August 24, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011

Dear Dr. Berwick:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the proposed rule entitled, “Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011,” as published in the July 13, 2010 Federal Register. We look forward to continuing to collaborate with the Centers for Medicare and Medicaid Services (CMS) on the issues in this proposed rule, those associated with the Affordable Care Act (ACA), and other administrative simplification issues which will increase practice efficiencies while improving patient care.

MGMA, founded in 1926, is the nation’s principal voice for medical group practice. MGMA’s nearly 22,500 members manage and lead 13,700 organizations, in which 275,000 physicians provide more than 40 percent of the health care services delivered in the United States. MGMA’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. Key recommendations include:

- MGMA believes it is premature to rebase and revise the Medicare Economic Index (MEI) at this time. Instead, MGMA urges CMS to first convene MEI subject matter experts onto a fully transparent, proposed advisory panel, and subsequently utilize their recommendations to guide the appropriate rebasing and revising of the MEI.
MGMA opposes CMS’s proposal to expand the multiple procedure payment reduction to outpatient therapy services and to expand the current imaging reduction to include services performed on noncontiguous body parts, regardless of modality. MGMA has concerns that these cuts are arbitrary and may result in a payment rate that does not cover the costs of providing the services.

MGMA recommends a modification of the HPSA criteria relative to the general surgery bonus payments to allow a non-HPSA hospital to be part of a HPSA if: (i) the hospital is adjacent to a HPSA; (ii) the patient resides in a HPSA; or (iii) the general surgeon maintains an office in a HPSA.

MGMA was pleased that CMS proposes creating an additional Group Practice Reporting Option (GPRO-II) for medical practices with two to 199 eligible professionals working together.

MGMA strongly urges CMS to revise its proposal to impose 2012 e-prescribing penalties based on the e-prescribing activity reported by physicians in the first six months of 2011. We assert that any penalties in 2012 should be based on a review of a physician’s 2012 e-prescribing activity.

MGMA urges CMS to clarify issues regarding the reprocessing of claims from January through June immediately. The ACA contained a number of provisions that apply retroactively, which require CMS to reprocess claims for various 2010 physician services. There were also considerable RVU revisions as part of CMS’s final “corrections” rule to the 2010 fee schedule, published in May.

**Medicare physician reimbursement**

The proposed physician fee schedule confirms a 6.1 percent reduction in Medicare physician reimbursement levels as a result of the sustainable growth rate (SGR) formula for services rendered on or after Jan. 1, 2011. Barring Congressional intervention, this reduction will occur in addition to the approximate 23 percent cut scheduled to occur Dec. 1, 2010. These two massive cuts will have catastrophic consequences on medical group practices, the patients they serve, and the effective implementation of many new policies called for in the Affordable Care Act (ACA). While the effect of insufficient Medicare payments is severe, this issue alone does not fully reflect the extent of the program’s impact on the American health care system. Most of the nation’s private health insurance companies use the Medicare physician fee schedule as a benchmark for their fee schedules. Thus, the failure of
Medicare payments to reflect increasing operational costs is magnified throughout the delivery system and affects access to healthcare for both Medicare and non-Medicare populations.

MGMA data resulting from our medical practice cost surveys clearly demonstrates operational costs continue to rise, while Medicare reimbursements to physicians simply fail to keep pace with practice costs. Both CMS and the Medicare Payment Advisory Commission (MedPAC) estimate that Medicare payments under the current reimbursement formula will continue to be reduced each year for the foreseeable future. Unless these reductions are addressed, providers will face difficult decisions as they evaluate the economic feasibility of continuing to care for Medicare beneficiaries.

MGMA has long called for the use of more timely cost information to determine reimbursement levels. The proposed fee schedule forecasts the 2011 Medicare Economic Index (MEI) to be 0.3 and CMS proposes to rebase and revise the MEI. Given the significance of the MEI, MGMA urges CMS to make every effort to verify that the data used to calculate all aspects of the MEI is accurate, representative, and fully transparent. MGMA strongly supports the CMS proposal to convene a MEI technical advisory panel later this year to review all aspects of the MEI, including the inputs, input weights, price-measurement proxies, and productivity adjustments. The association looks forward to participating in and supporting this panel.

Since this important MEI technical advisory panel is scheduled to meet this year to discuss specific aspects of the MEI, MGMA believes it is premature to rebase and revise the MEI at this time. Instead, MGMA urges CMS to first convene MEI subject matter experts onto a fully transparent, proposed advisory panel, and utilize their recommendations to guide the appropriate rebasing and revising of the MEI. Rebasing and revising the MEI prior to the MEI technical advisory panel is counterproductive to the goal of using appropriate information to develop the MEI and may cause unintended consequences.

In anticipation of the December and January Medicare reimbursement cuts, MGMA will conduct extensive member research in the fall of 2010 to detail the steps medical practices have already taken to address payment uncertainty, as well as the actions they plan to take in the future to cope with the ongoing uncertainty surrounding Medicare payments. Upon completion of this important research, we look forward to sharing the data with the agency and with Congress, so that all parties fully understand the ramifications of continued failure to repeal the current SGR formula.

**Imaging**

*Proposed CY 2011 expansion of the imaging technical component MPPR policy to additional combinations of imaging services*
MGMA opposes cuts to the technical component of imaging services when the resulting payment may not cover costs and could limit patient access to imaging services. The association did not support the increase in the multiple procedure reduction from 25 percent to 50 percent when it was proposed by CMS or when it was being considered by Congress. Now that the ACA statute has mandated this increase, we are concerned that CMS’s proposal to expand this reduction even further (to include services performed on noncontiguous body parts, including tests done using different pieces of equipment) will have dire effects. Additional payment cuts to the technical component at this time would be imprudent.

CMS’s proposal would apply across modalities, which would mean that a payment cut would occur when a patient schedules, for example, a head CT and then an MRI on the shoulder. These are separate procedures requiring separate pieces of equipment. It is unlikely that performing them during the same “session” would result in a 50 percent savings in resources on the second procedure. Rather than attempt to arbitrarily reduce payment for these services, CMS should work through the CPT/RUC process to address this matter. If CMS finalizes this proposal, it must specifically define a “session,” which would be most appropriately done through a proposed rulemaking process. It must be clear, at the very least, that a session is a time-limited unit of measure that involves performing multiple tests in quick succession in the same room. Multiple tests scheduled and performed on the same patient on the same day but separated by time and/or location in the office will not achieve the expected efficiencies that would warrant a payment reduction.

Disclosure Requirements for In-Office Ancillary Services Exception to the Prohibition on Physician Self-Referral for Certain Imaging Services

MGMA appreciates CMS’s decision not to expand the disclosure requirement imposed by Sec. 6003 of ACA to additional radiology services beyond MRI, CT and PET. MGMA also appreciates the agency’s conclusion that, with respect to preparing a list of alternative suppliers, a practice can best furnish alternate suppliers in the area surrounding the practice location. It would not be practical or desirable to require an individual list tailored to each patient’s location as this would exponentially increase the burden on the practice, requiring individualized research on the part of practice professionals. The resulting list in those circumstances could be less useful to the patient, given that practices may not be able to discern relevant information about alternative suppliers outside of their area. CMS draws the right conclusion in assuming that a patient choosing to receive care at the referring practice’s location will be equally able to receive care at alternative suppliers in the surrounding area.

With respect to the list of alternative suppliers, each practice will be uniquely qualified to compile the most relevant and useful list. MGMA appreciates CMS’s decision to not require the practice to list the ten closest alternative suppliers, instead giving the practice flexibility to compile a list that is most helpful for its patients. Many benefits derive from providing diagnostic imaging services in the same office in which the patient is treated. For example, the patient’s physician
receives expedited test results and the test is performed by professionals skilled in
the specifically ordered test. If a treating physician must supply his/her patient with
alternative outside suppliers, he/she will, to the extent possible, try to list suppliers
skilled at performing the specific test being ordered in order to receive a high
quality scan that can be easily integrated into the patient’s plan of care. MGMA
supports affording flexibility to the referring physician or practice in compiling this
list, recognizing the intent of the statute to limit the list to suppliers who meet the
Medicare definition (e.g., physicians, practitioners, a facility or other entity that
does not meet the definition of a “provider of services.”). Beginning in 2012, when
Medicare suppliers of advanced diagnostic imaging services must be accredited,
CMS may want to revisit this issue. At that point, it may benefit all parties involved
to have the accrediting bodies play a role in generating lists of alternative suppliers
skilled in specific modalities and exams.

CMS proposes to require the patient’s signature in the patient’s medical record.
MGMA notes that this goes beyond the requirements of ACA. If CMS finalizes this
aspect of the proposal, we request that CMS harmonize this requirement with the
documentation requirement placed on covered entities (as defined by the Health
Insurance Portability and Accountability Act (HIPAA)) acquiring written
acknowledgement of a medical practice’s Notice of Privacy Practices. Such an
acknowledgment can be done in paper form, electronically or through other means.

MGMA also has significant concerns about the lack of an exception to the
disclosure requirement for emergency situations. It is imperative that CMS add an
exception to account for instances where a patient is incapacitated or otherwise in
need of emergency or time-sensitive imaging services. If, in the physician’s
professional judgment, it would not be possible or in the patient’s best interest to
attempt to obtain a patient’s signature on a notice of disclosure, CMS should have a
procedure in place to allow the physician to attend to the patient without fear of
violating the law.

**Multiple Procedure Payment Reduction for Therapy Services**

CMS proposes extending its multiple procedure payment reduction policy to
therapy services. Under the proposal, effective Jan. 1, 2011, the agency would
implement a 50 percent payment reduction to the practice expense component of
second and subsequent therapy services for multiple “always therapy” services
furnished to a single patient on the same day. MGMA is concerned with the
arbitrary nature of the 50 percent reduction and the dangerous precedent set by the
proposal. It is MGMA’s understanding that many of these RVU values were already
reduced by the AMA RUC to account for the inherent duplication of various
practice expense inputs. The RUC reductions were taken with the full
understanding of the multiple procedural-nature of therapy services. If
implemented, this proposal will significantly under-pay practices and practitioners
for the provision of therapy care under Medicare.
CMS cannot base its reimbursement policy for therapy services on assumptions that will in effect lead to payments below the cost of delivering care. Multiple therapy sessions across disciplines during the same day involve more than one therapist and/or aide. Within a therapy plan of care, “always therapy” services often involve different supplies and utilize different office space. This proposal will almost certainly lead practices with therapy services to reduce the number of Medicare beneficiaries they treat. MGMA is concerned with the potential negative impact this proposal could have on Medicare patient access and care. Given CMS’s use of flawed assumptions and the resulting beneficiary risk, MGMA urges the agency to withdraw the proposal.

**Geographic practice cost indices**

Geographic practice cost indices (GPCIs) are used to measure resource cost differences among geographic localities compared to the national average for the work, practice expense, and malpractice components of the fee schedule. In the proposed regulation, CMS calls for several modifications to the GPCI inputs, some as a result of ACA required changes, and others due to the rippling effect to the GPCI caused by the agency’s proposal to rebase and revise the MEI. Other changes are linked to the statutory requirement to update GPCI values every three years. This ultimately results in a convoluted blur of interconnected proposals that makes it next to impossible to understand the impact of one from the other. Further complicating the matter are the supplemental materials released by the agency’s GPCI contractor after the issuance of the proposed 2011 physician fee schedule.

Pending further congressional intervention, the work GPCI floor of 1.0 will expire at the end of 2010, which is of grave concern to rural healthcare providers. ACA also requires CMS to assess technical aspects of the practice expense GPCI by 2012, yet curiously CMS proposes finalizing these changes in 2011.

Since ACA already requires the Department of Health and Human Services (HHS) to analyze current methods of establishing GPCIs and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in different localities, MGMA urges CMS to simply slow down and not finalize the many proposed modifications to the GPCIs at this time. Similar to our recommendations concerning the MEI, MGMA urges CMS to convene a GPCI technical advisory panel in a formal and fully transparent manner. Then, allow key stakeholders to meet first, and subsequently use the panel’s input to develop formal recommendations to the agency concerning the GPCI values for 2011 and beyond.

**Transitioning newly “bundled” services**

Given CMS’ decision in the last year’s final rule to phase in the use of new practice expense values over four years, MGMA understands the position of CMS, consistent with that of the AMA RUC, that new codes are not transitioned as there are no historical PE RVUs to use in the computations. However, as suggested by the RUC
in its comments to CMS, the agency could differentiate from those codes that reflect new technology from those that have CPT modifications due to bundling efforts and other clarifications (i.e., existing services with new CPT codes). In accordance with the RUC’s recommendations to CMS, MGMA reiterates our request that the practice expense RVUs for existing services that should now be reported under a different coding structure as a result of being identified by the Five-Year Review Identification Workgroup be transitioned over the next four years as well.

Value-based payment modifier and the physician resource use and measurement reporting program

Given the daunting challenges that must be overcome before the value-based payment modifier is scheduled to take effect, MGMA appreciates the outreach the agency has shown in working with the provider community to further develop the complimentary programs of the RUR and the value-based payment modifier. Furthermore, MGMA looks forward to participating in the agency’s proposed large-scale effort to garner widespread stakeholder input.

Because transparency is one of the primary goals of CMS’ VBP initiatives, the association is pleased that the agency finally proposes to discontinue the use of proprietary commercial episode grouper software. MGMA also appreciates the agency’s proposal to gradually phase in the RUR over time and, more importantly, incorporate adjustments as the agency gains additional experience after each stage of the program. MGMA welcomes CMS’ assertion that the implementation of this program is dependent on the resolution of many important issues, specifically the challenges of proper risk adjustment, attribution, benchmarking, peer groups, minimum case sizes, cost and quality measures, and composting methods. Providers treat a wide range of patient population mixes in a variety of practice settings, and sometimes due to the practice’s longevity in a community or an established reputation of an experienced provider, they treat a disproportionate share of patients that are elderly, disabled and/or with complex co-morbid conditions. MGMA agrees with the agency’s concern that current episode grouper software technology, even enhanced with future software specifically designed for the Medicare patient population, cannot properly risk adjust for diverse geographic variations in quality, spending and patient characteristics.

The association is pleased CMS recognizes the need to distribute confidential feedback reports at both the individual provider and the group level since medical groups work as a team of providers to treat a specific patient. However, in order for the report to be meaningful and actionable for the practice, MGMA recommends that the group practice reports still include detailed confidential information on individual providers’ performance in the practice.

MGMA concurs with the need to send feedback reports both electronically and via regular mail. However, MGMA steadfastly opposes the proposal to distribute RUR reports by leveraging the existing infrastructure used to dispense Physician Quality Reporting Initiative (PQRI) feedback reports. According to MGMA member research
conducted in Feb. 2010, medical practices cited multiple administrative challenges associated with the arduous process to access PQRI feedback reports. This data shows that fewer than half (48 percent) of responding practices that attempted to participate in the 2008 PQRI were able to successfully access their 2008 PQRI feedback report. This is actually a decline from the 51 percent that were able to retrieve their 2007 PQRI feedback reports. Compared with the approximately five hours it took to access their 2007 PQRI feedback reports, on average it took almost nine hours by practice staff and physicians to successfully download the 2008 PQRI feedback reports. Instead of utilizing the flawed PQRI feedback report distribution method, MGMA strongly urges CMS to offer groups the same options as offered to an individual provider. Specifically, group practices must have the ability to receive feedback reports via email or through a significantly less onerous website download process. Finally, MGMA recommends that the agency offer providers the option of receiving both detailed feedback reports as well as condensed versions. This will facilitate the ability of time-stressed medical providers to absorb the information and benefit from the feedback, and then explore the detailed version when time permits.

Though MGMA members expressed interest in incorporating quality performance information in the confidential resource use measurement reports, MGMA remains concerned with the proposed use of quality data from the Generating Medicare Physician Quality Performance Measurements Results (GEM) project. Even if CMS proposed using data from the PQRI, our apprehension remains. For providers to trust these reports, accurate and reliable quality measurement data must be used. Considering that PQRI participation success rates for the 2007 and 2008 reporting periods have been dismal, in addition to the numerous measure analytic revisions the agency has been forced to make, the validity of incorporating PQRI data into the RUR would raise serious questions by providers. At the very least its use would be perceived as premature since providers currently only have feedback from the 2007 and 2008 PQRI reporting periods.

As MGMA has stressed in previous formal comments, no public or private transparency efforts to date utilize GEM data because of its flawed methodology. For example, there are situations where health systems operating across multiple states were only listed in one state in the GEM data file. In addition, GEM data is overly focused on preventive care services and thus would not apply to all medical specialties. Given these reasons, the use of either of these quality data sets in conjunction with measurement of provider resource use is imprudent at this time. Before CMS incorporates quality data information into these reports, MGMA urges the agency to first improve and correct the PQRI and GEM project data collection methodologies.

**Primary care incentives and general surgery in HPSA incentives**

Since ACA was only enacted in March of this year, MGMA appreciates CMS’ rapid inclusion of the primary care incentive payment program (PCIP) into the 2011 proposed physician fee schedule. This 10 percent payment incentive for certain
primary care practitioners for 2011 through 2016 is based on a threshold for which eligible providers must charge at least 60 percent of their total annual allowed Medicare charges as office, nursing facility, or home visits. Given the shortage of primary care providers and the swelling number of new Medicare beneficiaries, both Congress and the agency should utilize the PCIP to attract as many providers toward primary care as possible. Thus MGMA urges CMS to exclude lab and other ancillary service codes from the 60 percent threshold in order to maximize the number of providers that may qualify for the PCIP. MGMA also urges the agency to include all primary care service codes. The association notes the absence of the vaccination code and the two new Annual Wellness Visit codes, and believes the agency should include these in Table 39.

The proposed regulation also implements a 10 percent payment incentive for general surgeons enrolled in Medicare with a primary specialty designation of general surgery that furnish major procedures (10-day or 90-day global service period) in a Health Professional Shortage Areas (HPSAs). The agency cites 489 surgical procedures in a 10-day global period and 3,796 surgical procedures in the 90-day global period that are eligible for this bonus and also clarifies that providers are eligible for both the HPSA incentive as well as the general surgery HPSA incentive. MGMA is concerned that this proposal, as currently defined, does not fully address situations in which there is a shortage of general surgeons. MGMA recommends modifying the HPSA criteria to allow a non-HPSA hospital to be part of a HPSA if: (i) the hospital is adjacent to a HPSA; (ii) the patient resides in a HPSA; or (iii) the general surgeon maintains an office in a HPSA.

MGMA looks forward to working with the agency to improve these incentive programs in future years so that as many applicable providers as possible can fully benefit from them.

**Physician quality reporting initiative**

MGMA continues to support quality improvement initiatives that improve patient care and clinical outcomes. As advocated for by MGMA, CMS proposes two significant improvements to the 2011 Physician Quality Reporting Initiative (PQRI), both of which begin to address some of the substantial problems with this beleaguered program.

First, the agency proposes to reduce the PQRI reporting threshold for claims-based reporting from 80 percent to 50 percent. MGMA supports this proposal since it will allow a greater number of participants to earn the incentive (or in future years, avoid the penalty). We also appreciate CMS’ commentary regarding the limitations of claims-based reporting. Since the proposed fee schedule discusses how previous PQRI claims-based participants either successfully reported well above the 80 percent threshold, or alternatively, completely failed in their attempt to participate, MGMA remains concerned that lowering the threshold is largely a symbolic gesture and may have an unintended consequence of shifting prospective participant
interest toward a widely flawed reporting method that was not specifically designed for quality measure reporting.

MGMA agrees with the agency that one mode of quality reporting does not suit all practices, but advises CMS to carefully consider the potential negative implications of prematurely discontinuing PQRI participation via claims-based reporting. Many participants have struggled and finally achieved success via this reporting option. CMS should continue offering multiple reporting mechanisms, including the option of reporting via the claims-based method, for several years.

The second improvement to the PQRI is the proposal for a PQRI reporting option for realistically sized groups. We are pleased the agency accurately recognizes the significant value of a team of medical providers working together to provide care for a single patient. As a representative and proponent of the medical group practice delivery model, MGMA was pleased that CMS proposes creating an additional Group Practice Reporting Option (GPRO-II) for medical practices with two to 199 eligible professionals working together. Groups selected by CMS for the GPRO II must submit quality measure information for three to six individual 2011 PQRI measures, depending on the size of the group. This new option, while initially limited to 500 selected groups, holds the promise of improving the PQRI by eliminating redundant measure reporting by multiple providers in the same practice treating a single beneficiary. MGMA remains committed to assisting the agency in the further development of this innovative option and to help provide the much-needed details to our medical group practice members. Since it takes a significant amount of time and training to participate in the PQRI, MGMA urges the agency to announce the details surrounding this new group practice reporting option as soon as possible. Finally, MGMA approves of the CMS proposal to evaluate PQRI participation at the individual provider level, should the entire group not qualify for the incentive payment.

With the exception of the above two improvements, the agency proposes minimal additional changes to the 2011 PQRI. MGMA concurs with the proposal to offer the same 2010 PQRI reporting options in the 2011 PQRI and we also appreciate the agency’s commentary about the need to move in the direction of maintaining program stability and continuing program flexibility.

The final 2011 PQRI measure specifications, which will include the specific codes required for successful reporting, will be available in late 2010. Medical group practices and PQRI-qualified vendors need to properly train staff, reconfigure program software, and take other preparatory steps before 2011; therefore the PQRI measure specifications are needed as soon as possible and MGMA urges the agency to release them soon. Furthermore, MGMA urges CMS to release the names of the 2011 PQRI qualified registries and qualified EHR vendors as soon as possible so that medical practices can begin interacting with these eligible vendors.

CMS already intends to post the names of 2010 PQRI participating providers regardless of whether the participant was successful (i.e. earned the 2010 PQRI incentive payment) on a Physician Compare website. On this website, the agency is
now proposing in the 2011 physician fee schedule to differentiate which providers and group practices succeeded from those who attempted but were not successful. MGMA urges CMS to reconsider this proposal. Until further PQRI reporting problems are addressed and both the success rates and participation rates are significantly improved, prematurely posting PQRI information serves as a barrier to practices contemplating participation. Practices have legitimate concerns about this information’s potential be used and misinterpreted by third parties, private health insurers, and the practice’s patient population. Attempting participation in the PQRI should be rewarded and should not become a potential public liability. If CMS does finalize the proposal to post the names of participants that attempted but were not successful, at the very least MGMA urges the agency to make the linkage between PQRI participation and the Physician Compare website abundantly clear in its PQRI educational materials. MGMA recommends that the agency precisely specify the performance data the agency plans to post, so interested practices can be fully aware of the consequences of attempting to participate in the PQRI.

The association is very disappointed to not find more robust details in the proposed physician fee schedule surrounding the ACA requirements for the agency to provide interim feedback reports as well as details regarding the development of a PQRI appeals process. We will continue to urge Congress and HHS to provide the agency with additional resources so that CMS can enhance the PQRI in these two key areas.

MGMA does not believe that CMS even begins to meet the ACA requirement by simply providing a feedback report on or about the time of issuance of the incentive payments. MGMA maintains its longstanding position that for the PQRI to truly improve patient care, it should provide timely and actionable clinical information to physicians. Receiving a feedback report on a PQRI reporting period in the fall of the next year is simply not feedback, but just stale information that will only assist a struggling PQRI participant determine why they did not successfully qualify for the incentive. If CMS wants PQRI participation and success rates to significantly improve, it must provide quarterly or monthly feedback so that participants have the ability to correct their reporting habits during the same reporting period. We urge the agency to review our position on the inadequate PQRI feedback report distribution method in the Physician Resource Use and Measurement Reporting Program portion of our comments.

MGMA urges CMS to significantly augment the proposals regarding the much-needed PQRI appeals process. We urge the agency to consider basing the informal process on the current inquiry process as merely a starting point. According to MGMA member feedback, practices seeking assistance from CMS PQRI contractors often experience long wait times for assistance, especially following major PQRI announcements such as the release of the feedback reports and incentive payments. Medical practices spend considerable time, money, and energy on attempting successful participation in the PQRI and deserve to seek recourse when they disagree with the agency’s feedback report. Now that the agency proposes to post additional PQRI information on a public website, an appeals process is more important than ever. Finally, should a practice successfully appeal a PQRI decision,
MGMA urges CMS to immediately revise the Physician Compare website to minimize further practice liabilities.

The ERX Incentive Program

MGMA strongly supports electronic prescribing (eRx) and other health information technology initiatives that will improve clinical care and reduce administrative costs. ERx offers a number of important opportunities to prescribers and pharmacists. From the clinical perspective, eRx can permit the clinician and pharmacist to review allergies, drug-drug interactions and contraindications that, if not identified, could have a dangerous impact on the patient. ERx can also facilitate administrative functions such as accessing information related to formulary and benefit management. Additionally, fully integrated eRx systems have the potential to reduce the time prescribers and pharmacists spend on formulary management issues, create efficiencies in the delivery of health care, and provide enhanced access to electronic patient health information.

Eligibility

CMS proposes to continue to require the current criteria for determining an eligible professional’s success as an e-prescriber. For the 2011 incentive program, CMS proposes that each eligible professional report the G-code indicating that he/she electronically generated at least one prescription during a patient encounter for at least 25 patient encounters during the reporting period. MGMA supports this continued streamlined eligibility requirement. This simplified approach, requiring qualified professionals to report 25 or more instances of electronic prescribing during a reporting period, is reasonable and should continue to facilitate increased adoption of this important technology.

Reporting options

For 2011, CMS proposes three reporting mechanisms for individual eligible professionals. The agency would:

- Retain the claims-based reporting mechanism used in the 2009 incentive program;
- Retain registry-based reporting mechanisms; and
- Permit EHR-based reporting mechanism for reporting the eRx.

We strongly support offering providers multiple methods for reporting eRx data. Under this proposal, only 2011 PQRI-qualified registries could submit measure results and numerator and denominator data on the eRx measure. We also support the ability of practitioners to report both PQRI measures and the eRx incentive code using the same registry if he or she uses the registry reporting option. While MGMA concurs with the CMS commentary regarding the limitations of claims-based
reporting since the claims processing system was not developed for the submission of eRx data, MGMA encourages CMS to continue offering claims-based reporting system for reporting eRx measures until the transition to reporting via registries and EHRs has been fully developed.

Similar to the PQRI program, MGMA encourages CMS to release all measure specifications as quickly as possible to ensure sufficient time for vendors to modify software.

Denominator codes

MGMA supports the proposal to expand the scope of the denominator codes for 2010 to professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home-care setting. We encourage CMS to continue expanding the program, adding additional codes where appropriate, to facilitate additional medical specialties adopt eRx.

Intersection with the Medicare EHR incentive program

It is clear that there exists significant overlap between the 2011 Medicare eRx initiative and the 2011 Medicare EHR incentive program. As CMS has historically been unable to provide feedback to providers until the year following their participation in the program, it will be extremely challenging for providers to determine if they have qualified for one or both of these incentive programs in a timely manner. Thus, it is expected that many eligible professionals will apply for both the eRx and EHR incentive programs in 2011. As eligible professionals are not eligible to receive payments from both programs in 2011, it is critical that CMS accurately and quickly ascertains if an eligible professional has successfully completed all requirements for either program, and expediently report the results to the eligible professional.

Penalties

The proposed rule states, “…we believe the payment adjustment should be applied primarily to assure that those who have a large volume of prescribing do so electronically, without penalizing those for whom the adoption and use of an electronic prescribing system may be impractical given the low volume of prescribing.” While we concur with the idea that low volume prescribers should not be penalized, we also believe that CMS should exercise additional flexibility in assigning penalties. For example, a higher volume prescriber may be located in a geographic area where the local pharmacies do not have eRx capabilities. Similarly, certain medical specialties experience a high volume of controlled substance prescribing. While the DEA has issued an interim final rule permitting the e-prescribing of controlled substances in certain circumstances, the regulation has not been finalized as of this writing and presents numerous barriers that prevent the
wide use eRx for controlled substances. CMS should, therefore, carefully review the individual practitioner’s circumstances prior to assigning any penalties.

CMS states that “…although earning an incentive payment under the EHR incentive payment program precludes an EP from earning an eRx incentive payment, it does not preclude the EP from being subject to the eRx penalty. In order to avoid the eRx penalty, an EP participating in the Medicare EHR incentive program still must meet the relevant eRx penalty criteria for being a successful electronic prescriber.” We contend that if CMS has determined that an EP is a “meaningful user of EHR” no eRx penalties should be assigned. The eRx criteria vary significantly between the two programs. Low volume prescribers could potentially meet the EHR incentive program requirement of 40 percent of prescriptions sent electronically yet fail to meet the minimum of 25 electronic Medicare prescriptions. It would be unfair to penalize these practitioners when they have met the requirements of the EHR incentive program. We strongly encourage the agency to reexamine these proposed penalties and synchronize the eRx and EHR incentive program to ensure that “meaningful EHR users” are not subject to eRx penalties.

In addition, no penalties should be assigned in 2012 to:

- EPs, who have registered for the EHR incentive program in 2012, 2013 or 2014. EPs seeking to qualify for the payments must have certified systems (including e-prescribing capability) and thus should not be subject to eRx penalties. It is unreasonable to expect EPs to purchase and implement complicated and expensive stand-alone eRx systems to avoid penalties in 2012, only to replace those systems with complete and certified EHRs to meet the EHR incentive program requirements.

- EPs who indicate that they intend to retire in 2013 or 2014. It is unreasonable to expect EPs to transition to a complicated and expensive stand-alone eRx system for a short period of time prior to retirement.

- EPs who prescribe a large percentage of controlled substances. As the DEA has not yet released a final rule on the e-prescribing of controlled substances, vendors have not yet produced the required software. As a result, EPs may be forced to utilize paper prescriptions until the final rule is published and the appropriate software is widely available.

We also have serious concerns with the CMS proposal to assign penalties in 2012 based on 2011 reporting. CMS states, “For purposes of the 2012 eRx penalty, we propose that the proposed 2011 criteria for successful electronic prescribing would need to be satisfied during the 2012 eRx penalty reporting period of January 1, 2011 through June 30, 2011 for the same operational reasons that we are proposing a 6-month reporting period for the penalty for individual EPs.” Using this logic, even if a practitioner satisfied the reporting requirement within the later part of 2011, they
would be subject to 2012 penalties. We contend that EPs satisfying the minimum of 25 electronic prescriptions at any time during the reporting period (January 1, 2011 to December 31, 2011) should not be subject to penalties. We believe that the agency should review 2011 data after the February 28, 2012 deadline for reporting before assigning any penalties.

We support the CMS proposal to not penalize any practitioner who has less than 10 percent of their Medicare allowable charges “comprised of services which appear in the denominator of the 2011 electronic prescribing measure…”

Group practice reporting option

We are pleased to see that for the 2011 incentive program CMS has significantly expanded the definition of “group practice.” Expanding this definition will facilitate the adoption of eRx by a larger number of practitioners. We support the proposed definition of “a single Taxpayer Identification Number (TIN) with 2 or more EPs, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN. ‘Group practice’ would also include group practices participating in Medicare demonstration projects approved by the Secretary…” We also appreciate the reasonable, minimum number of e-prescriptions required for program participation by the various sizes of group practices.

Feedback Reports and Payments

To date, CMS has not yet released feedback reports or made any payments to EPs for the 2009 eRx incentive program. We strongly encourage the Agency to expedite these reports and payments as quickly as possible for the 2009 program and take all appropriate steps to ensure that feedback reports and payments for the 2010 and 2011 programs are issued to EPs in a timely manner. Should an EP, for example, complete the 2011 incentive program requirements in January 2011, they should not have to wait 18 or more months to receive feedback and payment. Reports and payments issued soon (i.e., 30 days) after completing the program requirements would act as an additional incentive for EPs to transition to eRx. This more rapid reporting process would also permit EPs that failed to meet the 2011 program requirements the opportunity to correct the problem and qualify for 2011 payments.

Public reporting

In 2011, CMS intends to post the names of eligible professionals who successfully e-prescribed for the 2010 eRx Incentive Program at www.medicare.gov. In addition, the agency proposes to post the names of eligible professionals and group practices that are successful electronic prescribers on the Physician and Other Health Care Professionals Directory. MGMA urges CMS to carefully review all data for accuracy
and post only those names of eligible professionals and group practices that have satisfactorily submitted data and successfully earned the incentive payments.

Signature Requirement for Clinical Diagnostic Laboratory Tests

CMS proposes requiring a physician’s or non-physician practitioner’s (NPPs) signature on requisitions for clinical diagnostic laboratory tests. MGMA opposes this ill-conceived requirement and recommends that CMS withdraw the proposal and maintain the long-standing policy of not requiring provider signatures on requisitions. This current policy stems from an exhaustive 2001 negotiated rulemaking process, in which MGMA participated, through which it was determined that a physician signature is not required on a laboratory requisition. This is the status quo and should be maintained.

CMS’s rationale for the proposal is that it would help alleviate confusion about the existing requirements. However, much of the confusion stems from CMS itself. CMS acknowledges its large role in creating the confusion and illustrates its missteps such as dropping language from manuals, using the terms “order” and “requisition” interchangeably, and including unclear language in transmittals. Since CMS is at fault for creating the confusion, it should not impose onerous requirements in an attempt to remedy the problem.

As acknowledged in the proposed fee schedule, the CMS manual states that “while a physician order is not required to be signed, the physician must document in the medical record, his or her intent that the test be performed.” The manual also states that in addition to a written document, orders may be submitted via telephone call or electronic mail. In its latest proposal to require signatures on requisitions, CMS claims that “it would be less confusing because a physician’s signature would then be required for all requisitions and orders.” Contrary to the attempt to simplify and clarify requisition and order requirements, it appears the current proposal has the potential to nullify the current flexibility providers have with order documentation.

Requiring an explicit provider signature on a requisition (or order) creates a significant burden for medical practices already subject to a multitude of administrative hassles. CMS is overlooking the onerous practical implications of this proposal. The Agency states that the proposal would not increase the burden on physicians because they are already providing a signature to laboratories, but CMS does not provide any evidence or data to support this claim. According to MGMA member feedback, it is uncommon for physicians to sign requisitions since administrative professionals typically complete the forms on their behalf. The proposed requirement will create an additional administrative burden on physicians, taking their time away from patients to sign requisition forms. MGMA estimates this could double the amount of time to complete a requisition. By having to wait for a physician signature, it will delay test submission to the laboratory. After receiving a requisition, laboratories will also spend time following up with providers for missing signatures. These delays will impair the quality of a
specimen, possibly impacting test results or requiring a patient to provide a new specimen. Additionally, the delays will needlessly postpone when the physician and patient receive the test results, disrupting the treatment process and possibly causing additional harm to the patient. Timely laboratory testing and reporting test results to the physician are essential to patient care and should not be impeded.

**2010 claims reprocessing issues**

The ACA contained a number of provisions that apply retroactively, which require CMS to reprocess claims for various 2010 physician services. There were also considerable RVU revisions as part of CMS’s final “corrections” rule to the 2010 fee schedule, published in May. While contractors prospectively implemented revised fee schedules in June, there is significant confusion regarding the re-processing of claims from Jan. through June. MGMA members have received different instructions from different contractors, MGMA urges CMS to clarify this situation immediately.

MGMA appreciates your consideration of these comments and looks forward to collaborating to educate medical group practices on the numerous Medicare program changes. If you have any questions, please contact Patrick Smith in the Government Affairs Department at (202) 293-3450.

Sincerely,

William F. Jessee, MD, FACMPE
President and Chief Executive Officer