August 24, 2010

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Payment Policies under the Physician Fee Schedule, CMS-1503-P

Submitted Electronically

Dear Administrator Berwick:

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 2011. 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 370 medical groups in forty-nine states, with nearly 109,000 physicians treating over 100 million patients.

Many of the proposals in this notice of proposed rulemaking implement statutory provisions from the Affordable Care Act of 2010 (ACA). Ongoing concerns about physician reimbursement in the Medicare program have created a climate of uncertainty. Health care providers are burdened by ever-growing administrative requirements, while at the same time they face legitimate concerns about future reimbursements, making it difficult for them to plan activities and investments. Against this backdrop, our comments on specific proposals follow.

Medicare Economic Index (MEI): ***AMGA supports the use of more current data upon which to base the MEI and the proposal to convene a technical panel to review all aspects of the MEI since inputs have not been revised for years, however, CMS should wait until the technical panel has done its review.***

The inputs into the practice of medicine have changed dramatically since the last time they were updated in 1973, as have the requirements for physician offices to remain in business. Federal requirements such as the Health Insurance Portability and Accountability Act and numerous

other compliance-oriented activities, in addition to quality and electronic medical records reporting programs that will in time become mandatory, while representing progress, have dramatically changed the administrative needs surrounding the practice of medicine. AMGA therefore supports a thorough review of all aspects and elements of the MEI, in addition to rebasing it using the most current data from the Physician Practice Information Survey (PPIS) from 2006. The data should nevertheless be adjusted upward to reflect the increases in practice expense during the intervening years in order to account for new administrative requirements to meet the objectives of federal programs, which involves utilizing more health care information technology staff, administrative staff, lawyers, compliance officers, and coding professionals.

AMGA suggests that CMS not make any changes to the MEI, therefore, until after the technical panel has met to consider all inputs into what it takes to operate a medical practice today, before making necessary changes, since physician expenses have grown dramatically compared to the MEI.

Practice Expense Geographic Practice Cost Index (PE GPCI): ***AMGA is concerned that the proxy source data used to estimate non-physician wage costs in the current PE GPCI do not adequately reflect all of the labor categories present in today's physician offices. We urge CMS to update the labor categories used to determine the PE GPCI to reflect the true costs incurred by physician groups in the delivery of health care to Medicare beneficiaries.***

The ACA requires CMS to "evaluate data that fairly and reliably establishes distinctions in the cost of operating a medical practice in different fee schedule areas" to determine the PE GPCI. The current physician employee wage index captures geographic differences in only four labor categories, those most commonly employed in physician groups when the Medicare physician fee schedule was first established: 1) registered nurses, 2) office and administrative support, 3) licensed practical and licensed vocational nurses, and 4) health care technical and medical assistants.

Since the fee schedule was established, however, more labor categories have become essential in the delivery of health care in multi-specialty medical groups, including health care information technology staff, pharmacists, and legal and accounting professionals. The EHR incentive program, for example, essentially mandates greater use of health care information technology staff, while compliance with ever-evolving regulatory guidelines requires legal staff.

AMGA therefore recommends that the employee wage proxies upon which the PE GPCI is based be updated to reflect the additional labor categories, that have become so essential in the delivery of health care in recent years, to more accurately reflect the true costs incurred by physician groups that provide services to Medicare beneficiaries.

Timely Feedback on Satisfactorily Submitting Data on Quality Measures: ***Eligible professionals will benefit from timely feedback reports from CMS on whether they are satisfactorily submitting data on quality measures, and AMGA strongly supports this requirement, however, we believe the timeframe should be revised to a point during the reporting period so that eligible providers can act on the information they receive.***

The ACA provision that requires CMS to provide timely feedback on reporting rates and performance rates could greatly assist eligible professionals in determining whether they are on the right track and will be earning incentives. Providing feedback reports at the same time payments are issued several months later, however, is inadequate and will not provide eligible professionals with the opportunity to learn from what they are doing incorrectly in time to make appropriate modifications during that calendar year if they are not satisfactorily reporting.

The lack of timely feedback has been a source of frustration to eligible professionals in the past and has prevented many from participating in the program. The timing for feedback reports should therefore be at some point during the reporting period in order for the feedback to be actionable. This modification will also serve to increase program participation in the health care provider community.

Group Practice Reporting Option I Data Collection Tool: ***Medical groups that are participating in GPRO in 2010 will not complete data collection tool until the first quarter of 2011 and therefore will not have direct experience to share until after this time, although estimates made of staff resources required to pull charts and populate the tool show that they will be extensive.***

CMS solicits comments on the proposed use of the data collection tool currently in use for the 2010 GPRO. Since medical groups participating in the 2010 program will not be required to collect and report on quality data until the first quarter of 2011, they do not have direct experience to share at this time. However, concern exists about the 411 patient/per measure data collection requirement.

CMS will select 411 patients for the first measure, and then assign any other measures that are applicable for those patients. After this, CMS will move to the next measure and select additional patients, as needed, out of the patient population to reach 411 (also assigning these patients to any other applicable measure). Groups will be able to report on several measures for discrete patients, in many cases. Based on AMGA member groups that are participating in GPRO for 2010, their estimates are that this level of reporting will require them to look up charts for approximately 2,000 or more patients.

Another AMGA member, a participant in the Physician Group Practice Demonstration that utilized the same data collection tool, wound up hiring two full-time employees for a period of two months to collect the information for the data collection tool. The member's information technology staff was also involved in the initial set-up and extraction of this data, including the EMR upload of data to CMS.

AMGA suggests that CMS therefore limit the reporting requirements to 411 patients *in toto*, rather than 411 patients per measure, in order to reduce the associated resource burdens to participation.

Maintenance of Certification Program (MOC): ***AMGA suggests CMS satisfy the ACA requirement for "more frequently" met certification than is currently required, by working closely with the the American Board of Medical Specialties (ABMS) to determine a means which would be the least disruptive to existing MOC programs. An optimal approach would also be a simplified approach such as an interval more frequent than the longest MOC interval currently in force. We believe that creating such a simplified approach is within the interpretive authority of CMS. Consultation with the ABMS is critical to meeting requirements of the law in a manner least disruptive to existing programs.***

An additional 0.5 percent incentive payment for years 2011-2012 is available for eligible professionals under the Physician Quality Reporting Initiative (PQRI) for having quality data submitted on their behalf through a Maintenance of Certification Program (MOCP) operated by a specialty body of the ABMS. Physicians must maintain a valid medical license in the US, and participate in educational and self-assessment programs, among other requirements. Since there is not uniformity of intervals between MOCs as this is determined by individual medical specialty boards which collectively make up the ABMS, implementing the "more frequently" requirements, if implemented for each and every MOC, stands to be hugely disruptive. This would not serve the greater good and might require reconfiguring many, if not most, of the MOC timetables. This is not desirable, nor practicable. Therefore, we propose defining "more frequently" in the following fashion, one we believe will meet congressional intentions to offer bonuses widely, increase frequency of MOC , and disrupt existing programs only minimally:

An optimal approach would be to require any interval more frequent than the periods of time that are less than the longest MOC interval currently in force. We believe that creating such a simplified approach is within the interpretive purview of CMS. Consultation and negotiation with the ABMS is critical to meeting requirements of the law in a manner least disruptive to existing programs.

Primary Care Bonus: ***Because eligibility for the bonuses will be calculated as a percentage of all allowable Part B charges and redetermined every two years after enrollment in Medicare, resulting in new physicians not being eligible for two years, AMGA suggests that CMS aggregate early claims data for these physicians and use appropriately weighted or otherwise adjusted averages as the basis from which to make the bonus payments.***

The ACA provides a 10 percent bonus payment to primary care practitioners with more than 60 percent of Medicare allowable charges allocated to a defined set of nursing home and outpatient visits. Eligible professionals are defined as those with family practice, internal medicine, pediatrics, or geriatrics as their primary specialty. The methodology used to calculate the bonuses would result in physicians not becoming eligible for the bonuses until two years after they enroll in Medicare. Asking doctors new to Medicare to wait two years for eligibility for these bonuses is not necessary, nor fair.

AMGA recommends that CMS aggregate early claims data and determine averages in order to calculate and distribute payments to physicians in the early months of the program, and not wait

two years to pay newly enrolled physicians. Alternatively, a lump sum payment could be made to newly enrolled physicians until exact calculations could be made based on their allowable Part B charges, even if this payment is imprecise. A two-year lag in payments will not accomplish the policy objective of rewarding new primary care physicians for their acknowledged role as the linchpins of health care reform, nor attract new medical students to primary care disciplines. Rewards for desired behaviors should be given close to the time of that behavior in order to have the desired outcome.

In the proposed rule, CMS indicates that bonus payments will be made on a quarterly basis to eligible physicians. AMGA supports the proposed quarterly payments for primary care physicians once they are eligible for the bonuses, because this payment schedule will meet the policy objectives of the statutory provision.

We would also urge CMS to include all services paid for in the Medicare physician fee schedule, and not just Part B services, in determining 60 percent of allowed charges on which to base the bonus. The statutory language was meant to be expansive in order to bolster primary care practice. Rural primary care physicians, for example, typically provide a wide variety of services to patients, such as laboratory work. Therefore, CMS should revise the proposed definition of "allowed charges" to include all services paid for under the Medicare physician fee schedule, rather than Part B.

Integration of PQRI and EHR Reporting: ***AMGA supports the ACA provision requiring CMS to integrate the PQRI and EHR reporting by January 1, 2012 for the opportunity it provides to streamline administrative processes for health care providers and for CMS.***

AMGA is pleased by the ACA provision that requires CMS to integrate reporting for PQRI and the EHR incentive program, and we have some suggestions for CMS to consider that would help accomplish alignment of these two reporting requirements.

To achieve effective and efficient integration, AMGA recommends that the metrics for both programs be defined in the same manner, be reported using the same format currently used for PQRI reporting, and be submitted to CMS at the same time. CMS should also take the lead in encouraging other payers to integrate their quality and/or EHR program reporting formats and timing to allow for even greater administrative efficiency. Lastly, metrics should not be aligned by specialty at this time, given that the goals for the EHR program and the PQRI program diverge around medical specialties. There is an opportunity, however, to align these two programs around those measures and metrics in the PQRI that focus on population health, since this is the primary focus of the EHR program.

Multiple Procedure Payment Reductions (MPPRs) for Therapy Services: ***The MPPR reductions in the practice expense component of the second and subsequent therapy service for multiple therapy services are arbitrary in nature, will have a negative effect on Medicare beneficiaries, and will harm the therapy professions. AMGA urges CMS to reconsider this policy in light of the likely consequences.***

The proposals for 2011 include a 50 percent reduction in the practice expense component for all therapy services beyond the first unit (8-15 minutes). Physical therapy, occupational therapy, and speech-language pathology services will all be affected. Based on the Government Accountability Organization (GAO) report entitled "Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved when Services are Provided Together," CMS believes that when more than one therapy service is furnished in one session, that efficiencies exist in providing the second and subsequent service. However, therapy services include differing modalities, which do not overlap with other services. The payment reduction is even more arbitrary and unfair for therapists who see patients that may have seen another type of therapist earlier on the same day.

This reduction will have a devastating effect on Medicare beneficiaries who depend on these services to maintain their functionality. At a time when the Medicare rolls are swelling with new beneficiaries, integrated health care delivery systems that employ therapy providers are already strained by previous cuts to the sustainable growth rate (SGR), and implementation of therapy caps. Medical groups may be forced to limit the new Medicare patients they see for these essential services, cut other staff, or limit planned improvements that are necessary to participate in other CMS initiatives. The provision of therapy services that allow Medicare beneficiaries to maintain their functional status is widely acknowledged as a wise use of health care resources.

Moreover, workforce shortages exist in all of the allied health professions, and cuts of this magnitude will only serve to discourage interested students from becoming therapists. In addition, private payors, many of whom follow Medicare's lead, will likely implement reductions in reimbursements for therapy services in subsequent years, should this policy go into effect.

The consequences of such severe cuts should be considered carefully before implementation of the practice expense reductions, and we urge CMS to forestall this policy change, especially in light of the uncertainty surrounding Medicare reimbursements that all health care providers are facing in the future.

We believe that a less deleterious way to achieve efficiencies in the provision of therapy services could be arrived upon through the Common Procedural Terminology/Relative Utilization Committee (CPT/RUC) process. This would allow stakeholder input as to how the matter can be appropriately resolved without risking patient access or harming the therapy professions.

Disclosure Requirement for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services: ***AMGA believes that furnishing patients with information for three alternate suppliers of imaging services would provide them with sufficient choices of alternative imaging providers, while satisfying the intent of the provision.***

The Affordable Act of 2010 (ACA) enacted a disclosure requirement for the in-office ancillary services exception on physician self-referral for magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET) and other designated health services that

the Secretary deems appropriate. This provision went into effect immediately upon enactment of the law and left providers of these services with many questions about implementation. AMGA is grateful for the details provided in the proposed rule stipulating that the disclosure is written in an easily understandable format; be given to the patient at the time of referral; indicate that the services can be obtained elsewhere; include a list of ten alternate suppliers located within a 25 mile radius; and include the name, address, phone number, and distance from the physician's office.

CMS asks whether providing a list of 10 alternative suppliers is sufficient, or too burdensome. AMGA suggests that providing patients with a list of three alternate suppliers of these imaging services would suffice to meet patient choice and program integrity concerns, and compliance would be less burdensome for medical groups and smaller practices.

Potentially Misvalued Services under the Physician Fee Schedule: ***AMGA believes the current partnership between CMS and the American Medical Association (AMA) Relative Update Committee (RUC) has been a successful one and that steps have been taken to address the identification of misvalued codes. The ACA requirement to validate relative value units (RVUs) should continue to build integrity into the RUC process.***

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 recommendations. Involving RUC experts, those who are most intimately acquainted with and possess the deepest level of expertise and experience makes the most sense. These same experts are also those best equipped to provide insights and guidance to help shape an independent validation system. This kind of collaboration will help fulfill the requirements of the law but will also provide insights available nowhere else.

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 specialties and individuals is sufficiently diluted to prevent invalidation of the work.

We do, however, believe that the existing process can be improved and strengthened and believe the ACA provision that requires CMS to establish a formal process to validate relative value units is an opportunity to strengthen the integrity of the existing process. 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.

Furthermore, the external validation required in law would best be done in consultation with the RUC. The experience of nearly two decades of work by the RUC should be used to create the

best validation tools possible. We urge CMS pursue the legislative mandate by working in collaboration with the RUC to that end.

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. We are excited to see the expansion of the GPRO program to include medical groups of all sizes and believe that encouraging group formation is an important facet of transforming our health care delivery system.

Accountable Care Organizations (ACOs), established in the ACA, extend and refine integration of health care delivery. ACOs offer the promise to reformulate health care delivery, in a voluntary way, using as building blocks existing medical practices, institutions, and referral patterns. ACOs will implement evidence-based protocols, information systems, and other activities that can reduce unnecessary volume, provide cost savings, improve quality, and foster accountability. AMGA has long called for abolition of the fatally flawed SGR system. However, political and fiscal realities may preclude such actions in the foreseeable future.

Thus, although we favor a cost-based system for setting doctors' fees in Medicare, a move that seems unlikely in the near term, we suggest a refinement and strengthening of the SGR formula and urge CMS to support the idea. We recognize that legislation would be required to make this change, but wanted to take the opportunity to present our views on the funding of ACOs, soon to be implemented, since the success of the program will depend on how viable it will be for medical groups, and others, to participate. We propose establishment of a separate, sub-national SGR pool for each ACO. This would allow those who are successful to earn a more favorable conversion factor and be protected from the fluctuations of the main SGR pool.

Creation of such a separate payment pool for ACOs was included in early House health care reform legislation and most recently in the initial version of the American Jobs and Closing Tax Loopholes Act of 2010. The discrete ACO SGR pool language was incorporated because it is good public policy, which supports Medicare program objectives of value-based purchasing and quality improvement, strong steps toward attaining more effective and efficient care delivery systems.

More widespread adoption of these systems and activities will require consistent and predictable funding. Medical groups will not be able to plan for the future and make appropriate changes to care processes and infrastructure without a reliable funding stream. The uncertainty surrounding

the flawed Sustainable Growth Rate (SGR) formula currently used to determine Medicare payment rates for physicians does not offer the necessary sense of financial stability to medical groups. For this reason, AMGA supports a separate SGR pool for ACOs. Initial investment and maintenance costs for care management processes are significant, and ACOs need a stable Part B funding stream. Moreover, since ACOs will coordinate care for Part A and Part B, the current SGR mechanism should not apply to ACOs.

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 at kferguson@amga.org.

Sincerely,

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