December 29, 2009

Charlene Frizzera  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS–1413–FC  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

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

Dear Ms. Frizzera:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the final rule entitled, “Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010,” as published in the November 25, 2009 Federal Register. We appreciate the outreach conducted by the Centers for Medicare & Medicaid Services (CMS) and the willingness to participate in constructive dialogue to improve the Medicare program. We look forward to continuing to collaborate on this and other issues of importance to medical group practices.

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 physician time and resources can be focused on patient care.

MGMA offers detailed critiques and recommendations related to this rule. Key recommendations include the following:

- MGMA applauds CMS for finalizing its proposal to remove physician-administered drugs from the sustainable growth rate formula calculations. Repeatedly called for by MGMA, this administrative step will mitigate the size of future Part B reductions.
- MGMA urges CMS to quickly finalize testing the Physician Quality Reporting Initiative (PQRI) reporting mechanism via electronic health records (EHRs) and allow for 2010 PQRI participation through qualified EHRs.
- MGMA opposes the CMS definition of a group practice for purposes of the new PQRI group practice reporting option. Instead, the Agency should allow any interested medical group, regardless of size, to report on the proposed measures through a properly structured group practice reporting mechanism.
- MGMA opposes the increased utilization assumption for magnetic resonance imaging
(MRI) and computed tomography (CT). The change is based on erroneous assumptions and will result in payment rates so low as to make it economically unfeasible for physicians to perform imaging services in their offices.

- MGMA remains concerned about several provisions implementing the accreditation requirements for advanced diagnostic imaging services in the Medicare Improvements for Patients & Providers Act (MIPPA). In some instances, the Agency has finalized changes that unnecessarily expand on the statutory requirements for entities seeking to be designated as accrediting bodies, which would ultimately have a negative effect on the suppliers of advanced diagnostic imaging services.

- MGMA remains extremely concerned over the Agency’s continued use of proprietary commercial episode grouper software, since transparency is one of the primary goals of CMS’ Value Based Purchasing (VBP) initiatives. MGMA strongly questions whether the episode grouper software properly risk adjusts for diverse geographic variations in quality, spending and patient characteristics.

**Medicare physician reimbursement**

The final physician fee schedule implements a 21.2 percent reduction in Medicare physician reimbursement levels for services rendered on or after Jan. 1, 2010. Both CMS and the Medicare Payment Advisory Commission (MedPAC) estimate that payments will be reduced every year for the foreseeable future — a trend that will have critical consequences for the entire health care system without legislative action. Since the president has signed legislation temporarily halting this cut, we wish to acknowledge the Agency’s efforts to release information to providers and to CMS contractors to manage this delay. In addition, as future changes to the Medicare reimbursement system are legislated by Congress, MGMA looks forward to working with the Agency to ensure that any future Medicare reimbursement system is implemented in a fair and transparent manner.

MGMA applauds CMS for finalizing the proposal to remove physician-administered drugs from physician expenditure targets in previous years. This important step, long advocated for by MGMA, significantly reduces the cost of a long-term solution to the sustainable growth rate (SGR) formula.

**Resource-based practice expense relative value units (RVUs)**

MGMA has long supported the need to update the practice expense per hour data used in the development of practice expense RVUs. The Association recognizes this year’s final rule is pursuant to the recommendation of more than 70 physician specialty societies that the Agency use a new survey to update practice expense data across specialties at the same time in a standardized manner. The goal is a multi-specialty approach to collect recent, reliable, and consistent practice expense data for all specialties and healthcare professionals.

In adopting this recommendation for 2010, CMS finalized its proposal to use the Physician Practice Information Survey (PPIS), which was coordinated by the American Medical Association (AMA) and CMS’ contractor, the Lewin Group, along with significant support from the national medical specialty societies. MGMA understands that all physician specialty organizations had an opportunity to assist in the development of the survey instrument and were provided frequent updates throughout the process. In this context, MGMA does not endorse or dispute the results, but recognizes using the PPIS data will result in a payment redistribution among the specialties. MGMA urges CMS to continue to work closely with the AMA and the physician specialty organizations that participated in the survey to make every effort to ensure the resulting practice expense data are accurate and representative.

Given CMS’ decision in the final rule to phase in the use of new practice expense data 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 RUC recommendations to CMS, MGMA requests that the practice expense RVUs for existing services that are now 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.

**Equipment usage assumption**

While MGMA appreciates the Agency’s decision to scale back the proposed changes to the equipment usage assumption by limiting it to MRI and CT, MGMA maintains its objections to the assumption that all MRIs and CTs are used (or should be used) 90 percent of the time (or 45 hours/week), rather than the current 50 percent of the time (or 25 hours/week) for purposes of calculating the practice expense payment for use of the equipment. CMS fails to recognize that, while the Agency appears on the surface to assume that medical equipment is used 50 percent of the time, the actual medical equipment allowances paid to physician practices reflect an effective utilization rate of approximately 90-100 percent. This is because the physician fee schedule methodology only takes into account 50-60 percent of medical equipment costs. Assuming a 50 percent utilization rate but taking into account only 50 percent of actual equipment costs yields a medical equipment allowance that is the same as if CMS assumed a 100 percent utilization rate but took into account all of the estimated equipment costs. Thus, if CMS changes the equipment utilization assumption used in the physician fee schedule methodology, the equipment allowance clearly will be inadequate to cover the medical equipment costs of even the most efficiently operated practices.

More generally, CMS appears to assume that the current physician fee schedule methodology overpays services with relatively high medical equipment and other direct costs. In fact, we believe that precisely the opposite is true. Most of a practice’s expenses paid under the physician fee schedule consist of “indirect costs,” such as rent, utilities, administrative costs and other types of overhead costs. The “pot” of funds paid for indirect costs is allocated among services based primarily on the relative time, intensity and complexity of the physician work associated with each service, as measured by work RVUs (W-RVUs). Services involving the acquisition of diagnostic images have no W-RVUs. For this reason, the indirect costs associated with these services are undervalued.

Of additional concern, CMS relies on the studies of advanced diagnostic imaging cited by MedPAC and others. We do not agree with the reasoning cited by MedPAC and CMS that the availability of CT in rural hospitals would eliminate any concerns about access to services should these changes decrease or eliminate comparable services in physician offices. Shifting services from the office setting to the hospital outpatient department, where reimbursement is higher than in a physician office, is not a cost-efficient means of providing services. In addition, this argument denies the long-recognized benefits associated with physicians and group practices providing comprehensive services to their patients in their offices, especially in rural areas.

Finally, we have concerns that utilizing equipment 45 hours per week is simply not a realistic objective, given the need to leave space in a practice’s schedule for patients with urgent needs, to accommodate the elderly or other patients that require additional time pre- and post-scanning assistance and to account for cancellations or other unexpected occurrences. Keeping equipment in use 45 hours per week would also require a practice to employ more than one full-time technician. By implementing this change, CMS is jeopardizing the ability of practices to own MRI and CT equipment and to provide needed comprehensive services to its patients.

**Specific coding issues related to physician fee schedule**

*Consultation services*
Practices are very confused regarding the proper billing procedures in a variety of situations. MGMA urges CMS to require Medicare contractors to continue the education process relative to the consultation issue well into 2010. The Association continues to encourage CMS to monitor the transition for any unintended consequences that may result, such as difficulties that may occur with claims processing issues. These include situations such as crossover claims, because other payers may retain the distinction between new and established patient visits versus consultation services as well as split/shared billing.

MGMA appreciates CMS’ development of G-codes for telehealth delivery of initial inpatient consults; however the Association remains highly concerned that a modifier to distinguish between the admitting physician and those furnishing services has yet to be created. CMS needs to educate the provider community on the usage and claim submission timing requirements of the modifier. The Association encourages the Agency to monitor inadvertent consequences that may result, such as an admitting physician forgetting to put the modifier on a claim or where an admitting physician does not submit a claim, but the furnishing physicians do.

**Issues related to MIPPA**

*Physician payment, efficiency, and quality improvements – PQRI*

**Feedback reports**

MGMA continues to support quality improvement initiatives that focus on improving patient care and clinical outcomes and studying the cost-effectiveness of resource use. CMS still must address significant PQRI analytical issues and continue to offer educational and outreach opportunities to providers as the program evolves.

Yet again, MGMA urges CMS to provide participating practices with the ability to appeal PQRI feedback reports. Detailed confidential interim feedback reports should be provided by the Agency that clearly identify reporting errors to PQRI participants. The Agency should also provide detailed instructions on how practices can make timely corrections to meet the reporting threshold and receive the appropriate incentive.

In the spirit of improving PQRI participation, the Association again urges CMS to provide MGMA and other medical associations with PQRI data set files, so physician organizations can analyze this information, help CMS improve the clinical appropriateness of physician quality measures and better understand and correct potential barriers to successful reporting.

**Reporting mechanisms**

MGMA supports the expanded number of available PQRI quality measures as well as multiple reporting mechanisms and reporting periods to address the widespread variation in types of medical practices.

The Association strongly concurs with CMS’ concerns regarding the limitations of claims-based reporting, since the claims processing system was not developed for the submission of quality data. Therefore, MGMA urges CMS to quickly finalize testing the PQRI reporting mechanism via EHRs and allow for 2010 PQRI participation through qualified EHRs. MGMA remains committed to assisting the Agency as it tests the EHR data submission process. Given that many practices are either accustomed to participating in the PQRI via claims-based reporting or have not yet invested in EHRs, MGMA urges CMS to carefully consider the potential negative implications of prematurely discontinuing PQRI participation via claims-based reporting.

**Reporting on quality measures by group practices**
As a representative and proponent of the medical group practice delivery model, MGMA appreciates that CMS recognizes the value of a team of providers working together to provide care for a single patient. A properly structured PQRI group practice reporting method would also help eliminate redundant measure reporting by multiple providers in the same practice treating a single beneficiary.

By unreasonably restricting participation to 200 individual eligible professionals who reassign their billing rights to the group, CMS essentially limits this reporting method to large multispecialty group practices. The vast majority of group practices have far less than 200 individual eligible professionals so it is therefore unfortunate that CMS finalized the proposal to implement this reporting option in a manner that only a select few group practices could utilize. MGMA recommends that CMS, at the very least, offer an alternative reporting option that uses a statistical sampling model for primary-care oriented medical group practices that report measures only applicable to primary care physicians. MGMA eagerly awaits further details on this program and offers CMS assistance in implementing improved alternatives, so the majority of interested medical group practices can participate via the PQRI group practice reporting option.

Physician Resource Use Measurement and Reporting Program

MGMA is committed to supporting CMS’ further development of the Physician Resource Use Measurement and Reporting Program so that it properly assesses provider efficiency and furnishes a confidential feedback report comparing physician resource use with that of their peers.

Given that transparency is one of the primary goals of CMS’ VBP initiatives, the Association remains extremely concerned over the Agency’s continued use of proprietary commercial episode grouper software. In addition to lack of transparency, MGMA strongly questions whether the episode grouper software properly risk adjusts for diverse geographic variations in quality, spending and patient characteristics.

MGMA appreciates the Agency’s recognition of the group practice business model and the value of a team of providers working together to treat a specific patient. Therefore MGMA concurs with the Agency’s decision to offer confidential feedback reports to medical group practices. However, in order for the report to be meaningful and actionable for the practice, MGMA recommends that the group practice report still include detailed confidential information on individual providers’ performance in the practice.

Incentives for electronic prescribing (e-prescribing) – The E-Prescribing Incentive Program

MGMA is strongly supportive of e-prescribing and other health information technology initiatives. We believe utilization of e-prescribing specifically will improve clinical care and reduce administrative costs. The challenge for medical groups, however, continues to be how best to adopt this technology in the most cost-effective manner.

The Association is well aware that e-prescribing offers a number of important opportunities to prescribers and pharmacists. From the clinical perspective, e-prescribing can permit the clinician and pharmacist to review allergies, drug-drug interactions and contraindications that, if not identified, could have an adverse impact on the patient. E-prescribing can also facilitate enhanced administrative functions including access to information related to formulary and benefit management. Additionally, fully integrated e-prescribing systems have the potential to limit 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.

As evidence of our strong commitment to the use of e-prescribing technology to improve clinical care and administrative functions, MGMA and several healthcare organizations founded the Center for Improving Medication Management. MGMA has also collaborated with a number of
leading professional medical societies to develop the www.GETRXConnected.com website and educational campaign.

**Eligibility**

MGMA applauds the decision by CMS to change the criteria for determining whether an eligible professional is a successful e-prescriber. In the 2009 program, the Agency required reporting of the e-prescribing measure in 50 percent of applicable cases. For the 2010 incentive program, CMS will allow each eligible professional to report the G-code indicating that he/she electronically generated at least one prescription during an encounter in at least 25 instances during the reporting period. MGMA supports this 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 facilitate increased adoption of this important technology.

**Reporting options**

For 2010, CMS has outlined three reporting mechanisms for individual eligible professionals. The Agency would:

- Retain the claims-based reporting mechanism used in the 2009 incentive program;
- Implement a registry-based reporting mechanism; and
- Make available an EHR-based reporting mechanism for reporting the e-prescribing measure if it finalizes the EHR-based reporting mechanism.

Under this approach only 2010 PQRI-qualified registries could submit measure results and numerator and denominator data on the e-prescribing measure. Practitioners may report both PQRI measures and the e-prescribing incentive code using the same registry if they use the registry reporting option. MGMA strongly concurs with the CMS commentary regarding the limitations of claims-based reporting since the claims processing system was not developed for the submission of e-prescribing data. While MGMA encourages the continuation of the claims-based reporting system for reporting e-prescribing measures for several years, the Association urges CMS to quickly finalize testing the e-prescribing reporting mechanism via EHRs and allow for 2010 e-prescribing participation through qualified EHRs. In addition, similar to the PQRI program, MGMA encourages CMS to release all measure specifications as quickly as possible to ensure that vendors have sufficient time to modify software. Finally, echoing our earlier PQRI comment, the Association recommends, for the e-prescribing program, that CMS reconsider the 200 individual eligible professional threshold for the definition of a group practice or at least offer an alternative reporting option that uses a statistical sampling model for primary care-oriented group practices.

**Denominator codes**

MGMA is supportive of the decision 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 the Agency to continue expanding the program to facilitate the adoption of e-prescribing by additional medical specialties.

**Public reporting**

In 2010, CMS intends to post the names of eligible professionals who successfully e-prescribed for the 2009 E-Prescribing Incentive Program at www.medicare.gov and plans 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 post only those names of eligible professionals and group practices that have satisfactorily submitted data and successfully earned the incentive payments.
Implementation of accreditation standards for suppliers furnishing the TC of advanced diagnostic imaging services

As required by Sec. 135 of MIPPA, CMS finalized standards for bodies seeking to be designated as accreditation organizations by the Secretary. Such accreditation organizations will accredit the suppliers of the TC of advanced diagnostic imaging.

The Association appreciates the recognition by Congress and CMS that many suppliers are already accredited to provide the TC of advanced diagnostic imaging services by one or more organizations. MGMA again urges the Agency to work with existing accrediting bodies and to build on their existing procedures to minimize disruption in the process. MGMA notes, for example, that throughout its standards, CMS assumes that an on-site survey of a supplier will occur. MGMA understands that such a requirement is not standard for all existing accrediting bodies. The Association asks that CMS not reinvent the wheel with respect to accreditation processes that are already in place and thoroughly examine whether there is a need for such a requirement, given the longstanding practice of current accrediting bodies not to require a survey.

With respect to medical directors and supervising physicians, MGMA notes that Sections 1834(e)(3) and (e)(4) of MIPPA direct the Agency to establish procedures to ensure that accreditation organizations have standards for the evaluation of medical directors and supervising physicians that recognize a number of factors, including specialty-specific training in advanced diagnostic imaging in a residency program, expertise attained through experience, the completion of continuing medical education courses or other standards set forth by the Secretary. In its commentary on both the proposed and final rule, CMS appears to marry two of these requirements: “Recognizing whether a particular medical director or supervising physician received training in advanced imaging services in a residency program; and has attained, through experience, the necessary expertise to be a medical director or supervising physician….” Given that physicians can gain the needed expertise to supervise advanced diagnostic imaging through a variety of ways, MGMA urges the Agency to recognize these two qualifications as separate, alternative ways to evaluate qualifications, as assumed in the statute.

Finally, MGMA reiterates its grave concerns about provisions that require an accrediting body to use the information it gathers throughout the accreditation process against a supplier should CMS decide to take an adverse action against such supplier. While the Association understands CMS’ need to enforce the accreditation requirements, MGMA also believes that the process of accreditation is educational, offering healthcare providers an opportunity to learn about the applicable requirements and strive toward meeting those requirements. To turn an accrediting body into a potential adversary interferes with the goal of an industry-wide cooperative effort to improve the quality of care for all patients.

Improvements for Medicare anesthesia teaching programs

MGMA applauds CMS for interpreting the special payment rule for teaching anesthesiology in section 139 of MIPPA to allow payment to be made at 100 percent of the fee schedule rate for teaching anesthesiologist involved in training residents in one case or two concurrent anesthesia cases.

MGMA appreciates CMS’ interpretation of the definition of teaching anesthesiologist for the purpose of being present at the key or critical portions of the anesthesia service to include different anesthesiologists in the same group practice.

Conclusion
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 Robert Bennett in the Government Affairs Department at (202) 293-3450.

Sincerely,

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