August 31, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1413-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: *Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, Proposed Rule*

Dear Ms. Frizzera:

On behalf of the American Medical Group Association (AMGA), thank you for the opportunity to comment on the proposed rule regarding revisions to the payment policies under the Physician Fee Schedule for 2010. AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA counts among its members more than 340 medical groups in 47 states, with nearly 100,000 physicians treating over 90 million patients. Our comments on specific proposals follow.

Equipment Usage Rate Assumption: ***AMGA urges CMS not to change the usage rate assumption in its practice expense relative value unit computations (PE/RVU) for equipment priced over $1 million until a broader sample of data can be analyzed and applied from a statistically significant foundation.*** Based on a Medicare Payment Advisory Council (MedPAC) review of data from six markets around the country, CMS is proposing to change the equipment usage rate assumption in its practice expense relative value unit computations (PE RVU) for equipment priced over $1 million, from 50 percent to 90 percent.

Using data from only six markets is not a statistically valid basis from which to extrapolate and reflect national usage. Basing a decision of such magnitude on limited findings is unreasonable and inaccurate. The consequences of such a change include potentially devastating reductions in reimbursements for the technical component of advanced diagnostic imaging services. In some cases, payment would not cover the costs of providing the services. According to a health law update on the provisions of this proposed rule, prepared by the law firm of Bass, Berry, and

Sims, industry experts predict that the reductions in reimbursement for these services could be as much as 40 percent, which could prove financially devastating for providers and limit access for patients.

AMGA, therefore, urges CMS to withdraw this change until statistically valid data can be obtained, studied and applied.

Elimination of Consultation Codes: ***AMGA suggests that CMS keep consultation codes as written and, instead, make its documentation requirements consistent with those of CPT, and increase educational outreach to spread the word.*** Consultation services are evaluation and management services that are provided by physicians and requested primarily by another physician (or other source, e.g., a second opinion from a patient). CMS's current policy is to reimburse consultation services if such request is documented and includes a written report prepared by the consulting physician. The American Medical Association (AMA) CPT coding manual does not contain this documentation requirement, and there are significant differences in how the process and handling of documentation manifests itself in the "real world" of referrals between physicians. There are further disparities regarding the differences between a consultation and a "transfer of care," the point at which the consultant takes over the care of the patient, thus becoming the treating physician. The "transfer of care" is the nexus between a consultation and continuation of treatment and care. Due in part to the differences between CMS policy and AMA guidance, physicians have been confused about how to document, charge, and comply with Medicare requirements for reimbursement of consultation services for a long time.

Abolishing consultation codes and incorporating their RVU values into office visit evaluation and management codes (E/M) as proposed would be administrative simplification at its best, were it truly "neutral" in its outcome, but it is not. While these changes may be "budget neutral" in the realm of rulemaking, they will have financial consequences to physicians in practice. Depending on the frequency and blending of E/M codes billed (office visits, new and established, hospital vists, consultations, etc.), reimbursement consequences will vary. A physician who infrequently bills consultation codes will experience a bonus when the work RVUs for office visits, etc., increase, and a physician specialist who supplies a large portion of his efforts as consultation services, will see a net decrease in reimbursement. While "budget" neutral and administratively attractive, this "simplification" will financially punish or reward many who deserve neither.

Table 39 of the NPRM shows the impact of all policy changes for 2010 upon the various specialties, including elimination of consultation codes, and can be found on page 33661. Yet, examination of Table 39 shows that the results of redistribution do not leave all specialties "whole", i.e., at a 0 percent net change. While the percentage "spread" of changes is relatively small and most specialties end up with the changes producing no net effective change, it is not universally the case. If CMS eliminates consultation codes as proposed, we suggest it employ an additional, smoothing step in its methodology to achieve an equitable redistribution for all, a 0 percent net change since only this action would make the redistribution of RVU values from consultations codes truly neutral and fair.

We believe there is a better solution than eliminating consultation codes and urge CMS to avoid compounding confusion and the inequities that would result from that action. We suggest that unifying documentation requirements to comport with the CPT definitions, and concomitantly increasing educational efforts to communicate this information, would help eliminate confusion and misapplication of consultation codes and would not produce the resulting unintended bonus reimbursements, or punitive financial reductions.

EHR Reporting Option for the Physician Quality Reporting Initiative (PQRI) Program: ***Given the favorable outcome of testing for the EHR-based reporting mechanism, AMGA encourages CMS to finalize this option as a means of reporting PQRI data in 2010.*** AMGA strongly supports CMS' proposal to accept PQRI data from a qualified EHR system on a subset of measures on common chronic illnesses and preventive services for 2010. We also agree that it is much less burdensome for an eligible professional to report measure #124, which assesses the adoption and use of EHRs through EHR-based reporting, rather than through claims-based reporting. We believe that EHR-based reporting is a viable option for overcoming the limitations associated with claims-based reporting of quality measures and is consistent with CMS's stated goal of lessening reliance on claims-based reporting for the PQRI after 2010.

PQRI Group Practice Reporting Option: ***CMS should reconsider several of the proposed requirements for this reporting option in order to improve the attribution methodology, to be consistent with the intent of Congress to stimulate greater participation in the PQRI program, and to streamline reporting.*** CMS defines a group practice that is eligible for participation in the group practice PQRI program as one that has 200 or more eligible professionals who report under one tax ID number; is willing to provide CMS with the NPI numbers and names of all eligible professionals associated with the tax ID; are willing to have the group practice's PQRI quality measurement performance rates for each measure publicly reported by posting on the CMS website; and have an active Individuals Access to CMS Systems (IACS) user account. In addition, medical groups will need to submit self-nomination letters to CMS and utilize a data collection tool similar to the one being used in the Medicare Care Management Performance Demonstration project and the quality measure and reporting methods used in the Physician Group Practice (PGP) Demonstration. CMS further states that group practices may be familiar with these criteria, because they are the ones used in the PGP Demonstration.

AMGA urges CMS to reexamine its assumption that large medical groups are familiar with the criteria for the PGP Demonstration simply because they are large, multispecialty medical groups. The PGP Demonstration was limited to only ten medical group participants nationwide, thus it is incorrect to assume that the criteria for participation in the PGP Demonstration are broadly well-known. Even reading the program specifications does not translate into operational knowledge and experience with the program.

Requirement for 200 Eligible Professionals

Although we understand that CMS would like to limit the number of groups participating in the PQRI group practice option for 2010, until CMS gains more experience, we recommend reconsideration of the requirement for medical groups to have 200 or more eligible professionals to participate. The 200 provider threshold is arbitrary and unnecessary. Electronic submission capabilities should be the principal criterion for eligibility. This and the other requirements in the

proposed rule will easily achieve the objectives of limiting participation to a manageable number of participants given the limited number of group practices that have the ability to meet the other technical requirements in the rule. This will still allow CMS to gain experience in working with EHR submitted data from a limited number of participants and will also allow highly motivated groups below the 200 threshold to participate.

We also believe that use of this number is not justified by the statutory language establishing the PQRI group practice reporting option. We therefore recommend that instead of requiring a specific number of eligible professionals, CMS should focus on a medical group's capability to report the data electronically in an aggregated manner, and meet all of the other requirements outlined in the proposed rule.

Attribution Methodology

AMGA has learned from member participants in the PGP Demonstration that the retrospective attribution methodology used in the demonstration presented numerous problems for them. For example, patients seen for a medical emergency, such as a diabetic patient arriving in urgent care to be treated for a laceration, can wind up in the sample for a primary care-oriented measure . If the physician is not seeing that patient for treatment of their diabetes, even though the patient may technically fit the clinical picture, this patient should not be attributed to the sample. To ensure that only patients who are actively being treated for disease states are included by any attribution method for purposes of quality reporting, we strongly urge CMS to consider implementation of a prospective attribution methodology.

While we oppose retrospective attribution for the reasons mentioned above, we believe that CMS is likely to move forward with it anyway. This puts us in the difficult situation of suggesting changes to that which we do not support. Nonetheless, we offer these observations for ways to improve the process. Based on the experiences of the PGP Demonstration participants, the following refinements to the methodology would yield a more accurate patient sample at the end of the year: 1) use claims that have the CPT code for "established" patients only, 2) use claims that show the place of service code 11 (the code for office visits), and 3) require that the patients have had at least two office visits during the year in order to get into the sample. These additional refinements to the retrospective attribution methodology would improve the accuracy of the sample group, and the resulting data.

Number of Measures

CMS proposes that medical groups participating in the PQRI group reporting option for 2010 report on 26 National Quality Forum-endorsed measures that target high-cost chronic conditions and preventive care. Reporting on this many measures in the first year will prove challenging for most medical groups who may wish to participate in this option. Indeed, PGP Demonstration participants began reporting on only 10 measures the first year, and gradually ramped up over a three-year period to reporting 32 measures, the number reported in 2008. We urge CMS to scale back the number of measures for the first year, increasing the requirements over time. The current proposal to report on 26 measures the first year will surely serve as a deterrent to groups that otherwise wish to participate in the program and will serve to discourage those who participate and fall short of targets. Twenty-six measures in year one sets the standard too high, and positions the program to discourage participants by design.

E-Prescribing

Until such time that eligible professionals are provided an incentive for using health information technology in a meaningful way, pursuant to the American Recovery and Reinvestment Act of 2009, the PQRI and e-prescribing incentive programs are separate and distinct. Eligible professionals can choose to participate in one program and not the other for all other methods of reporting (claims-based, registry-based, and EHR). Yet for the PQRI group practice reporting option, e-prescribing is a requirement, even though the measure cannot be reported at the group practice level with other PQRI data, and eligible professionals must choose one of the existing methods of reporting.

Some group practices will have difficulty ramping up for participation in both the PQRI group reporting option and the e-prescribing program between now and January 1, 2010. The technical requirements and expense will outweigh the financial incentives in most cases, and will preclude participation. AMGA therefore urges CMS to keep the PQRI and e-prescribing programs separate and distinct for group practices wishing to participate in the PQRI group reporting option, like they are for other eligible professionals.

AMGA would also like to urge CMS to use all avenues at its disposal to encourage the Drug Enforcement Administration to finalize a workable plan for e-prescribing of controlled substances. Such action would stimulate more widespread adoption of the technology, with all of its attendant patient safety benefits. Until such time that the DEA finalizes rules for e-prescribing of controlled substances, there will be reluctance by some in the physician community to adopt this technology due to work flow issues and the need to utilize two processes (electronic and paper) for writing prescriptions.

AMGA also urges CMS to use the authority given it in Section 132(a)(2)(B)(iii) of the Medicare Improvements for Patients and Providers Act of 2008 to utilize Part D claims data to determine if physicians are prescribing a sufficient number of prescriptions electronically. This is an elegant and very efficient approach that would allow CMS to gather needed data without participants in the e-prescribing program having to change work processes to submit data on a per-encounter basis. The broadly phrased statutory text implicitly suggests modification of the claims form to accommodate fields that would capture the necessary data. We urge CMS to move forward with implementation of this provision.

MedPAC Recommendation to Establish a Separate Panel of Experts to Review Relative Value Units: ***AMGA believes the current partnership between CMS and the AMA RUC has been a successful one and that steps are being taken to address the identification of misvalued codes and, therefore, no major change is needed.*** For nearly two decades, the public-private partnership between CMS and the AMA RUC has been effective. Over the years, CMS has accepted about 90 percent of the RUC's recommendations. Although there have been concerns about the identification of codes that are overvalued, there has been recent movement by the RUC to address this issue. CMS has neither the resources nor the expertise to conduct the work of the RUC and carrying on the public-private partnership addresses this need well. However, the appearance of "self-serving" decision-making weighs on the process. While those making the determinations and valuations do have a financial interest in the outcomes, the actual, direct benefit to specialities and individuals is sufficiently diluted to forestall invalidation of the work.

We do, however, believe that the existing process can be improved and strengthened. First, CMS should restate and clarify the role it wishes for the RUC to fulfill, a specific charge to examine fully, within the context of current statutory requirements, existing methods and schedules, all codes to determine correct valuation, to include codes "undervalued," "overvalued" and new procedures. Secondly, the RUC process would benefit from greater openness. The process would benefit from being as open and public as possible, a further means to address the concerns of critics. The internal "survey" process of the RUC is the primary method used to determine physician work, and is a closed process done by the specialty societies. Since CMS accepts almost all RUC recommendations, the results of the surveys are essentially tantamount to changes in RVUs. Since this survey process is entirely internal to the organizations undertaking the survey, the results effectively underlying Medicare RVU work values are shielded from the "light of day" leaving open the door to suspicion about misuse if not abuse of the process. Some audit of its results should be created. These steps will make the successful RUC process more transparent and render the participants more publically accountable for their decisions. These steps, and the reasonable passage of time to allow CMS to evaluate progress, will put the already largely effective RUC process on even more solid footing without the imposition of additional and unnecessary external bureaucracies.

Resource Based Practice Expense (PE) Relative Value Units (RVUs) – Physician Practice Information Survey (PPIS): ***AMGA endorses the use of the PPIS Survey Data.*** CMS proposes to update the practice expense (PE) per hour data in its PE/RVU methodology and to rely on data from the Physician Practice Information Survey (PPIS), rather than the previously used information from the AMA Socioeconomic Monitoring System (SMS) and supplemental survey data provided by some specialty societies. The SMS data is outmoded, and mathematically adjusting 10 year-old data to update it is a weak and flawed approach. AMGA and many others, including the MedPAC, have for some time called for use of the most currently available practice expense data.

AMGA also finds the use of supplemental survey data problematic because it was not universal and was blended with old SMS data for costs not updated by supplemental surveys. Not all specialty societies provided supplemental, more current data. Using a mix of old and "new", i.e., supplemental information, skewed the results and disadvantaged those who did not provide new, supplemental survey information. This is fundamentally unfair.

The PPIS followed SMS formulations and was inclusive of almost all medical specialty information. Use of PPIS survey data by CMS is a strong step in the right direction to update old data and be more broadly based and AMGA supports this action.

Recognition of Multi-Specialty Groups/Organized systems of Care: ***AMGA recommends that CMS recognize large multi-specialty medical groups and other organized systems of care based on certain characteristics, attributes, infrastructural elements, and desired actions in future rulemaking because these entities distinguish themselves by delivering high quality services to patients in the most cost-effective model of care currently available.*** Multi-specialty medical groups and other organized systems of care are the most effective and efficient vehicle to provide the highest quality and most cost effective medical services to Americans. The strongest underpinning of truly integrated delivery systems is the multi-specialty medical group

or other organized system of care. As such, it is becoming a significant national health care reform policy to stimulate formation, foster growth, and support development of organized systems of care.

Typically the capacity to deliver care in an integrated manner comes with a practice size of 25 or more physicians, but we do not believe that size alone should be the only part of the definition, rather, that it should be a demonstration of numerous other factors of advanced practice. Such an organization could be defined as one that provides a coordinated continuum of health care services and is willing to be held clinically accountable for the health status of the community served, and subscribes to the following core values:

- Quality: continuous striving to improve patient care through measuring, reporting, and application of findings using evidence-based clinical and service quality measures and tools such as benchmarking, best practices, and peer review;
- Patient-centered care: timely information sharing by patients and physicians allowing patients to become active participants in their own care and receive services for their individual needs and inconsideration of their preferences;
- Care coordination: supporting collaboration and communication among medical specialties and non-physician care givers;
- Accountability: shared physician responsibility and accountability for patient care;
- Innovation: openness to adoption and adaptation of evolving health care delivery models and modern infrastructure (electronic medical records, patient registries, electronic prescribing);
- Physician self-governance: support of professionalism, physician participation in group governance and independence of clinical decision-making;
- Leadership development: creating a practice environment supportive of and seeking to enhance skills, knowledge and experience of physicians' management and executive abilities.

MedPAC, in its 2007 report to Congress, identified these as "desired activities" and suggested that Congress consider legislation that would incentivize these activities[i].

Attributes of this organizational structure would include:

- A multi-specialty group medical practice or other organized system of care;
- A stable governance structure;
- A centralized administration;
- A quality-driven mission statement.

Going forward, we suggest that CMS foster the growth of this delivery model through regulatory means, when possible. CMS has numerous opportunities to encourage growth of this model and should consider offering exceptions or exemptions to rules when possible to recognize those who fit the profile above in cases when the benefits to the Medicare program are significant.

We thank you for your serious consideration of our comments. Should you have questions or require additional information, please do not hesitate to contact Karen Ferguson, Associate Director, Regulatory Affairs, of my staff, at 703-838-0033x349, or kferguson@amga.org

Sincerely,

Donald W. Fisher, Ph.D.
President and CEO

---

[i] Medicare Payment Advisory Commission, Report to Congress: Assessing Alternatives to the Sustainable Growth Rate System. March 2007.