September 6, 2013

Marilyn B. Tavenner
Centers for Medicare & Medicaid Services
Administrator
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule and Other Revisions to Part B for CY 2014

Dear Administrator Tavenner:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the proposed rule entitled, “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule and Other Revisions to Part B for CY 2014,” released on July 19, 2013. We look forward to continuing to collaborate with the Centers for Medicare & Medicaid Services (CMS) on the issues in this proposed rule.

MGMA-ACMPE, founded in 1926, is the nation’s principal voice for medical group practices. Our nearly 22,500 members manage and lead 13,200 organizations, in which 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States. The Association’s core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them. Individual members, including practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently so that patient care remains the focus of physicians’ time and resources.

MGMA offers detailed critiques and recommendations related to this rule on behalf of our members. In summary, we urge CMS to:

• Immediately address the burdensome and complicated nature of its multiple federal quality reporting programs. Physicians should meet government quality reporting criteria by reporting through a single program – not four.

• Withdraw its proposal to expand implementation of the value-based payment modifier (VBPM) to groups of 10 or more eligible professionals and not require mandatory participation in quality-tiering.

• Withdraw its proposal to increase reporting thresholds to both earn an incentive and avoid a penalty under PQRS.

• Finalize its proposal to establish Medicare payment for complex chronic care management, but remove the excessively complex requirements for the newly proposed codes.
• Withdraw its proposal to cap the physician fee schedule (PFS) payment for 211 services at either the hospital outpatient department or ambulatory surgery center (ASC) rate. In the majority of cases, comparing physician payment rates to those in a facility results in payment rates that do not cover expenses in the physician office setting.

• Address existing deficiencies with the Physician Compare website before considering inclusion of additional information, especially as it relates to Medicare quality reporting programs.

Medicare Physician Reimbursement

CMS anticipates, barring changes to current law, an approximate 24.4 percent cut in physician payment rates for 2014 under the sustainable growth rate (SGR) methodology. The 24.4 percent rate cut is based on a March 2013 analysis from CMS. This massive cut will have catastrophic consequences on medical group practices and the patients they serve. Although Congress has repeatedly taken action to override most of the SGR’s prescribed fee schedule reductions, these temporary “fixes” have increased both the size of future cuts and the cost of repealing the flawed payment system. As a consequence, the frequent need to override increasingly steeper cuts is undermining confidence in the Medicare program and jeopardizing the financial stability of medical practices. The current environment is forcing group practices to make operational changes that severely challenge their ability to provide quality care to Medicare beneficiaries.

MGMA will continue to work with congressional leaders, urging them to permanently address the broken Medicare physician payment system and replace it with a more stable and predictable update mechanism that accounts for the actual cost of providing care to Medicare beneficiaries.

Practice expense (PE) RVUs

MGMA opposes CMS’ proposal to limit the PFS payment for certain services where the PFS non-facility payment is higher than the total payment to furnish the same service in a facility setting (either a hospital outpatient department or an ambulatory surgery center (ASC)).

CMS’ proposal would reduce the PE RVUs of approximately 211 codes. The payments for some of these codes will be reduced dramatically, in some cases by over 50 percent. One of the agency’s rationales for implementing this policy is that it is unable to obtain accurate information regarding supply and equipment prices as well as procedure time assumptions. CMS is required by the Social Security Act to establish payments for physician services based on the relative value units that account for relative resources used in furnishing the service. Data on resources needed to perform a service is submitted through a standardized process and is reviewed by a cross-specialty panel. The Ambulatory Payment Classifications (APCs) used to determine hospital payment are based on hospital charge data and, as CMS states elsewhere in the proposed rule, this process “is not consistent or standardized.” More importantly, APCs are based on average low and high margin hospital services within a single APC whereas the PFS’s relative value determination captures costs for each individual code. Consequently, a service-by-service comparison will be inappropriate and inaccurate as CMS would not be comparing like items.

MGMA, along with the American Medical Association (AMA) and 38 other medical associations, submitted a separate comment letter to CMS, spelling out in greater detail our specific concerns with
this proposal. The letter contains several examples of the negative effect it will have. Most notably, an AMA analysis of the codes proposed to be reduced found that for 82 percent of them, the proposed payment rate would not even cover the direct expenses needed to perform the services, including the clinical labor, supplies and equipment. There are several examples of services where the new proposed rate would not even cover the cost of a single high cost supply.

CMS has a process in place to identify potentially misvalued codes. While a comparison of services that are paid higher in a hospital outpatient setting than in a physician office may be an appropriate way for CMS to identify services to review as potentially misvalued, it would not be appropriate to simply substitute hospital payment rates for physician payment rates. Moreover, several of the services proposed to be subject to this proposal are currently undergoing a comprehensive review by CMS.

Finally, as proposed, CMS’ policy would use 2013 rates for hospital outpatient departments and ASC rates to cap 2014 rates for physicians. Services in both hospital outpatient departments and ASCs will be increased in 2014 but the physician payment for these services would be set at the lower 2013 rate. This standard is inequitable.

CMS proposes to exempt a number of services from this policy, including services that are subject to the imaging cap established by Section 5102(b) of the Deficit Reduction Act of 2005 (DRA), which reduces the PFS payment for the technical component of imaging services to the payment amount under the Outpatient Prospective Payment System (OPPS). In its proposed 2014 OPPS rule, CMS proposes to establish separate cost centers for computed tomography, magnetic resonance imaging and cardiac catheterization. If adopted, payment for these services in the hospital outpatient setting would decrease significantly. As a result of the DRA cap, PFS payment for these services would also decrease. Both of these policies could result in significant reimbursement decreases based on factors that are unrelated to the PFS relative value determination.

We urge CMS to withdraw its PFS proposal to cap services in the physician office setting and to use extreme caution in adopting policies in the OPPS that would dramatically impact physician payment.

Collecting data on services furnished in off-campus hospital provider-based departments

CMS is considering collecting data on services furnished in off-campus hospital provider-based departments (provider-based departments) in order to better understand the trend of hospital acquisition of physician offices and treatment of those locations as provider-based departments. The agency would collect information on the frequency, type and payment for such services, and proposes three different ways to collect this information:

- A claims-based approach that would create a new place of service code for provider-based departments as part of item 24B of the CMS-1500 claim form
- A claims-based approach that would create a HCPCS modifier that would be reported for services furnished in a provider-based department on the CMS-1500 claim form for physician services and the UB-04 (CMS form 1450) for hospital outpatient claims
- A requirement that hospitals break out the costs and charges for their provider-based departments as outpatient service cost centers on the Medicare hospital cost report form 2552-10
Based on the current complexities of Medicare billing which require numerous HCPCS modifiers, we do not support creating a new modifier for this purpose. We recommend CMS explore the other two proposed alternatives with the intent of minimizing administrative burden on practices.

**Complex chronic care management services (CCCMS)**

CMS is developing a number of initiatives to enhance care coordination for Medicare beneficiaries, including the agency’s proposal in the proposed 2014 Medicare PFS for new complex chronic care management services (CCCMS). MGMA has pledged our support for Health and Human Services’ (HHS’) Partnership for Patients which is aimed at improving quality, safety and affordability of healthcare in the United States. Establishing new codes for complex chronic care management is a step in the right direction for providing high quality, coordinated care for Medicare beneficiaries and for preventing adverse events such as unnecessary hospital readmissions.

Currently, payment for non-face-to-face care management services is bundled into the payment for face-to-face E&M visits. However, CMS acknowledges that E&M codes do not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain Medicare beneficiaries, especially those with multiple chronic conditions. In order to address this, CMS proposes to establish a separate payment beginning in 2015 for two new G-codes for CCCMS furnished to patients with multiple complex chronic conditions. Many practices have been providing this type of service without receiving reimbursement. By recognizing and reimbursing for these services, it will allow practices to continue to enhance their focus on care coordination. We appreciate CMS emphasizing the importance of coordinating beneficiary care and managing complex chronic conditions, and we have a number of recommendations regarding the specific proposal outlined in this rule.

While the agency proposes a number of criteria that would be required as part of these services, CMS is not proposing any RVUs for these services at this time. Without proposed RVUs, it is difficult to evaluate and comment on the overall amount of work required to furnish these services. We understand that the agency is still formulating the specific aspects of these codes, which would not be available until 2015. We encourage CMS to work closely with the American Medical Association (AMA) / Specialty Society Relative Value Scale Update Committee (RUC) to identify fair and accurate valuation of these codes. Additionally, while we support establishing CCCMS, we urge the agency to work with the AMA CPT editorial panel to create CPT codes that would meet the goals of the CCCMS. Utilizing CPT codes, rather than creating new Medicare G-codes, would encourage broader use of these services across the healthcare industry.

CMS proposes that a beneficiary must have received an initial preventive physical examination (IPPE) or Medicare Annual Wellness Visit (AWV) in the past 12 months for a practitioner to be eligible to bill for CCCMS. While we understand that IPPE and AWV services will help a practitioner develop a foundation for providing CCCMS, such as by developing a beneficiary’s plan of care, we feel specifically requiring the IPPE or AWV will limit the number of beneficiaries able to receive CCCMS. If, as the agency states in the proposed rule, CMS’ goal is to make CCCMS broadly available to Medicare beneficiaries, the agency should use IPPEs or AWVs as ways to encourage providers to then furnish CCCMS but should not specifically require IPPEs or AWVs as a condition of furnishing CCCMS.

In the proposed rule, CMS states that it expects many CCCMS would be furnished incident to a physician’s services. We agree that many practices would use a team-based approach to providing
these services, which would include the use of incident to billing. Both of the proposed CCCMS G-codes include one or more hours of work over a 90-day period, including the G-code for initial services and the G-code for subsequent services. The agency proposes that time spent by a clinical staff person furnishing aspects of CCCMS outside the practice’s normal business hours during which there is no direct physician supervision would count towards the one hour requirement to bill each G-code, even though the services do not meet the direct supervision requirement for incident to services. We appreciate CMS acknowledging the challenges with supervision requirements for incident to billing in relation to these proposed services. We support the agency’s proposal to count time spent by a clinical staff person furnishing aspects of CCCMS outside the practice’s normal business hours during which there is no direct physician supervision, and we recommend the agency finalize this proposal.

Based on the statutory limitations of what services qualify for increased payment under the Medicare Primary Care Incentive Payment (PCIP), CMS explains that the CCCMS would not qualify for the PCIP bonus. CMS proposes that the allowed charges for CCCMS would not be included in the denominator when calculating a physician’s or practitioner’s percent of allowed charges that were primary care services for purposes of the PCIP. We support this proposal and encourage the agency to finalize this.

Under CMS’ proposal, beneficiaries would have to consent to receive CCCMS and a healthcare provider would need to document in the medical record that the beneficiary agrees to accept these services. The patient’s acceptance would need to be reaffirmed and documented every 12 months. CMS also proposes that prior to submitting a claim for CCCMS, the practitioner must notify the beneficiary that a claim for these services will be submitted to Medicare. CMS proposes that a beneficiary would need to receive a separate notice for each 90-day period for which the services would be billed, and a copy of the notice would be included in the medical record. Requiring a separate notice prior to submitting each claim is burdensome for practices, especially when the beneficiary has already given consent to receive the services. We recommend that during the discussion in which a beneficiary gives consent to receive the services, the practice would also notify the beneficiary about claims submission for these services and not be required to do so separately every 90 days.

In addition to the requirement that at least an hour of CCCMS be furnished to the patient, CMS proposes that billing for subsequent CCCMS would be limited to those 90-day periods in which the medical needs of the patient require substantial revision of the care plan. CMS explains that substantial revision to a care plan typically is required when the patient’s clinical condition changes sufficiently to require: significantly more intensive monitoring by clinical staff, significant changes in the treatment regimen, and significant time to educate the patient/caregiver about the patient’s condition/change in treatment plan and prognosis. Providers will have no way of knowing in advance whether a patient’s plan of care will need to be substantially revised. This means that practices would continue to provide complex chronic care management throughout a 90-day period but then may not be able to bill for the service at the end of that period. This will be a considerable disincentive for providers, and we recommend the agency not finalize this proposal. CMS’ stated goal of establishing these services is to improve chronic care management, which cannot be done if CCCMS are only provided intermittently.

In addition to the required CCCMS components, CMS proposes that practices would have to meet certain criteria for their practitioners to be eligible to furnish these services. We have concerns that CMS is setting the bar too high for the required practice criteria, which will prevent many practices
from being eligible to provide CCCMS. For instance, a practice would have to be using an electronic health record (EHR) certified for the meaningful use incentive program and practitioners would need to be able to access this system 24 hours a day, 7 days a week. CMS specifies that the practice must be using a certified EHR that meets the most recent HHS regulatory standard for meaningful use. If finalized, CCCMS would go into effect in 2015, during Stage 2 of meaningful use. As of Aug. 26, there were only 23 complete ambulatory EHRs certified for Stage 2, which begins in about five months. We urge CMS to not require a specific stage of meaningful use certification and to reconsider if an EHR is really essential to providing these services. While an EHR may help a practice furnish these services, many practices – especially smaller ones or those in rural areas – do not have EHRs, and it would be unfortunate to prevent those practices from furnishing CCCMS based on this criterion alone.

CMS proposes that a practice must employ one or more advanced practice registered nurses or physician assistants whose written job descriptions indicate that their job roles include and are appropriately scaled to meet the needs for beneficiaries receiving CCCMS. This will be difficult for practices that may not already have a physician assistant or an advanced practice registered nurse on staff. Many practices would be reluctant to hire a new practitioner solely to meet this requirement and be eligible to bill for these services. Also, practices will have no way to know how many beneficiaries will utilize the CCCMS, especially given all of the other mandates that CMS proposes must be met in order to furnish these services, so it will be very difficult to know how to properly scale their job roles to meet the needs of beneficiaries receiving CCCMS. We urge CMS to reconsider this and other stringent criteria which will be a barrier for beneficiaries to receive CCCMS. Some practices currently utilize registered nurses or case managers to help with care coordination. We recommend that CMS consider the role of these professionals in helping to provide CCCMS.

Additionally, CMS proposes almost a dozen other required protocols that a practice would have to document in writing to be eligible to furnish CCCMS. One of the proposed elements would require “a systematic approach to communicate and electronically exchange clinical information with and coordinate care among all service providers involved in the ongoing care of a beneficiary receiving complex chronic care management services.” This will be difficult for many practices, even those with EHRs, considering that the healthcare industry still has a long way to go to be interconnected and have the capability to electronically exchange clinical information. Mandating that information be electronically exchanged is too onerous and unrealistic. We urge CMS to remove this requirement from the list of practice protocols.

CMS suggests that one way for a practice to demonstrate that it meets care coordination standards for furnishing CCCMS would be for the practice to be a patient-centered medical home (PCMH). This would include practices formally recognized as a medical home by one of the national organizations including: the National Committee for Quality Assurance, the Accreditation Association for Ambulatory Health Care, The Joint Commission, and URAC. Medical homes would be good candidates to provide CCCMS, but PCMHs represent a relatively small percentage of medical groups across the country. We urge CMS to consider other ways to allow practices to meet the practice protocol, which we recommend should be scaled back from the proposal. For instance, CMS should consider allowing practices to self-attest that they meet the finalized practice protocol.

Overall, while we support establishing Medicare payment for complex chronic care management, CMS’ proposal is very onerous and, if finalized, would dramatically limit the ability of beneficiaries to receive these services. We recommend that CMS reconsider the complexity of the requirements proposed and work
with the AMA CPT editorial board and RUC to establish CPT codes that would address the goals of the CCCMS.

**Ultrasound screening for abdominal aortic aneurysms**

Medicare Part B currently covers ultrasound screening for abdominal aortic aneurysms (AAA) when a beneficiary receives a referral for the screening during the initial preventive physical examination (IPPE) and has not previously received an AAA screening under the Medicare program. The IPPE must occur within one year of the effective date of the beneficiary's first Part B coverage period. CMS proposes to expand access to this preventive service based on a recommendation from the United States Preventive Services Task Force by removing the requirement that a beneficiary receive a referral for AAA screening as part of his or her IPPE. MGMA supports this proposal.

**Physician Compare**

Since the [Physician Compare website](#) launched, many physicians and practices have expressed concerns about inaccurate information, which is difficult to correct and confuses beneficiaries. CMS recently added information to Physician Compare, including participation in the Medicare EHR Incentive Program (meaningful use), secondary specialties, hospital affiliations, languages spoken and board certification information from the America Board of Medical Specialties. For group practices, CMS added information on quality reporting programs, including satisfactory reporting in Group Practice Reporting Options (GPRO) under the Physician Quality Reporting System (PQRS) or electronic prescribing (e-prescribing) programs. We appreciate CMS’ efforts to address existing flaws with Physician Compare through the June website redesign. We were pleased that CMS took steps to enhance the usability and accuracy of the information and that the agency upgraded the search capabilities, such as adding the ability to search by various locations or specialty type. We also welcome the use of Medicare claims data to help verify or sort demographic data from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

However, we continue to receive reports from our members of inaccuracies as well as complaints related to the new features. Without accurate information and user-friendly capabilities, Physician Compare does not provide value to Medicare beneficiaries. If a physician identifies inaccurate information, it often takes months for it to be corrected on the site. This is frustrating for beneficiaries who receive inaccurate information and for physicians and practices that must deal with the administrative hassles to correct the misinformation and must also address any adverse effects from the undue harm to their reputation. In fact, inaccurate or misleading information may be more harmful to beneficiaries and providers than no information at all. We urge CMS to conduct a thorough analysis of the accuracy of information on Physician Compare and to continue to work with providers to identify necessary changes that must be made to ensure that the information is correct, the new functionalities operate in an appropriate manner, and errors can be corrected in a timely manner.

**Existing issues**

In referring to PQRS, meaningful use and e-prescribing, CMS is inconsistent in its terminology. It lists “Quality Programs” on the website’s left hand side and in a number of other places on the site, but in another place on Physician Compare these programs are listed as “Quality Reporting Programs.” These programs focus on quality reporting and do not accurately reflect whether a physician is providing high quality care to patients. Therefore, in order to properly convey the nature of these programs and to not
confuse beneficiaries, Physician Compare should consistently refer to the programs as “quality reporting programs”.

As of Aug. 26, 2013, Physician Compare had information related to eligible professionals (EPs) and group practices that took part in the e-prescribing and PQRS programs and successfully reported for these programs in 2011. Physician Compare includes information related to EPs who successfully participated in meaningful use in 2012. The lag time between program participation and posting this information on Physician Compare is unreasonable and misleading for beneficiaries. Beneficiaries would only know how old this information is if they drill down to learn more about the program specifics. Additionally, this is how Physician Compare shows EPs who participate in meaningful use:

![Quality Programs:](image)

This representation would lead many beneficiaries to think that physicians without this displayed do not have an EHR. This is unfair for many physicians and practices who have EHRs but either choose not to participate in the meaningful use program, are unable to participate based on program criteria or have participated more recently than the information shown on Physician Compare.

The page explaining the PQRS program states, “Participation in PQRS is voluntary. There are many reasons why physicians or other healthcare professionals may choose not to report quality information even though they are committed to providing high-quality healthcare. Participation in this and other Centers for Medicare and Medicaid Services (CMS) quality programs indicates a commitment to quality care but does not provide information about the actual quality of care provided.” A similar explanation is not included on the e-prescribing or meaningful use pages, and we recommend that it be added. Additionally, the Physician Compare e-prescribing page explains, “The eRx Incentive Program is a pay-for-reporting program that encourages physicians and other healthcare professionals to use electronic prescribing to improve communication, increase accuracy, and reduce errors.” Unlike the Physician Compare PQRS and meaningful use pages, there is no mention of the payment adjustments that are a growing part of the e-prescribing program. These penalties began in 2011, and it is deceptive to explain this program as one which only offers bonuses. We recommend that CMS modify this language to accurately describe the program.

The inconsistent manner in which CMS explains its quality reporting programs and the delay of pertinent information related to these programs underscores the need for CMS to address existing Physician Compare deficiencies before including additional information.

2014 Proposals

CMS is required to report performance information on quality measures and, in 2014, will begin a phased approach to doing so. CMS proposes to expand quality measures posted on Physician Compare, beginning as early as 2015, to include performance on all measures collected through the
GPRO web interface for groups that participate in the 2014 PQRS GPRO and use the web interface reporting option and for ACOs in the Medicare Shared Savings Program (MSSP). CMS also proposes to report, no earlier than 2015, performance data on a wide range of measures for groups participating via registries and EHRs in 2014 PQRS GPRO. Prior to reporting further quality measure performance data for these groups as proposed, we recommend that the agency conduct a thorough analysis of the accuracy of the information reported on the initial set of performance data on 2012 and 2013 PQRS GPRO measures. CMS should not add more measure performance data until the existing data is correct.

If finalized, CMS would provide a 30-day preview period for group practices and ACOs to view their data as it will appear on Physician Compare before it is publicly reported. We appreciate CMS’ proposal to provide a preview period but feel that 30 days is an unrealistically short timeframe, and we encourage the agency to extend this preview period from 30 days to 90 days. This will allow more time for practices to review the data and make corrections, if necessary. CMS does not propose details for the preview and states that it will specify this process, including a timeline and instructions, at a later time. We strongly urge the agency to share any information months in advance of when the preview period is available and to conduct extensive provider education alerting impacted parties to the preview opportunity.

CMS proposes to publicly report PQRS measure data for individual EPs participating in 2014 PQRS using the claims, EHR or registry reporting options. This would be the first time Physician Compare would include measure performance data on individual EPs. As early as 2015, the agency proposes to report performance rates on select individual PQRS measures and on measures in the PQRS Cardiovascular Prevention measures group for PQRS data collected in 2014. We understand that the agency is statutorily required to report quality measure performance data. However, based on the current inaccuracies of information on Physician Compare, we have significant concerns about CMS' ability to add more information to the site without exacerbating existing problems or creating further confusion for beneficiaries. Based on these concerns, we urge the agency to report individual measure performance data on the smallest scale possible to meet its statutory obligations and to do extensive testing of the initial data to evaluate its accuracy before adding more measure performance data. We have significant concerns about how beneficiaries will interpret quality measure performance information. For example, some physicians will have certain measure performance data while it will not be available for other physicians who do not report those same measures. It is imperative that CMS work with the provider community and consumer groups to identify how to best explain what quality measure performance means and why some physicians may have this data available while others may not.

As we have previously requested, we urge CMS to add a robust review process prior to posting information on the site to assure accuracy. Practices and physicians should also have an option to include comments in the public report on the website, which would allow them to clarify information or explain why they may not have participated in a program like PQRS. Physician Compare will only be useful if beneficiaries, providers and CMS are confident in the information reported. Existing problems present substantial risks to patients’ access to information and to physicians’ and practices’ valued reputations. We urge the agency to make these changes to increase that confidence.

**Physician Quality Reporting System (PQRS)**

MGMA is disappointed at the slow speed of CMS’ efforts to align quality measures available across all four federal quality reporting programs including the Physician Quality Reporting System (PQRS). The agency’s efforts fail to address the tremendous burden placed on practices to navigate and meet
the criteria for four separate quality reporting programs. CMS’ highest priority should be to remove the overlap and duplication that exists among the plethora of federal quality reporting programs and allow providers to receive credit for all quality reporting criteria through a single program. Current reporting requirements are unnecessarily onerous and costly, and emphasize reporting over quality and improved outcomes. The complexity of the PQRS program grows each year, and continuity in program criteria from year to year is lacking, thus exacerbating the challenge of educating providers of current program requirements. Federal quality reporting programs as currently structured are too complex and duplicative, and the inconsistencies that plague the programs intensify these problems.

Proposed changes to PQRS reporting criteria

CMS proposes to significantly increase the required number of measures to report to both earn an incentive and avoid penalties under the PQRS program from three to nine measures. MGMA urges CMS to finalize more achievable criteria for both earning a 2014 PQRS incentive and avoiding a 2016 penalty. Many physicians will have difficulty identifying nine relevant measures that they could report successfully for 50 percent of their Medicare patients as proposed by CMS. CMS does not have sufficient evidence to show that such a dramatic increase in the number of measures required to report is justified, as the most recent PQRS experience report shows that participation in the program continues to lag, and reporting is fraught with errors. Additionally, many physicians and practices do not yet have sufficient experience with the program to justify such a dramatic increase in the number of measures required, particularly to avoid a penalty.

In 2013, CMS finalized the requirement to report one valid measure in 2013 to avoid the 2015 PQRS penalty. In CMS’ own words, the one-measure requirement was to “ease eligible professionals and group practices who have not previously participated in PQRS as well as for “encouraging participation and [out of] concern about eligible professionals’ familiarity and experience with the program.” Making the proposed changes outlined above will not assist CMS in reaching their goal of encouraging participation in the PQRS program, and instead will have the opposite effect, causing some practices and providers to leave the program all together. Therefore, we strongly urge CMS to not increase the required measures from three to nine and to retain the option of reporting one measure in 2014 to avoid the 2016 penalty.

We also urge CMS to clarify the availability of an option to report three individual measures via claims in 2014 to avoid the 2016 penalty. CMS discusses this option in certain educational materials, however this was not clear in the proposed 2014 rule and needs further clarification. Additionally, this reporting option is inconsistent with the simultaneous proposal to require reporting nine measures to avoid the 2016 PQRS penalty and is recognition that the nine measure requirement is not an achievable metric.

Lastly, we continue to strongly object to CMS’ basing a 2016 payment adjustment on what a provider does in 2014. As we have previously commented, we oppose quality reporting penalties and, if levied, the government should only apply payment adjustments that take into account performance during the relevant year, rather than previous years.

Administrative claims reporting option

MGMA urges CMS to continue the use of the administrative claims reporting option to maintain continuity of program criteria. It is necessary to maintain this option, which will likely be utilized by a
number of practices in 2013 to avoid a 2015 penalty, to ensure physicians are not unfairly penalized under the Value-Based Payment Modifier (VBPM) and PQRS programs. Further, CMS should work to include more measures that are applicable to additional specialties. The 2013 Administrative Claims measures focus on primary care and therefore preclude use of the reporting mechanism for certain specialty groups for which these measures are not clinically relevant.

Proposed removal of certain claims-based reporting mechanisms

MGMA opposes the removal of claims-based reporting mechanisms, including the proposed removal of the claims-based option for individual eligible professionals (EPs) using measures group reporting. The 2011 PQRS and eRx Experience Report indicates that claims-based reporting continues to be the most popular method of reporting, and for this reason, claims-based reporting mechanisms should continue to be maintained to encourage ongoing participation in the PQRS program.

Proposed addition of a “qualified clinical data registry” reporting method

Section 601(b)(1) of the “American Taxpayer Relief Act of 2012” requires the Secretary to treat an eligible professional (EP) as satisfactorily submitting data on quality measures if, in lieu of reporting measures under PQRS, the EP is satisfactorily participating in a qualified clinical data registry for the year. This provision was meant to leverage quality reporting that is already taking place in the private sector, thereby reducing the administrative burdens on practices to also report this information to CMS for the PQRS program. The proposals put forth by CMS to include a new “qualified clinical data registry” reporting option fail to meet this objective. Many practices already report clinical quality data to various registries which are meaningful and help improve patient care. As proposed, CMS has created yet another reporting mechanism with the same burdens that already exist in the PQRS program, increasing complexity and confusion. The certification criteria for “qualified clinical data registries” to participate are equally onerous, including the unrealistic deadline for submitting applications by January 31 of the applicable reporting year. Many registries will simply forgo certification due to the complexity set forth in the proposed rule. CMS must streamline this option to allow EPs to take advantage of meaningful and valuable quality reporting already being performed outside of the CMS PQRS program as Congress intended.

Proposed changes in criteria for those electing the Group Practice Reporting Option (GPRO)

We applaud CMS’ ongoing support for the group practice model through the availability of the GPRO mechanism. However, we are concerned with the proposal to change the GPRO self-nomination deadline from Oct. 15 to Sept. 30. Changing the self-nomination deadline will be detrimental to participation in the GPRO mechanism by practices that are familiar with current Oct. 15 date, and we urge CMS to retain this deadline going forward to maintain consistency in the program and to encourage broader participation.

Proposed changes to measures groups

MGMA is pleased to see the proposed inclusion of additional measures groups that seek to incorporate more meaningful quality measurement for specialists, and we urge CMS to continue the development of robust measures for a variety of specialties. However, MGMA is concerned with CMS’ proposal to increase the number of individual measures included for reporting a measures group from four to six measures. CMS shows no rationale for increasing the number of individual measures in a measures
group, and we request that CMS maintains the current criteria. Requiring EPs and practices to report additional measures does not provide CMS with more meaningful quality data, and increases the burden on practices to report.

Value-Based Payment Modifier

The Affordable Care Act requires the Secretary of Health and Human Services to apply a Value-Based Payment Modifier (VBPM), first to specific physicians and groups of physicians that the Secretary determines appropriate and ultimately to all Medicare Part B physicians by Jan. 1, 2017. The VBPM is intended to assess both quality of care furnished and the cost of providing that care under the Medicare Physician Fee Schedule. In 2016, CMS proposes to continue the implementation of the VBPM to groups of providers with 10 or more eligible professionals (EPs). The 2016 VBPM would be based on 2014 performance, and those who do not meet satisfactory reporting criteria would be subject to a 2 percent penalty. Additionally, under the proposed rule CMS would make quality-tiering mandatory for 2016, imposing downside risk on groups with 100 or more EPs.

While MGMA supports efforts to improve the efficiency and quality of care physicians provide to their patients, we are extremely concerned that several technical issues related to the VBPM have yet to be appropriately addressed. We believe more time is needed to test valid measures of cost, outcomes and quality as well as mechanisms to accurately adjust for risk, before expanding implementation of a program that modifies physicians’ payment based on CMS’ definition of value. For this reason, CMS should not expand implementation of the VBPM to groups of 10 or more EPs or require mandatory quality-tiering until CMS and stakeholders have more confidence in the program’s measures and methodologies.

It is premature to apply the VBPM to approximately 60 percent of Medicare providers as proposed. Many physicians are unaware of the program’s existence, and many more continue to struggle with understanding the criteria and methodologies used by the program, which is still in its infancy. We have yet to discover possible unintended consequences from the measurements and criteria being used currently, and we urge CMS to seek a more cautioned approach to implementation. CMS states in its own words in the 2013 final Physician Fee Schedule that, “we believe in increasing the group size from 25 to 100, we would be addressing the concerns raised by commenters regarding attribution, new group reporting mechanisms, and cost comparisons.” These issues all still remain, and results at the 100 or more EP level have yet to be observed or analyzed for any unintended consequences and/or problems.

For example, the 2015 VBPM will be the first time CMS has established national benchmarks for PQRS quality measures for the 2013 performance year. CMS states in the 2013 final Physician Fee Schedule that, “we believe groups of physicians should have time to understand how their performance compares to these benchmarks, and to have time to adjust their performance based on these comparisons, before their payment is adjusted.” MGMA asserts that groups have not yet had this opportunity, which highlights the fact that it is premature to expand implementation of the VBPM as proposed.

Additionally, groups with 10-24 EPs will not be given an opportunity to preview the VBPM cost and outcomes measurements as CMS states. The agency will distribute Quality and Resource Use Reports (QRURs), which preview VBPM methodologies to groups with 25 or more EPs in mid-September 2013. The agency’s inability to provide data for groups of 10-24 providers demonstrates the lack of
capability to provide meaningful feedback to smaller groups, and highlights the problematic nature of expanding implementation of the VBPM to them at this time. In its “Summary of 2015 Physician Value-Based Payment Modifier Policies” document, CMS states that “we view these reports as a way to help educate groups of physicians about how the Value Modifier could affect their payment under the PFS. These reports will be made available in September 2013, to allow groups of physicians to make informed decisions regarding the selection of their 2013 PQRS reporting mechanism and whether to elect quality-tiering to calculate the Value Modifier.” MGMA asserts that this opportunity will not be afforded to these practices.

The VBPM program utilizes a number of complex and complicated methodologies to arrive at VBPM and quality-tiering amounts for impacted physicians. Practices will need time to view these results, and to determine how to configure their practice management systems and EHRs to analyze this data and validate CMS calculated results. They will also need time to identify any problematic outcomes of measurements currently used in the program. We urge CMS not to expand implementation of the VBPM until the methodological and technical issues outlined below are resolved.

**VBPM reliance on PQRS GPRO**

CMS proposes to continue to base the VBPM on performance in PQRS GPRO, which has achieved minimal participation due to operational issues that continue to plague the program. MGMA continues to believe that these PQRS measures do not provide an accurate and reliable method for evaluating the quality of care performed by certain physicians. While a number of quality measures are applicable to primary care physicians, there are fewer suitable measures for specialists. We urge CMS to continue to work with stakeholders to develop adequate quality measures that accurately reflect physicians’ practices and are relevant and meaningful to quality improvement and specialty, including those available under GPRO.

There are many large group practices which are diverse and therefore use multiple reporting modalities based on the availability of applicable measures. It may not be possible for all physicians in the group, especially multi-specialty practices with a wide array of specialists, to report the same measures. For this reason, we urge CMS to retain the Administrative Claims option to allow groups to report via multiple mechanisms, including those outside of GPRO, to avoid VBPM penalties for the reasons stated above. CMS proposes to allow groups that do not participate in PQRS GPRO to meet satisfactory reporting criteria under the VBPM if at least 70 percent of their EPs satisfactorily meet PQRS reporting criteria for avoiding the 2016 penalty as individuals. This threshold is far too high, particularly given the dramatically increased reporting thresholds proposed to avoid a 2016 PQRS penalty. Instead, groups impacted by the VBPM should be afforded the flexibility to report in the manner most appropriate for its physicians and practices by retaining the Administrative Claims reporting option to provide this necessary flexibility and to maintain consistency in program requirements.

**VBPM performance year**

MGMA continues to object to CMS’ basing a 2016 VBPM on what a provider does two years prior (in 2014). The government should only apply payment adjustments that take into account performance during the relevant year, rather than previous years.
Minimum case size

MGMA continues to object to CMS’ proposal to calculate the VBPM based on reporting of measures on only 20 beneficiaries, and this is particularly problematic when applying the VBPM concept to smaller groups as proposed. We do not believe CMS has fully evaluated the impact of its methodological decisions with respect to statistical validity. CMS must clearly demonstrate that its performance measures are reliable and robust. A higher minimum case size requirement would increase the validity of the information.

Outcome and cost measurement

We continue to have concerns that the outcome and cost measures utilized in the VBPM program will not apply to many practices, and do not allow physicians to be compared on an “apples to apples” approach. Limiting implementation of the VBPM to larger groups will alleviate some of these concerns and address some of the ambiguity around the measurement in the cost and outcome composites. It will also alleviate the challenges that smaller groups would face meeting a higher, more statistically reliable threshold for encounters. We must first see outcome and cost data resulting from the current 2013 performance year before expanding implementation.

Additionally, MGMA recommends that when comparing performance scores, CMS should score registry and data submission vendors separately from claims-based submissions. We believe that there are significant problems with comparing data that is submitted via claims-based CPT-II codes and data gathered from an EHR data submission vendor or a registry. Differing standards are reason to consider the data differently. As the 2011 PQRS and eRx Experience Report illustrates, PQRS participants are often more successful when utilizing registry and EHR data submission rather than the claims-based reporting option. This has no bearing on the quality of care provided but rather a function of the reporting modality utilized.

Risk adjustment

MGMA continues to have concerns regarding CMS’ use of risk adjustment methodologies to ensure fair measurements and comparisons in the VBPM program. Linking quality measurement and performance to payment adjustments without properly tested risk adjustment mechanisms could have a host of negative consequences. If CMS does not risk adjust adequately, it could discourage physicians from treating atypical or disadvantaged populations that may be more costly to treat. Lack of sufficient risk adjustment mechanisms is one of the greatest risks of the VBPM program. We recommend CMS adjust for additional factors such as patient compliance to address these concerns, and to study the impact of this risk adjustment methodology. Once again, it is incumbent upon CMS to demonstrate the success of these methodologies before expanding implementation.

Attribution

MGMA has concerns about the attribution methodologies currently utilized in the VBPM program. Current models do not address attribution appropriately when a patient sees multiple physicians. Further refinement is needed before expanding implementation with this largely untested mechanism to attribute Medicare costs, especially for smaller physician groups. It is critical that CMS invest in ensuring the accuracy of physician cost measurement in Medicare prior to further implementation of
the VBPM. The agency should share results of testing in future rulemaking to solicit stakeholder feedback in this area.

**Group size determination**

MGMA reiterates our concerns regarding CMS’ definition of a group practice for purposes of defining group practice size under the VBPM program. We urge CMS to limit the VBPM to multi-specialty groups of physicians, as defined in section 1861(r) of the Social Security Act. We continue to disagree with CMS’ interpretation of the statute to include EPs as part of this definition.

MGMA also opposes the proposal to move the PQRS GPRO self-nomination deadline from Oct. 15 to Sept. 30, and is concerned that changing the deadline will be detrimental to participation in GPRO, which the VBPM requires. We urge CMS to retain the current Oct. 15 deadline going forward to maintain consistency in the program and to encourage broader participation.

**Quality-tiering amounts**

If CMS is unable to receive quality performance data for those EPs reporting through the new PQRS “qualified clinical data registry” reporting mechanism, and if all EPs in the group satisfactorily participate in a PQRS qualified clinical data registry in 2014, CMS proposes that the providers’ group would be classified as having average quality for quality-tiering purposes due to the lack of data available to CMS to make a high-, or low-quality determination. We reiterate our concerns with the “qualified clinical data registry” option, and question CMS’ ability to make fair measurement comparisons using this option.

**Inclusion of the Medicare Spending per Beneficiary measure in the VBPM**

CMS proposes to expand the cost component of the VBPM to include an additional measure, the “Medicare Spending per Beneficiary” (MSPB) measure. The measure as proposed would include costs from three days before to 30 days after a hospital admission. CMS proposes an attribution method that would include the full costs of care during the period to every group where any practitioner submitted a Medicare claim during the covered time frame. While the rule promotes this measure as a method of addressing geographic variation in the use of long term care services, the use of this measure also would enable CMS to produce cost measures for a larger number of groups. As of the publication of the proposed rule, the NQF had not approved the use of this measure in the physician setting. As proposed, this measure could routinely penalize certain physicians whose practices focus on nursing home or home care, as well as physicians billing the new Medicare transitional care management services (99495 and 99496). MGMA opposes its inclusion in the VBPM.

**Specialty benchmarking inclusion in the VBPM cost measures**

We agree with CMS’ assertion that cost data must be adjusted to account for differences in specialty mix. However, the specialty impact table included in the discussion of this issue indicates that even with the proposed specialty adjustment, VBPM penalties are likely to be concentrated in certain specialties that treat patients with multiple and/or costly conditions. For example, approximately 15 percent of geriatricians, geriatric psychiatrists, neurosurgeons and medical and surgical oncologists would be designated as “high cost” on the total aggregate costs measure suggesting a systemic problem in the methodology. As pointed out in the rule, CMS does have a process for designating
additional specialties, which might lead to more sensitive and accurate adjustments. However, for a variety of reasons, a number of physicians, such as hospitalists, may not meet the current requirements for a separately designated specialty, which suggests that CMS also needs to identify other ways to recognize legitimate variation even within the same specialty.

**VBPM Advisory committee**

MGMA urges CMS to create an advisory committee to serve as a resource for implementation concerns regarding this program. This advisory committee should include, at a minimum, practice administrators and practicing physicians who can provide practical feedback to the government regarding the VBPM and its application in real-world care delivery situations, particularly since the statute does not allow for administrative or judicial review of the VBPM. Many implementation issues will need to be addressed after the first performance year concludes.

Lastly, the program’s reliance on PQRS emphasizes quality reporting program redundancy. There is extreme provider frustration with the administrative complexity, redundancy and inconsistent criteria associated with federal quality reporting programs. Strong anecdotal evidence from MGMA members suggests this, coupled with mounting frustrations over the risk of both SGR cuts of 24.4 percent and sequester cuts of 2 percent, creates a significant disincentive to both participate in federal quality reporting programs and accept Medicare patients altogether. CMS must immediately address the overly burdensome and complicated nature of the multiple federal quality reporting programs.

**EHR Incentive Program**

In the 2014 PFS proposed rule, CMS proposes additional options for eligible professionals (EPs) to report clinical quality measures (CQMs) under the EHR Incentive Program (meaningful use) beginning in 2014. CMS proposes an option for EPs to submit CQM information using qualified clinical data registries (as defined for PQRS) for purposes of meeting the CQM reporting component of meaningful use beginning in 2014. EPs would have to use certified EHR technology, as required under meaningful use, and report on CQMs included in the Stage 2 final rule.

The agency proposes the following additional criteria for an EP who seeks to report CQMs for the meaningful use program using a qualified clinical data registry:

- EPs must use Certified EHR Technology (CEHRT) as required under meaningful use. The EHR must be certified to all of the criteria required for CQMs, including certification of the qualified clinical data registry itself for the functions it will fulfill (e.g., calculation, electronic submission). The registry also must be a certified EHR Module that is part of the EP’s CEHRT.
- CQMs reported must be included in the Stage 2 final rule and use the same eSpecifications established for meaningful use.
- Report nine CQMs covering at least three clinical domains.
- If an EP’s CEHRT does not contain patient data for at least nine CQMs covering at least three domains, then the EP must report the CQMs for which there is patient data and report the remaining CQMs as “zero denominators,” as displayed by the EP’s CEHRT. CMS proposes this qualified registry reporting option only for those EPs who are beyond their first year of demonstrating meaningful use. CMS notes, however, that this may not satisfy requirements for other quality reporting programs that have established 12-month reporting periods, such as PQRS.
CQM Reporting Period

While the main objective of the meaningful use program is not clinical quality measure reporting, it certainly is one of the key components of the program. Appropriately aligning meaningful use with PQRS will enable successful participation and avoidance of the Medicare payment adjustments imposed for both programs in the coming years. To facilitate improved alignment between the PQRS and meaningful use, MGMA recommends that the agency reduce the reporting periods for CQM reporting mechanisms involving either an EHR or an EHR certification. While we appreciate limiting the 2014 meaningful use reporting requirements to 90 days, we remain concerned that the PQRS reporting mechanisms involving certified EHRs still require a year-long reporting period. We assert that the only way for EPs to avoid this is to use claims-based PQRS reporting, essentially requiring EPs to participate in redundant reporting because the CQM reporting requirements are the almost identical, with the one exception being the requirement under Stage 2 of meaningful use to use a certified EHR. Given all of the changes to Stage 2 and the certification requirements for 2014, as well as the ARRA-required clinical quality program alignment, we oppose continuing to require the year-long reporting period for certified EHR-enabled PQRS pathways as burdensome and overly administratively complex for EPs. Thus, we recommend a 90-day reporting period for PQRS that aligns with Stage 2 of meaningful use.

Qualified Clinical Data Registry Option

We appreciate the agency’s efforts to provide for additional reporting methods for Stage 2 of meaningful use. Streamlining the reporting process for EPs will be a critical step if quality reporting is to become effective and efficient. However, we have concerns regarding the current proposal for CQM reporting using qualified clinical data registries. We have concerns regarding the agency’s proposal to apply the new qualified clinical data registry pathway to the meaningful use program. While we agree that it is appropriate to extend this option to the meaningful use program, we are concerned about the requirement that a qualified clinical data registry be certified by an Authorized Certification Body (ACB) through the same application utilized by complete and module EHRs. Clearly registries were not part of the original certification program design. Requiring clinical registries to undergo the same type of certification process as complete or module EHRs undergo may have the unintended consequence of discouraging registries from participating in the meaningful use program and/or limiting the number of registries available to EPs. As well, it is important to remember that there is no evidence that ACBs are prepared to test and evaluate clinical registries.

Clinical registries today must undergo a rigorous approval process prior to being accepted for participation in PQRS. Each of these registries has completed a thorough vetting process which includes: (i) checking their capability to provide the required PQRS data elements; (ii) reviewing measure flows and algorithms to perform use case calculations (this checks to see whether the registry calculates the measure’s reporting and performance rates correctly); and (iii) transmitting the required information in the requested file format (XML). To encourage widespread use of these clinical registries, the PQRS approval process should be deemed as meeting the meaningful use program requirements. EPs, however, would still be required to use certified EHRs.
Electronic Specifications for CQMs

The electronic specifications for the clinical quality measures that were finalized under the meaningful use program for use by EPs beginning in 2014 are updated routinely to account for issues such as changes in billing and diagnosis codes and changes in medical practices. CMS proposes that EPs who seek to report clinical quality measures electronically under meaningful use must use the most recent version of the electronic specifications for the clinical quality measures and have CEHRT that is tested and certified to the most recent version of the electronic specifications for the clinical quality measures. EPs who do not wish to report clinical quality measures electronically using the most recent version of the electronic specifications (for example, if their CEHRT has not been certified for that particular version) would be allowed to report clinical quality measure data to CMS by attestation for the meaningful use program. We urge CMS to stipulate that an EP’s EHR does not need to be recertified for the CQMs if the specification changes.

We are also concerned that potentially having two sets of measure specifications available for the same measure at the same time through the different clinical quality measure reporting programs is not only burdensome, but potentially confusing to program participants as well. CMS should address the inconsistency of PQRS measures being added, deleted or modified on an annual basis while the meaningful use clinical quality measures are only examined every two years. This results in clinical registries and EHR vendors potentially needing to maintain two sets of specifications to assist EPs in gathering the information, even if they cannot be reported electronically. This adds to the burden and costs for not only EPs but also the clinical registries and EHR vendors themselves. With this potential for confusion and additional burdens imposed on all program participants, we recommend that CMS use the Medicare physician fee schedule process to determine the clinical quality measures and specifications for both the PQRS and meaningful use programs.

Reporting Nine CQMs Covering Three Clinical Domains

We are concerned with the proposed requirement that EPs report nine CQMs covering at least three domains for successful participation in the meaningful use program. Increasing the number of CQMs to be reported adds additional burden for Stage 2 participation due to the continued lack of appropriate CQMs for each medical specialty. Reducing the number of CQMs required to be reported by EPs and increasing the number of appropriate CQMs for the numerous medical specialties would be a strong encouragement for additional EPs to participate in meaningful use.

We appreciate your consideration of these comments. If you have any questions, please contact Anders Gilberg, senior vice president for government affairs at (202) 293-3450.

Sincerely,

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