obtain access to identifiable data from patients, physicians and other health professionals, and suppliers that are participating in an Innovation Center program. Both public and private sector participants are subject to this. According to the rule, identification of data at the individual level is necessary for a variety of purposes including the construction of control groups and to effectively evaluate such factors as patient outcomes, clinical quality, adverse effects, access, utilization, patient and clinician satisfaction, sustainability, and total cost of care.

ACP supports the need for the Innovation Center and its contractors to obtain sufficient data, both in patient identifiable and de-identified form, to allow for vigorous evaluation of the models being tested. The College emphasizes that these evaluations should consider such factors as outcomes, clinical quality, adverse effects, access, utilization, patient and provider satisfaction, sustainability, potential for the model to be applied on a broader scale, and total cost of care. ACP is assured by the rule that any data collection by the Innovation Center or its contractors will be covered by relevant federal law (e.g. HIPAA) and appreciates that the data collection requests will take into consideration the burden and cost associated with collecting and reporting such data, including the complexities associated with abstracting data from electronic health records.

Reports of Payments or Other Transfers of Value to Covered Recipients (Changes to the Open Payments Program)

The final rule implements a significant change to the Open Payments program, which requires the public reporting of specified transfers of value or ownership interests involving applicable healthcare industries (e.g., pharmaceutical and durable medical equipment companies) and covered physicians and teaching hospitals. The change addresses industry-subsidized continuing medical education (CME) events and affects both the CME event speakers and attendees.

Under the current regulations, neither speaker payment nor subsidized tuition fees linked to applicable industry are reportable if the event meets the accreditation or certification requirements and standards for continuing education for one of five specific organizations. Under the new final rule, industry-linked speaker payment or subsidized tuition fees for CME events are not reportable only if one of the following criteria is met:

- Where applicable industry is “unaware” of, that is, “does not know,” the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year; or,
- Where applicable industry provides funding to support a continuing education event but does not require, instruct, direct, or otherwise cause the CME provider to provide the payment or other transfer or value in whole or in part to a covered recipient—a “no strings attached” funding.

CMS stated that this change was made for several reasons including to remove the appearance of CMS endorsing specific CME accreditation/certification entities, to reduce regulatory redundancy, and to increase consistency and clarity in reporting. In order to provide time for applicable industry to develop processes to meet this change in reporting requirements, it will not be implemented until January 1, 2016.

ACP is concerned about the finalized changes to the Open Payments program regarding the reporting of transfers of value for payment to speakers and subsidized tuition for attendees at continuing education (CE) events. The original regulation, which was removed by this final rule and which essentially made transfers of value provided by third party accredited and certified CE entities excluded from public reporting, was very clear cut and consistent with CMS’ recognition in both the proposed and final rules that the “industry support for accredited or certified continuing education is a unique relationship.” We continue to support this original exception. The College believes that the remaining exception “where the applicable manufacturer is ‘unaware’ of, that is, ‘does not know,’ the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year” is of little or no value—speakers and attendees will not be able to prospectively know whether a CE event transfer will be reported prior to speaking or attending. The second maintained reporting exception—“where an applicable manufacturer or applicable GPO

provides funding to support a continuing education event but does not require, instruct, direct, or otherwise cause the continuing education event provider to provide the payment or other transfer or value in whole or in part to a covered recipient”—is at least clear and is preferable. **Additionally, ACP strongly supports the decision to delay implementation of this significant change in reporting requirements until January 2016.**

Further ACP strongly encourages CMS to:

- Include all relevant stakeholders in the process of developing the promised sub-regulatory guidance regarding tuition fees provided to physician attendees and further recommends that this process be expanded to provide further guidance to CE providers regarding their decision about whether speaker fees are reportable and how this information should be communicated to potential speakers; and,
- Change from optional to mandatory, the indicating by applicable industry of whether a transfer of value involved an accredited or certified continuing education under CE situations that are reportable.

Medicare Shared Savings Program (MSSP)

In its final rule, CMS outlines several changes to the Medicare Shared Savings Program, including:

- Modifying the quality scoring system to recognize and reward Accountable Care Organizations (ACOs) that make year-to-year improvements in quality performance scores on individual measures, in addition to the current strategy of rewarding quality points based upon meeting absolute performance thresholds. **The College has been a supporter of this change and further appreciates CMS increasing the number of potential quality points (from 2-4 points) obtainable from year-to-year improvement.**
- Modifying the rate in which benchmarks are reset from 1 to 2 years. **ACP supports this as a method of promoting more stable quality improvement targets.**
- Modifying the quality measures to reflect up-to-date clinical guidelines and practices, reduce duplicative measures, increase the use of claims-based outcome measures, and reduce overall reporting burden.
- Each new measure will be “pay-for-reporting” for its first two reporting periods in use, rather than pay for performance for the ACO. **ACP appreciates CMS’ decision to make each new measure “pay-for-reporting” for its first two reporting periods in use.** This is an appropriate strategy in that it helps to ensure that ACOs have adequate time to phase in their own care processes and infrastructure before they are held accountable for performance and that CMS has adequate data to set benchmarks for new measures before they transition to pay for performance.

Overall, the finalized changes support CMS’ attempt to align requirements for ACOs with the Meaningful Use, PQRS and the Value-Based Payment Modifier programs, which is consistent with ACP’s push to better align quality initiatives and reporting systems to ease the reporting burden on physician practices.

Additionally, the College, while recognizing that this issue was not specifically addressed in the final rule, is pleased to see that CMS has issued a proposed rulemaking that includes modifications to the MSSP attribution methodology to address concerns with “ACO exclusivity” from non-primary care specialty physicians.

Physician Compare Website

In the final rule, CMS continues its phased in approach to developing the Physician Compare website to include information on physicians and eligible professionals (EPs) enrolled in the Medicare program. CMS finalized that it will continue to report satisfactory individual and Group Practice Reporting Option (GPRO) PQRS reporters, satisfactory reporters on the clinically relevant measures that are part of the Million Hearts initiative, and those that earned the 2014 PQRS Maintenance of Certification Incentive on the website. In general, no measures that are new to PQRS (in their first year of use) will be publicly reported on Physician Compare.

For individual EPs, CMS finalized that it will publicly report all 2015 measures collected through a registry, EHR, or claims. For groups, CMS finalized the reporting of all 2015 PQRS measures via all reporting options for group practices of 2 or more EPs participating in PQRS GPRO, and all 2015 measures reported by ACOs (with the ACO measures being reported on Physician Compare in the same way as for group practices). CMS further stated that all group practices and ACOs will be given a 30-day preview period of their measures prior to publication on the website. Group practices and EPs will be informed via email when this preview period will take place and will be provided with a detailed timeline and instructions for this preview.

CMS finalized that it will include all measures in a downloadable file, while still limiting the measures available on the website profile pages to those that fully meet the public reporting requirements of validity, reliability, accuracy, comparability, and ease of understanding by consumers. CMS noted its plan to continue to conduct consumer testing for both usability of the Physician Compare website and understanding of the measures that are publicly reported.

The College supports the overall goals of the Physician Compare Website and supports efforts to improve transparency in the health care system. ACP supports and continues to encourage CMS to engage in increased efforts to determine and employ the most effective means of presenting performance information to patients/consumers and to educate these information users on the meaning of performance differences among clinicians, and on how to use this information effectively in making informed healthcare choices. ***Therefore, ACP is supportive of the Agency's policy to make all measures be available for download and to only include a select group of measures on the webpage.***

Additionally, ACP appreciates the 30-day preview period prior to publication of quality data on Physician Compare so EPs, groups, and ACOs can review their data prior to public reporting, and the College encourages the Agency to consider extending the preview period if physician access issues to the data occur. It is essential that physicians have sufficient time and access to review data prior to public reporting as Physician Compare reporting measures continue to expand and have ample opportunity to appeal inaccuracies should they occur. CMS should also provide physicians and stakeholders with educational feedback periodically and ensure that any data collected is not used against physicians in health plan credentialing, licensure, or certification. ***In addition, the College urges CMS to engage in significant outreach prior to publicly reporting data to ensure that physicians are able to have sufficient time to review, validate, and appeal their data.***

CMS did not finalize its proposal to create composites using 2015 data and then publishing those composite scores in 2016; however, the Agency noted that they will consider proposing these composites again in future rulemaking. CMS also did not finalize its proposal to publicly report benchmarks for 2015 PQRS GPRO on Physician Compare in 2016. The agency noted the need to more thoroughly discuss potential benchmarking methodologies with key stakeholders, and to evaluate other programs' methodologies (such as the Value Modifier) before moving forward. Additionally, CMS did not

finalize its proposal to include specialty measures on Physician Compare but stated that the Agency may consider addressing them in future rulemaking.

ACP would be supportive of CMS calculating composite scores for measures as they often are easier for consumers to understand and give a broader picture of clinical quality. The College encourages CMS to be transparent on the methodology used to calculate these scores and ensure that scores are accurately and appropriately risk adjusted. Additionally, if CMS decides to include specialty society measures on physician compare, ACP encourages CMS to ensure that the measures have a strong evidence base, are vetted externally, and include a description of how the measure differs from PQRS measures.

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

In the final rule, CMS continued the reporting mechanisms that were in place in 2014 for 2015 reporting. However, for groups of 100 or more EPs that register to participate in the PQRS GPRO, reporting of CAHPS for PQRS is now required and, for groups of 2-99 EPs, reporting of CAHPS for PQRS is optional. For all EPs and groups that are reporting individual measures via all mechanisms in 2015, CMS finalized that they are required to report on at least 9 measures, covering 3 National Quality Strategy (NQS) domains—this is generally aligned with the approach CMS took in 2014. CMS also finalized a new requirement for individual EP claims and registry-based reporting: if an EP sees at least one Medicare patient in a face-to-face encounter, then he/she is required to report on at least one cross-cutting measure from a designated set of these measures. For reporting of measure groups via registry for 2015, CMS largely finalized the same requirements from 2014.

ACP supports the use of structure, process, and outcomes measures in programs and is encouraged by their inclusion in the PQRS program. ACP also supports measuring patient care experiences. However, since the cost to administer the survey will be at the practice's expense, ACP is concerned that CMS is requiring this for practices of 100 or more. The College also is concerned that if this requirement is expanded to smaller practices in future rulemaking, it would have a significant financial impact that those practices may not be able to bear.

Additionally, the College appreciates CMS exploring ways to provide more timely feedback to physicians and would be supportive of giving physicians and practices the option to report more frequently throughout the reporting year. Allowing practices the option to report more often would be beneficial especially for those practices working on quality improvement and are experienced with the reporting requirements. If CMS includes this policy in future rulemaking, ACP would not support making more frequent reporting mandatory as many practices are still new to the reporting requirements.

Further, ACP appreciates CMS' focus on aligning requirements with other quality reporting programs, such as Medicare EHR Incentive Program, Physician Value-Based Payment Modifier, and the Medicare Shared Savings Program. ***However, the College remains concerned that the measures and reporting periods within the PQRS program continue to be unaligned with maintenance of certification (MOC) requirements. The College has long supported quality improvement, both through quality measurement and reporting. The College continues to encourage CMS to improve alignment among quality improvement programs and reporting systems to decrease burden on physician practices.***

In terms of the specific measures to be used for PQRS reporting in 2015, CMS made several NQS domain category changes to the existing measures, added 20 new individual measures and two measure groups

to fill existing measure gaps, and removed 50 measures from reporting for the PQRS. These changes bring the total number of PQRS individual measures to 255.

ACP supports CMS' decision to remove measures with or near 100 percent adherence, duplicative measures, and measures that no longer reflect current guidelines.

Value-Based Payment Modifier and Physician Feedback Program

As is required by statute, in the 2015 final rule, CMS stated that it will begin to apply the Value-Based Payment Modifier in calendar year (CY) 2017 (based on CY 2015 reporting data) to all physicians—including those in solo practice and in groups of 2 or more EPs—as well as to all non-physician EPs in CY 2018. CMS also finalized that, beginning with the CY 2017 payment adjustment period, the Value Modifier will apply to all physicians and non-physician EPs that participate in ACOs under the Medicare Shared Savings Program, the Pioneer ACO Model, and the Comprehensive Primary Care Initiative, or other similar Innovation Center models or CMS initiatives.

ACP supports transitioning our health care system to a value-based payment approach, rather than a volume-based payment system. The College believes that a new value-based system should facilitate coordinated, comprehensive, longitudinal care provided by physicians working in collaboration with other health care professionals. ACP recognizes that CMS is required by law to apply the value modifier to all physicians in 2017. ***However, due to continuing low participation rates in PQRS among physicians and non-physician EPs, ACP strongly recommends that CMS engage in outreach to all practices to encourage them to participate in the PQRS program and work to increase PQRS participation rates.*** ACP encourages CMS to continue engaging with specialty societies in education outreach but also explore new opportunities such as working with the local Medicare Administrative Contractors (MACs) to ensure that those new to the program are aware of the requirements and penalties. In addition, CMS needs to ensure that practices, especially solo and groups with 2-9 EPs are:

- Aware of the value based payment program;
- Aware of the alignment of the value based payment program with PQRS reporting;
- Able to understand what the value based payment program involves and how it will impact them; and,
- Able to provide meaningful feedback to CMS throughout the implementation of the value-based payment program.

CMS continues to use a two-category approach for the CY 2017 Value Modifier based on successful participation in PQRS. Category 1 includes groups that meet the criteria for satisfactory reporting of data on PQRS during 2015 via GPRO and groups that have at least 50% of their EPs meet the criteria for satisfactory reporting of data on PQRS as individual reporters, or in lieu of satisfactory reporting, participate in a PQRS qualified clinical data registry (QCDR). Category 1 also now includes solo clinicians that meet the criteria for satisfactory reporting or, in lieu of satisfactory reporting, participate in a PQRS QCDR. Category 2 includes all other groups or solo clinicians.

The College appreciates the option to allow group practices to satisfy the value-based payment modifier program requirement by having 50% of the group's EPs report PQRS as individuals. This will be especially helpful to smaller groups that do not have the experience with or have not used the group reporting option for PQRS in the past. This approach continues CMS' goal of increasing quality reporting and does not apply restrictions on how a group must report, allowing groups to choose an option that best fits their practice.

CMS finalized the amount of payment at risk in CY 2017 based on successful 2015 PQRS participation. Groups of 10 or more EPs that do not meet the reporting requirements for PQRS in 2015 (i.e., that fall into Category 2) will be subject to a downward adjustment of -4.0 percent in CY 2017. Solo physicians and groups of 2-9 EPs that do not meet the reporting requirements for PQRS in 2015 will be subject to a downward adjustment of -2.0 percent in CY 2017, rather than the proposed -4.0 percent penalty. These adjustments are in addition to the -2.0 percent penalty from failing to satisfactorily report under the PQRS program.

For all solo physicians and groups that fall into Category 1, CMS finalized that they are subject to quality-tiering to determine their CY 2017 Value Modifier payment adjustment (based on their CY 2015 data). As it is their first year in the program, solo EPs and groups with 2-9 EPs will be held harmless from any downward adjustments and are only subject to either neutral or upwards payment adjustments based on where they fall within the quality tiers. However, groups of 10 or more EPs will be subject to upward, neutral, or downward payment adjustments determined under the quality-tiering methodology.

While the College does not support the increase in payment at risk from 2.0 percent to 4.0 percent, ACP appreciates CMS's decision to reduce the maximum downward adjustment to -2.0 percent for groups of 2-9 and solo EPs who do not meet reporting requirements for PQRS in 2015 and hold harmless from any downward adjustment those solo and small group EPs who do meet the PQRS requirements. Physicians and eligible professionals are facing a large amount of penalties in the future (an upwards of 9% in 2017 based on PQRS, Value Modifier, and Meaningful Use requirements), and many EPs will be new to the PQRS program and the Value Modifier program. In addition, due to the changes every year in the requirements for these programs many physicians—especially those in solo and small group practices—find it challenging to keep up and ensure they are doing the necessary work to meet the new requirements. As CMS notes, the law does not specify the amount of payment that should be subject to the adjustment. Since CMS and physicians lack any experience with the program, as 2015 will be the first year that the Value Modifier is applied to physician groups, ACP encourages CMS to fully implement and evaluate the program before increasing the potential penalties in future years.

For CY 2017, the Value Modifier quality composite score will be based on PQRS quality measures that are reported via all available PQRS reporting mechanisms, plus three additional claims-based measures that CMS will calculate. Additionally, groups of 2 or more EPs can elect to have the patient experience of care measures collected through the CAHPS for PQRS survey in CY 2015 included in their quality of care composite for the CY 2017 payment adjustment. The CY 2017 cost composite will be calculated using the same cost measures that were finalized in the 2014 final rule—five total per capita cost measures and the Medicare Spending for Beneficiary (MSPB) measure.

ACP appreciates the alignment between the PQRS and Value Modifier program. In addition, ACP encourages CMS to explore appropriate ways to adjust quality and cost scores for socioeconomic status and location of care to ensure accurate physician-to-physician comparison groups.

Informal Inquiry Process and Physician Feedback Program

CMS stated that it will expand the informal inquiry process starting with the CY 2015 payment adjustment period to allow solo and group EPs a brief window to request a correction of a perceived error prior to application of the Value Modifier payment adjustment. The Agency disseminates this information through the Quality and Resource Use Reports (QRURs) to all solo and group EPs. These QRURs contain performance information on the quality and cost measures used to calculate the quality and cost composites of the Value Modifier for CY 2015 payment adjustments (however, the 2015 payment adjustments are only applicable for physicians in groups of 100 or more EPs). For the CY 2015

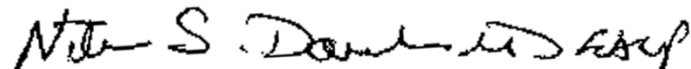
payment adjustment period (based off of CY 2013 data), CMS made the QRURs available on September 30, 2014. The final rule extends the deadline to request a correction on these QRURs from January 31 to February 28, 2015. Beginning with the CY 2016 payment adjustment period, CMS will allow 60 days after the release of the QRURs for group or solo EPs to request a correction.

ACP appreciates CMS developing this informal review process to allow physicians a clear avenue to address issues found within the Value Modifier program. However, the College remains concerned with the short response window of 60 days after the QRURs are disseminated, as finalized for 2016 and beyond—it is simply not enough time for physicians and their practices to become aware of the report being available, download the report, and review for accuracy. Anecdotally, download rates of the QRUR reports continue to be low; therefore, ACP strongly encourages CMS to expand this time frame. This will allow CMS to adequately address all issues before applying the VM and therefore avoid having to re-process claims during the year which the modifier is applied.

The College urges CMS to engage in significant outreach to physicians, group practices, specialty societies, etc. when the reports are available for downloading. Working closely with specialty societies and/or state MACs is critical to informing physicians about the content and response options to the reports so that they are better able to review the reports before the response window closes. Furthermore, as CMS explores ways to provide more frequent and timely feedback to physicians on their performance data, ACP encourages CMS to allow physicians and other health care professionals to have access to prior years' performance data at any time so they are able to make comparisons and quality improvement changes in their practices.

Thank you for considering ACP's comments. Please contact Shari M. Erickson, MPH, Vice President, Governmental Affairs and Medical Practice, 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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