



AMERICAN COLLEGE OF PHYSICIANS  
INTERNAL MEDICINE | *Doctors for Adults*<sup>®</sup>

August 30, 2007

Herb Kuhn

Acting Deputy Administrator

Centers for Medicare and Medicaid Services

Department of Health and Human Services

Attention: CMS-1385-P

Mail Stop C4-26-05

7500 Security Boulevard

Baltimore MD 21244-1850

Attention: CMS-1385-P

Dear Mr. Kuhn:

The American College of Physicians (ACP), representing more than 124,000 physicians specializing in internal medicine and medical students, is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule *Medicare Program; Proposed Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Proposed Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for 2008; and the Proposed Elimination of the E-Prescribing Exemption for Computer-Generated Facsimile Transmissions [CMS-1385-P]* published in the Federal Register on July 12, 2007. As the specialty that provides more care to Medicare beneficiaries than any other, internal medicine is particularly affected by the proposed rule.

#### **RESOURCE-BASED PE RVUS**

ACP continues to support the CMS transition to the “bottom up” method of assigning direct practice expense, which is scheduled for the second year of a four year phased implementation in 2008. This methodology is more clear and understandable than the “top down” methodology used in the past and CMS should endeavor to make all elements of the payment for a medical service as transparent as possible.

ACP does not believe that the current 50% assumption of the equipment utilization rate accurately reflects the rate of usage in most cases. ACP is concerned that CMS feels that it must gather more extensive data in order to justify a change in the utilization assumption rate. CMS is aware of data that exists on this subject that shows a higher utilization rate. When the resource-based practice expense methodology was first

introduced, CMS proposed to use a utilization rate of 70%, which was based on data from an Abt Associates study. Additionally, a Medicare Payment Advisory Commission (MedPAC) performed a study of the issue and found that magnetic resonance imagery (MRI) machines have a utilization rate that is higher than 90% and computed tomography (CT) machines have a utilization rate that is higher than 70 % in the representative surveyed markets.<sup>1</sup> CMS acknowledges that the current 50% utilization assumption is an arbitrary figure, so ACP urges CMS to make changes to this assumption immediately based on the data that it does have at its disposal.

ACP supports the creation of mutually exclusive categories of equipment with different utilization rates as suggested as a future option by CMS in the proposed rule as an appropriate next step after an immediate revision to the 50% assumption. ACP urges CMS to address these issues quickly because it has a significant impact on the valuing of these services as well as a significant impact on the payment for all other services. This change would be important step to ensure that payments for service that require high expense equipment are not overpaid. MedPAC and others have expressed concern that overvaluing and, thus, overpaying, services distorts the market and provide the incentive to increase utilization.

ACP is additionally concerned that the current interest rate assumption used for equipment also may be too high. ACP recommends that CMS use an interest rate assumption that accurately reflects what a physician practice would have to pay for capital to acquire this equipment.

#### **CODING - - ADDITIONAL CODES FROM 5-YEAR REVIEW**

ACP strongly supports the proposal to accept the Relative Value Scale Update Committee (RUC) recommendation to increase the work value for many of the nursing facility services codes as part of the 5-Year Review of work values. Many nursing home codes received significant revision through the CPT process in 2006, but they were unable to be properly valued because so many of the codes that could have served as reference codes for RUC work surveys were not allowed to be used because they were also under review in the 5-Year Review process. The substantial work and significant effort required of physicians that provide care in the nursing facility settings was evident in the survey data presented to the RUC. The RUC recommendations that CMS proposes to accept will place these codes much closer to where they should be on the relative value scale and will make the payment for these services more appropriate.

ACP is disappointed to see the increase in the work neutrality adjustor that resulted from the extraordinarily significant increase in the work values assigned to anesthesia services. This 32 percent increase in work values for anesthesia will cause an approximately one percent decrease in work values for every other code in the fee schedule. Each decrease in Medicare fees makes it harder for internists to consider treating Medicare patients to be a financially viable decision.

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<sup>1</sup> Medicare Payment Advisory Commission. Keeping Physicians' Practice Expense Payments Up to Date. Report to the Congress: Increasing the value of Medicare. June 2006. [www.medpac.gov/publications/congressional\\_reports/Jun06\\_Ch04.pdf](http://www.medpac.gov/publications/congressional_reports/Jun06_Ch04.pdf)

## **DRUG COMPENDIA**

ACP reviewed with interest the CMS consideration of the issue of drug compendia used as a basis for using chemotherapy agents for off-label uses. The reduction in the number of compendia could cause a reduction in the therapies available to patients. ACP continues to advocate that physicians should have the opportunity to prescribe drugs that are best for their patients as long as there is medical literature to support that decision. Limiting off-label uses to those found in compendia is a significant barrier to physicians being given the opportunity to independently evaluate scientific literature and care for their patients using their clinical judgment.

## **PHYSICIAN SELF-REFERRAL PROVISIONS**

ACP has followed the self-referral issue for many years and has significant concerns regarding some of the proposed and considered changes. Physicians throughout the country continue to struggle with the complex legal issues related to the physician self-referral statute and have often spent far too much on attorneys trying to navigate the confusing and ever-changing regulations. Too many physicians choose not to engage in particular service arrangements for fear of violating the complex strict liability statute despite the fact that the majority of arrangements are for legitimate purposes intended to provide necessary access to care for the physician's patients.

ACP recognizes the challenge in trying to balance the narrow drawing of exceptions to include only those legitimate purposes while excluding those "bad actors" from engaging in illegitimate activity. Unfortunately, ACP strongly believes that CMS has failed to strike that balance in the proposed rule. These proposals, if finalized, would make it even more difficult for physicians to participate in legitimate business ventures and will lead to a decrease in patient access to necessary services. ACP further believes that a far more effective way to balance these two competing interests is for CMS to make an aggressive effort to more accurately pay for the provision of designated health services (DHS). Coupled with the existing exceptions, this approach is a far more effective tool to "weed out" those who would be taking advantage of letter and spirit of the existing statute.

The College is pleased to offer comment on the following specific areas:

### *In-Office Ancillary Services Exception*

The in-office ancillary services exception is the principle exception most physicians rely upon to protect referrals to provide DHS within their own practices. Although CMS did not offer a proposed change, it did request comments on potential changes to the in-office ancillary services exception to include: (1) whether certain services should not qualify for the exception; (2) whether and, if so, how changes should be made to definitions of "same building" and "centralized building;" (3) whether nonspecialist physicians should be able to use the exception to refer patients for specialized services involving the use of equipment owned by the nonspecialists; and (4) any other restrictions on the ownership and investment in services that would curtail program or patient abuse.

ACP strongly opposes any attempt to further limit services that can be provided by a physician practice under the in-office ancillary services exception. This exception has enabled physicians throughout the country to provide services in their offices where patients are most likely to seek them and benefit from their timely provision. It additionally provides for integration of data systems so that lab values and radiology data are available immediately. This exception allows physicians the greatest amount of flexibility in managing the care of their patients and gives them the opportunity to add services that may be lacking in the community.

More specifically, ACP opposes any significant changes to the “same building” and “centralized building” definition. The use of a “same building” or “centralized building” for services allows both large group practices and coalitions of smaller practices to better provide necessary services for their patients. The in-office ancillary services exception has allowed physician practices to provide what is needed to their patients and the impact of changes to this exception could hurt the practice of medicine. It would be a serious mistake to make the practice of medicine less innovative and reduce the investment in the community of health care services that physicians are making.

#### *Obstetrical Malpractice Insurance Subsidies*

ACP is greatly encouraged to see the proposal loosen the restriction on the exception for obstetrical malpractice insurance subsidies. In the proposed rule, CMS states, “We have received accounts, through advisory opinion requests and anecdotally, of patient difficulty obtaining obstetrical care in some communities in States in which obstetrical malpractice insurance premiums are relatively high.” CMS is seeking input on requirements on these subsidies without creating program abuse.

ACP congratulates CMS for seeking to make the exception more flexible and ACP believes the proposed requirements are appropriate for physicians accepting a malpractice subsidy from another entity. ACP urges CMS, however, to expand this exception to include physicians in all medical specialties – not just obstetrics – that are in States where malpractice insurance premiums are relatively high. In doing so, ACP urges CMS to look at the percentage of increase of premiums relative to the average salary of the physician specialty involved. The rising burden of malpractice insurance is a reality for all physicians and this should be recognized. Patients in medically underserved areas will greatly benefit from an expansion of this exception to include all specialties. Finally, ACP urges CMS to work directly with the U.S. Department of Justice to ensure that the Anti-kickback Statute creates a similar safe harbor.

#### *“Set in Advance” and Percentage-based Compensation Arrangements*

CMS proposes to limit the type of percentage compensation arrangements that qualify as “set in advance” to personally performed physician services and can only be based on revenues directly resulting from physician services. While this proposed change appears to allow percentage-based compensation arrangements to individual physicians, it would call into question a whole host of other percentage-based arrangements (i.e., lease agreements, practice management agreements, pay-for-performance incentives, etc.) that

have little or no risk of abuse. Therefore, ACP believes that CMS should reconsider this proposal to include such arrangements or abandon any proposed change.

#### *Alternative Criteria for Satisfying Certain Exceptions*

ACP is also greatly encouraged to see an opportunity for physicians who inadvertently enter into arrangements that are missing a required procedural step to self-report through an alternative compliance method. The College views this attempt by CMS as a positive first-step in recognition that innocent and trivial violations of the statute should not be treated the same as those who knowingly and willfully violate the letter of the statute.

ACP believes, however, that the proposed criteria is far too narrowly tailored and it is unlikely that providers would submit – or be counseled to do so – to such an uncertain process that exposes them for innocent mistakes. The physician self-referral statute is confusing and complex; ACP believes that CMS should be focusing only on those who intentionally or willfully disregard the intent of the statute and should develop a proposal that encourages violators into compliance.

#### *Services Furnished “Under Arrangements”*

CMS proposes to significantly limit physician services provided “under arrangements” to hospitals. This proposal would revise the definition of “entity” to include the person or entity that presents claims for DHS (current definition) and the person or entity that either provides the DHS or “causes a claim to be presented” for the DHS. Under this proposal, CMS seeks to expand the scope of the statute to apply to entities that do not even bill the Medicare or Medicaid programs for DHS. ACP believes that this is not within CMS’s congressional authority. Nevertheless, this proposal would essentially prohibit all existing under arrangements services contracts with physicians, potentially disrupting access and unnecessarily causing the purchasing of equipment to provide needed services. Therefore, ACP believes that CMS should withdraw this proposal.

The College is greatly concerned over these and other proposed changes to the physician self-referral statute. This section of the proposed rule represents a marked and concerning change in direction to what was once an effort to create bright-line exceptions. As CMS prepares to release Phase III of the physician self-referral regulations, it must seriously consider the impact of significant changes on physician practices, which in turn have a significant impact on the health status of the beneficiary.

While ACP fully understands and shares concerns about inappropriate utilization of certain services, completely restricting the ability of physicians to invest in their own industry is far from the answer. Throughout the proposal, CMS continues to cite “anecdotal evidence” of arrangements that are at risk for fraud and abuse yet provides no actual evidence of program abuse. The College is eager to work with CMS to examine the causes of increased utilization and attack the more important issues of overvalued services that are driving growth in spending rather than making changes to the statute that will significantly deteriorate access to care for beneficiaries.

## **PROPOSED ELIMINATION OF EXEMPTION FOR COMPUTER-BASED FACSIMILES**

ACP opposes the CMS proposal to eliminate the computer-based facsimile exemption to electronic prescribing standards. ACP believes that the concerns that originally led to this exemption being created in 2005 are still concerns today. ACP believes that elimination of this exemption will result in physicians reverting to the use of paper-based prescriptions, which will only make it more difficult to move to electronic prescribing in the future. CMS must recognize the difficulties that physicians face in implementing electronic prescribing systems and not discourage them for using systems that improve the efficiency of the care that they provide just because the system may not meet the full compliance with electronic prescribing standards. ACP urges CMS to not eliminate this exemption.

## **TRCHA – SECTION 101(b) (PQRI)**

### MIEA-TRHCA Requirements for Measures Included in the 2008 PQRI

ACP supports the CMS proposal that the AQA adoption of quality measures meets the statutory requirement that PQRI quality measures be adopted or endorsed by a consensus organization. The College recommends a prominent and expansive role for the AQA so that it can continue to provide valuable contributions in the areas of: measure adoption; establishing criteria for measure implementation prioritization; and developing policies related to measure reporting and data aggregation.

ACP concurs with the CMS expectation that PQRI quality measures be endorsed by the National Quality Forum (NQF) and adopted by AQA. Specifically, ACP agrees with the CMS proposal to:

- Include quality measures in the 2008 PQRI that are endorsed by NQF and adopted by AQA by the November 15, 2007 statutory deadline;
- Include quality measures in PQRI 2008 that are adopted by AQA if NQF has been unable to make an endorsement decision by the November 15 deadline; and
- Decline to include quality measures in PQRI 2008 which AQA has adopted but NQF has specifically declined to endorse.

### Proposed 2008 Quality Measures

#### *Structural Measures Currently Under Development*

##### i. Definition of Structural Measures

ACP recommends that CMS work with the College and other stakeholders to develop a definition of a structural measure—that definition should encompass structural capability and use of that capability. A CMS definition of a structural measure, informed by public comment, would help influence further establishment of such measures.

While ACP does not have an official definition of structural measure, ACP does offer language describing how the College has thought of structural capability/measures and includes references to MedPAC's consideration of the issue. The agency can use this information as a starting point for establishing a working definition. In addition, ACP recommends that CMS consult the NQF and the AQA as these consensus organizations will review structural measures to decide whether to endorse and adopt.

ACP has thought of structural capability/measures as:

Tools and health information technologies that have the capability to support physicians' efforts to improve, measure, and report on the quality of care provided to beneficiaries, improve care coordination of patients with chronic diseases, reduce medical errors, and/or deliver care consistent with evidence-based guidelines of quality and appropriateness.

MedPAC describes structural measures as "measures designed to ensure that the provider is capable of delivering good care" in its March 2005 *Report to Congress*. In its discussion of structural measures specific to physician practices in the context of physician pay-for-performance, MedPAC characterizes structural measures as systematic processes to improve care management and notes that they can involve advanced or more limited health information technology.

#### ii. Need for Guidance as to what Constitutes Acceptable Structural Measure

ACP recommends that CMS encourage NQF and AQA to develop guidance as to what constitutes an acceptable structural measure based on an accepted definition of what constitutes structural capabilities in a physician practice setting.

#### iii. Inclusion of Structural Measures in PQRI 2008

#### CMS Proposed Structural Measures

ACP supports the CMS proposal to include structural measures in the 2008 PQRI. Specifically, the College supports the agency proposal to include the "Adoption/Use of E-prescribing" and the "Adoption/Use of Health Information Technology (Electronic Health Records)" structural measures in the 2008 PQRI. As CMS includes no description of these measures or how they are to be reported in this proposed rule, ACP offers its comments on the version of these structural measures released by Quality Insights of Pennsylvania, the Pennsylvania Quality Improvement Organization (QIO), under contract with CMS, for public comment in May 2007.

#### *Adoption/Use of E-prescribing*

The Quality Insights of Pennsylvania proposal that the physician report a Healthcare Common Procedure Coding System (HCPCS) G code for essentially every encounter with a patient in the ambulatory setting—including encounters for which no medication is prescribed—is excessive and imposes an unnecessary administrative burden on the

physician. It also requires the Medicare contractor/CMS to handle a large volume of additional data elements. ACP recommends that CMS establish a more streamlined method that allows a physician to indicate systematic e-prescribing. For example, the physician could sign an attestation to e-prescribing use and a commitment to notify the agency when he or she ceases to e-prescribe. CMS could require all or a subset of physicians who have attested to e-prescribing to provide an electronically generated e-prescription count, a common feature in electronic health records and other prescribing systems. CMS should explore the use of an electronic portal to allow for ease in transmission of attestation and verification related information.

Specific to the Quality Insights of Pennsylvania proposed structural measure, ACP recommends that:

- CMS “grandfather” stand-alone e-prescribing systems implemented prior to August 2006 so that they are exempt from the requirement that they “be fully interoperable with a fully functional Certification Commission for Health Information Technology (CCHIT) electronic medical record (EMR).” This would be consistent with the “Adoption/Use of HIT” proposed structural measure, assuming that CMS intends to retain the Quality Insights of Pennsylvania-proposed component that exempts EMRs implemented prior to August 2006 from the CCHIT certification requirement.
- CMS define the term “advanced patient/disease specific decision support.” CMS should reflect the extent to which advanced clinical decision support is common to e-prescribing systems in its definition of the term.

*Adoption/Use of Health Information Technology (Electronic Medical Records)*

ACP recommends that CMS make clear that this structural measure entails the adoption/use of an EMR.

ACP recommends that establish a process that allows physicians to indicate use of EMR and for the agency to verify that use without requiring physicians to report whether an EMR was used through a G code on each claim for an ambulatory encounter. This process should be electronic to minimize burden.

The College supports making CCHIT certification a prerequisite for receiving credit for an EMR structural measure for a post-August 2006 EMR. ACP recommends, however, that CMS examine its “entering laboratory tests as discrete searching data elements” requirement to ensure it is presently feasible. It is difficult for many physician practices to import laboratory test results directly into even a CCHIT-certified EMR because of barriers related to interoperability and the cost associated with such implementing these connections – especially for small, lower volume medical practices. ACP notes that Quality Insights of Pennsylvania proposed a structural measure that is to be added on to its “Adoption of Health Information Technology” measure that indicates the physician ability to receive laboratory data electronically directly into his or her EMR. ACP urges CMS to clarify the system capability the agency is requiring pertaining to laboratory data in the HIT/EMR structural measure it proposes. For many small and medium-sized

medical practices, the type of interoperability suggested by the draft measure fails to take into account the considerable impediments to implementation and costs associated with these interfaces. Even if the CMS expectation is that the physician practice manually enters laboratory test results into an EMR, this imposes burden on the practice. Accordingly, it is important that CMS clarify its expectation in this area and to ensure that it is practical.

#### ACP Recommended Additional Structural Measures

ACP recommends that CMS include physician “Adoption/Use of a Population Management Registry” and “Adoption/Use of Point-of-Care Evidence-Based Clinical Decision Support” as additional structural measures in PQRI 2008. Including these measures—which the literature supports as having high value—enables physicians to demonstrate that they maintain and use structural capability that facilitates quality improvement that is short of a fully functional and operational EMR. Further, installation of an EMR that includes the capability described in each of the individual structural measures does not ensure physician use of each individual component. The College urges CMS to work with it and other stakeholders to finalize these structural measures and to establish a mechanism that enables physicians to attest to maintaining/using the capability and allows CMS to verify it that imposes minimal burden.

##### *Adoption/Use of a Population Management Registry*

ACP recommends that CMS include physician “Adoption/Use of a Population Management Registry” as a stand-alone structural measure in PQRI 2008. ACP’s view is that Quality Insights of Pennsylvania proposed use of a population management registry, in part, through its “Ability to Use HIT to Perform Care Management” structural measure that it offered as an add-on to its “Adoption of Health Information Technology” structural measure. ACP recommends that CMS establish the adoption/use of a population management registry by using the Quality Insights of Pennsylvania-proposed HIT to Perform Care Management measure, without the “real-time decision support within patient encounter” component—which ACP recommends as a separate structural measure, detailed below—and the “patient specific care plan” component. ACP urges CMS to reconsider the patient specific care plan component because, despite the commendable and lofty goals apparent from its definition, it is not yet a common function even in a CCHIT-certified EMR. Further, physicians can use population management registries that are independent of an EMR. These registries can also facilitate the tracking of patients by disease or diagnoses on a longitudinal basis to promote appropriate interventions.

##### *Adoption/Use of Point-of-Care Evidence-Based Clinical Decision Support*

Quality Insights of Pennsylvania includes this component/capability in its proposed “Ability to Use HIT to Perform Care Management” structural measure. ACP recommends that CMS recognize the importance of this component by including it as a stand-alone structural measure in PQRI 2008, designated as “Adoption/Use of Point-of-Care Evidence-Based Clinical Decision Support.”

ACP's recommendation to include the adoption/use of a population management registry and the adoption/use of point-of-care evidence-based clinical decision support as structural measures for PQRI 2008 is supported by reports and literature:

- The 2007 Center for Information Technology Leadership report “The Value of Information Technology-Enabled Diabetes Management,” available at [http://www.citl.org/\\_pdf/The\\_Value\\_of\\_IT\\_Enabled\\_Diabetes\\_Management.pdf](http://www.citl.org/_pdf/The_Value_of_IT_Enabled_Diabetes_Management.pdf), cites the ability of diabetes registries and clinical decision support systems to improve patient care. The report determines that the use of a diabetes registry can generate significant net savings over time.
- The California HealthCare Foundation February 2004 report, “Using Computerized Registries in Chronic Disease Care” states that a disease registry is “one type of clinical information system that is effective for supporting new models of chronic care.” The background section of the reports cites literature showing how elements of the Chronic Care Model, clinical information systems that include registries and decision support, can improve effectiveness in treating chronic disease. An addendum describes the impact of the use registries by the provider organizations interviewed for the report.
- The October 9, 2002, *Journal of the American Medical Association* article, “Improving Primary Care for Patients with Chronic Illness,” by Thomas Bodenheimer, et al., provides case studies of how implementing elements of the Chronic Care Model can facilitate activated patients interacting with an informed healthcare team.

The California HealthCare Foundation report states that a lack of financial incentives discourages physicians from treating chronic diseases proactively. The CMS inclusion of a registry and decision support structural measure will help incentivize the use of tools that can improve care.

### CMS Process for Developing Structural Measures

ACP urges CMS to improve the process by which it initiates/facilitates the development of structural measures in the future. The CMS decision to contract with Quality Insights of Pennsylvania and the QIO process for developing the structural measures missed an opportunity to benefit from the experience of ACP and other entities that have been active in physician-level measure development. The Quality Insights of Pennsylvania-proposed structural measures need significant improvement. CMS use of a more inclusive process would have likely enabled CMS to include structural measures for use in 2008 in this proposed rule that are more fully and adequately defined—the agency fails to even indicate its thinking regarding the Quality Insights of Pennsylvania-proposed structural measures. Further, ACP reiterates its earlier recommendations that CMS work with stakeholders to develop a working definition of structural measures and guidance as to what constitutes an acceptable measure. Collectively, these recommendations will improve the process by which structural measures are developed and selected, increasing the likelihood that they will trigger quality improvement.

ACP would be glad to work with CMS to identify viable processes for physician reporting of the capability defined by structural measures and agency verification of that use. ACP notes that the capability defined by the structural measures discussed in our letter will be used optimally when integrated with an EMR. The College urges CMS to begin thinking about the a longer-term strategy for ensuring that structural measures provide the appropriate incentive to reach the next level of capability based on the current state of technology.

#### *Additional AQA Starter-Set Measures*

ACP supports the CMS proposal to include the measures in the AQA “starter set” that the agency did not include in the 2007 PQRI in the 2008 initiative. The CMS condition that these measures retain NQF endorsement and AQA adoption is appropriate.

#### Addressing a Mechanism for Submission of Data on Quality Measures Via a Medical Registry or Electronic Health Record

##### *Registry-Based Reporting*

ACP recommends that CMS work with the College and other stakeholders to determine the information—clinical and non clinical—necessary for optimal physician quality improvement/performance assessment, as opposed to confining quality reporting/performance assessment options to the parameters of the 2007 PQRI. Each of the five CMS registry data submission options involve the same information elements used in PQRI 2007—information to: determine if a physician successfully reported (80% of eligible cases threshold) using CPT II codes and modifiers; provide the physician a reporting and performance score; and to determine the amount of the bonus payment earned by a physician who reports successfully. While ACP understands that the Tax Relief and Health Care Act provisions that establish the PQRI constrain the agency’s options for 2008, ACP urges CMS to begin exploring a wide range of future quality data options.

ACP agrees that registries should comply with privacy and confidentiality rules.

ACP believes that registries should contain enough information to adequately assess a physician’s performance, e.g. not limiting registry information to Medicare beneficiaries.

Stakeholders should establish uniform rules pertaining to data collection through a registry. The AQA maintains, multi-stakeholder vetted policy pertaining to this and related topics. The AQA “Principles in the Use of Registries for Enhancing Quality of Care through Performance Measurement” document is at

<http://www.aqaalliance.org/files/RegistryPrinciplesDocumentV1Approved.doc>.

Additional AQA policies, including principles on data sharing and aggregation, are available at <http://www.aqaalliance.org/default.htm>.

The process by which physicians report data to a registry should impose minimal burden and cost.

*Physician Submission of Quality Data from an Electronic Medical Record*

ACP believes that the long-term goal is physician direct reporting of quality data—using defined standard elements and a standard format—to the entity that will use the information, which could include a variety of stakeholders. The extensive time likely required to define standard data elements and formats provides an opportunity for CMS and other stakeholders to determine the best use of data for quality improvement and other purposes, such as to measure physician/practice performance and, potentially, to measure efficient use of resources. These issues could include identifying quality indicators that have the highest impact.

In the meantime, testing physician direct EMR reporting through use of Doctors' Office Quality—Information Technology (DOQ-IT) ambulatory quality measures is an appropriate early step in the transition. ACP urges CMS to test physician direct reporting of the DOQ-IT measures as a voluntary alternative to claims based quality reporting in PQRI 2008.

ACP recommends that CMS consider measures/actions/initiatives to facilitate the transition to the time when physician direct EMR reporting is technically and operationally feasible on a widespread basis:

- Limited physician direct EMR reporting of DOQ-IT measures in 2008;
- Facilitate (public, private, and/or joint public-private) data element and format standardization efforts;
- Develop rules pertaining to CMS or its designee receiving data from quality registries; and
- Include the notion that physicians maintain multiple pathways to report quality data through an intermediary to ensure that physicians can provide data using a mechanism that works best for their practice, allowing them to take in consideration of practice redesign, administrative effort, and cost.

The research paper, “Comparison of Methodologies for Calculating Quality Measures Based on Administrative Data versus Clinical Data from an Electronic Health Record: Implications for Performance Measures,” by Paul Tang, et al., published in the January/February 2007 *Journal of the American Medical Informatics Association* finds that using coded fields in an electronic medical record is superior to using administrative claims data to identify a target patient population for which quality is measured. The paper, which describes a study that focused on identifying diabetics that was funded by Lumetra (the California QIO) under contract with CMS, states that more precise identification of the target population can facilitate more accurate performance measurement. Further, the NQF HIT Expert Panel, in which CMS has participated in a liaison role, is recommending that a coded problem list in the electronic health record be used to identify patients for quality measurement as opposed to billing codes reported through claims.

**TRCHA – SECTION 101(d) (PAQI)**

ACP strongly disagrees with the CMS proposal to use the \$1.35 billion allocated as part of the Physician Assistance and Quality Initiative (PAQI) fund entirely to fund the Physician Quality Reporting Initiative (PQRI) in 2008. ACP has supported positive financial rewards to fund quality reporting/improvement initiatives, but is very concerned about the impending 9.9% cut in the conversion factor that will cause physician payments from Medicare to plummet. CMS was given the opportunity to use some of that money to reduce the scheduled payment cuts, but choose to instead use it for this quality reporting initiative. ACP does not agree with the argument that CMS is unable to apply this payment towards a conversion factor adjustment. While ACP understands the difficulties that are associated with assigning a fixed pool of money to an entitlement program, it believes that CMS has the technical capability to apply the money in the fund to offset some of the scheduled conversion factor decrease. ACP encourages CMS to use the PAQI to offset the scheduled decreases to the conversion factor for 2008.

## **OTHER ISSUES**

### *Anticoagulation Management Codes*

ACP strongly disagrees with the CMS decision to continue to consider anticoagulation management codes (99363 and 99364) to be bundled into the work of evaluation and management codes. The initial impetus for the creation of these codes was the statement by CMS that these services were not managed as well as they should be and that the existing coding structure failed to provide incentives to optimize care. In reaction to this, ACP, in cooperation with other medical societies, considered for some time the best way to define the services performed by physicians managing this very serious medication regimen. The complete range of this work is not paid under the current system. During the creation of the code, the Current Procedural Terminology (CPT) editorial panel and the Relative Value Scale Update Committee (RUC) were very careful to create protections in the code that would prevent work from anticoagulation management being included in selecting the level of evaluation and management codes. CMS did not offer any explanation for its decision to bundle payment for these codes into evaluation and management services when it published this action in its final rule for the physician fee schedule for 2007. There is still no explanation offered in the 2008 proposed rule.

These CPT codes are recognition of the important work of managing serious disease and the CMS decision to not pay for this service could have a devastating impact. ACP was given the opportunity to review a proposed Correct Coding Initiative (CCI) edit to be used to prevent the billing of a 99211 on the same day of these codes, according to its common practice of reviewing all CCI edits. ACP opposed this edit based on the possibility that such an event could take place on very rare occasions. However, ACP supports the edit now that the College understands that CMS feels strongly that it will help prevent potential abuse and fraud. ACP believes that physicians should be paid fairly for the services that they provide and will do everything possible to avoid any potential fraud. ACP strongly encourages CMS to not finalize its proposal to consider these services bundled but instead change their status to active covered services in the 2008 fee schedule.

Researchers are increasingly recognizing the importance of chronic disease management in preventing more costly interventions and improving the quality of lives of patients. The patients who are receiving anticoagulation therapy require extensive medical work and attention from physicians, and in many cases they are forced to give this care away or refuse to accept patients who require this therapy into their practice. Reviewing the research on this issue shows the striking impact of the management of this drug on the healthcare system. It is estimated that there are more than 43,000 adverse drug events treated in the emergency room each year related to anticoagulation therapy.<sup>2</sup> Many of those treated in the emergency room will also end up admitted to the hospital, further degrading the health of the patient and adding to unnecessary spending.

Anticoagulation management services are an important responsibility and CMS should recognize the extensive work involved by paying for this service.

#### *Work Neutrality Adjustor*

ACP continues to disagree with the CMS decision to use a separate budget neutrality adjustor for the work portion of the RVUs and recommends that CMS apply the legislatively-mandated adjustment to the conversion factor in the 2008 fee schedule. ACP disagrees with this approach for a number of reasons. Notably, CMS used this approach in the past and found it to be problematic, noting when it was eliminated in 1999 that

“[W]e did not find the work adjustor to be desirable. It added an extra element to the physician fee schedule payment calculation and created confusion and questions among the public who had difficulty using the RVUs to determine a payment amount that matched the amount actually paid by Medicare” (*Federal Register*, Vol. 68, No. 216, Pg. 63246). We believe an adjustment to the conversion factor is preferable because it recognizes that budget neutrality is a fiscal issue, not an issue of relativity. Budget neutrality is mandated for monetary reasons. Thus, the conversion factor, as the monetary multiplier in the Medicare payment formula, is the most appropriate place to adjust for budget neutrality.

Finally, ACP believes that CMS must recognize that many insurers in the private market use the RVUs to determine payments. While the confidential nature of many private insurer payments has made it difficult to gauge the impact in 2007, ACP believes that a number of insurers are using the budget-neutrality adjusted numbers in order to calculate their own payments to physicians, because they base their payments on RVUs.

ACP appreciates the opportunity to communicate to CMS its perspective on the numerous proposals contained in this rule. If you have further questions, please contact Brian Whitman, Senior Analyst for Regulatory and Insurer Affairs at (202) 261-4544 or [bwhitman@acponline.org](mailto:bwhitman@acponline.org)

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<sup>2</sup> Budnitz. National Surveillance of Emergency Departments for Adverse Drug Events. *JAMA*. 2006;296:1858-1866

Sincerely,

A handwritten signature in blue ink that reads "Joseph W. Stubbs". The signature is written in a cursive style with a large initial 'J' and a prominent 'W'.

Joseph W. Stubbs, MD, FACP  
Chairman, Medical Service Committee