



AMERICAN COLLEGE OF PHYSICIANS  
INTERNAL MEDICINE | *Doctors for Adults*®

August 31, 2012

Marilyn Tavenner  
Acting Administrator and Chief Operating Officer  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
P. O. Box 8013  
Baltimore, MD 21244-8013

**RE: [CMS-1590-P] RIN 0938-AR11: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face to Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013; Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Quality Improvement Organization Regulations; Proposed Rules**

Dear Ms. Tavenner:

The American College of Physicians (ACP) appreciates this opportunity to comment on the above referenced Proposed Rule. ACP is the largest medical specialty society and second largest physician membership organization in the United States, representing 133,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults and medical students who are considering a career in internal medicine.

ACP commends CMS for its continued attention to improving payments for undervalued evaluation and management and care management services provided principally by internal medicine specialists in primary and comprehensive care of adults, internal medicine subspecialists, family physicians, and geriatricians. We agree with CMS that policies to improve payment for such services should not be restricted to a designated subset of specialties (as defined by their self-designation) or impose other restrictive criteria that could exclude physicians who legitimately and appropriately provide such services to their patients. Rather, the objective should be to pay more appropriately for

evaluation and care coordination services that bring value to the patient, no matter the specialty of the physician who is billing for the service. We support the proposed regulatory language to apply the payment increases to the *services* being provided without regard to specialty, which could include physicians who are not defined as “primary care” in the CMS Primary Care Incentive Program. Even with CMS’s specialty-neutral language, primary care physicians and their patients will likely benefit the most from the improvements proposed by CMS, because they bill the greatest proportion of the services proposed for increases.

### **Primary Care and Care Coordination**

ACP is pleased that CMS has prioritized the development and implementation of a series of initiatives designed to ensure accurate payment for, and encourage long-term investment in, evaluation and management and care management services. These initiatives include:

- The Medicare Shared Savings Program (MSSP - described in ‘Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule’)
- The Pioneer ACO model
- The Advance Payment ACO model
- The Primary Care Incentive Payment (PCIP) Program
- The patient-centered medical home model in the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration
- The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration
- The Comprehensive Primary Care (CPC) initiative

CMS also notes that, in coordination with these initiatives, it will continue to explore other potential refinements to the Medicare physician fee schedule that would appropriately value services associated with primary care and care coordination within Medicare’s statutory structure for fee-for-service physician payment and quality reporting. ACP’s specific comments on CMS’ proposals to implement a new HCPCS-G code for post-discharge transition care management and to recognize and potentially pay for services associated with primary care furnished in advanced primary care practices (i.e., patient-centered medical homes) follow in this letter.

In addition, the College calls to CMS’ attention our recent testimony before the United States House of Representatives’ Ways and Means Health Subcommittee, as part of its July 24, 2012 hearing on “Physician Organization Efforts to Promote High Quality

Care.”<sup>1</sup> As part of this testimony, ACP outlined a set of principles for developing a transitional quality improvement (QI) or value-based payment (VBP) program. *ACP recommends that CMS take these principles into consideration in its efforts to improve payments for services associated with primary care:*

1. ACP supports, in concept, the idea of providing an opportunity for performance-based updates based on successful participation in an approved transitional QI/VBP initiative that meets standards relating to the effectiveness of each program, building on successful models in the public and private sectors.
2. Transitional performance-based update programs should be incorporated into a broader legislative and regulatory framework to stabilize payments and transition to new models. This is important so that physicians and the Medicare program have a clear “destination” and pathway to achieving it, even as physicians begin the journey through the transitional QI/VBP initiative.
3. The transitional QI/VBP program should include models for which extensive data and experience already exist, and that can be more readily scaled up for broader adoption by Medicare. Specifically, participation in the Patient Centered Medical Home (PCMH) and Patient-Centered Medical Home Neighborhood (PCMH-N) models, as determined by practices meeting designated standards through a deemed accreditation body and/or standards to be developed by the Secretary with input from the medical profession. Participation in other established models that have demonstrated the potential to improve care coordination, such as Accountable Care Organizations (ACOs), bundled payments, and global primary care payments should also be considered for inclusion in a transitional QI/VBP program. In addition, physicians who agree to incorporate programs, like ACP’s High Value, Cost-Conscious Care Initiative<sup>2</sup>, into their clinical practice through shared decision-making with patients, might also qualify for a transitional QI/VBP payment. These initiatives are discussed in more detail in our full testimony before the House Ways and Means Health Subcommittee.
4. Existing QI/VBP payment models (i.e., the Medicare Physician Quality Reporting System (PQRS), e-prescribing (eRx), and meaningful use (MU) programs), if included in a transitional performance-based payment update program, should be improved to harmonize measures and reporting to the extent possible and to establish a consistent incentive program across all elements. Efforts should also

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<sup>1</sup> ACP’s testimony before the House Ways and Means Health Subcommittee, as part of the July 24, 2012 hearing on “Physician Organization Efforts to Promote High Quality Care” can be found at: [http://www.acponline.org/advocacy/where\\_we\\_stand/medicare/statement7-24-12.pdf](http://www.acponline.org/advocacy/where_we_stand/medicare/statement7-24-12.pdf).

<sup>2</sup> Additional information on ACP’s High Value, Cost-Conscious Care Initiative (HVCCC) can be found at [http://www.acponline.org/clinical\\_information/resources/hvccc.htm](http://www.acponline.org/clinical_information/resources/hvccc.htm).

- be made to align them with specialty boards' maintenance of certification programs.
5. Transitional performance-based updates could be tiered so that programs that provide coordinated, integrated, and patient-centered care get a higher performance update than less robust programs built on the current, compartmentalized, fee-for-service system.
  6. Performance-based payment updates should be in addition to a higher “floor” on payments for undervalued primary care/preventive and coordinated care services, not limited by physician specialty, so that any physician who principally provides such undervalued services could qualify for the higher update. This is important to address the continued under-valuation of these critically important services, even as payments also begin to reflect physician participation in the transitional QI/VBP initiative.
  7. For a transitional QI/VBP program to be effective in improving quality, CMS will need to improve its ability to provide “real time” data to participating physicians and practices. A method will need to be created to map practice-level participation in a transitional QI/VBP initiative to the individual physician updates under the Medicare Physician Fee Schedule.

Primary Care Services Furnished in Advanced Primary Care Practices (i.e., PCMHs)  
ACP applauds CMS for its proposal to consider recognizing and paying appropriately for care provided through an “advanced primary care practice” that has implemented a patient-centered medical home (PCMH) model. As noted in the proposed rule, since the adoption of the “Joint Principles of the Patient Centered Medical Home” by ACP, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA) in 2007,<sup>3</sup> the PCMH model has been the subject of extensive study in the literature.<sup>4</sup>

***ACP believes that the PCMH model has advanced enough to be scaled up for widespread implementation throughout Medicare in the immediate future.*** The growing amount of experience in both the public and private sectors on how to organize care around PCMHs, the thousands of physician practices that have already achieved recognition or accreditation as a PCMH, and the growing amount of data on its effectiveness in improving care and lowering costs, makes it a logical model to scale up to the broader Medicare program.

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<sup>3</sup> AAFP, AAP, ACP, and AOA. The Joint Principles of the Patient-Centered Medical Home. March 2007. Accessed at [http://www.acponline.org/advocacy/where\\_we\\_stand/medical\\_home/approve\\_jp.pdf?hp](http://www.acponline.org/advocacy/where_we_stand/medical_home/approve_jp.pdf?hp).

<sup>4</sup> PCPCC. “Benefits of Implementing the Primary Care Patient-Centered Medical Home: Cost and Quality Results”. 2012. <http://www.pcpcc.net/guide/benefits-implementing-pcmh>.

The College also agrees with CMS that the Innovation Center’s Comprehensive Primary Care Initiative (CPC Initiative) provides an appropriate starting point for discussing how the PCMH model could be incorporated into the Medicare physician fee schedule. The five comprehensive primary care functions that serve as the framework for the CPC Initiative project—risk-stratified care management, access and continuity, planned care for chronic conditions and preventive care, patient and caregiver engagement, and coordination of care across the medical neighborhood—are in line with the PCMH and PCMH–Neighborhood concepts, championed by ACP and other national membership organizations representing physicians and other clinicians and are supported by thousands of business, consumer, and payer groups represented in the Patient-Centered Primary Care Collaborative (PCPCC).

However, it is important to note that there are still a number of challenges to the successful implementation of the PCMH, including:

- The need for ongoing research

Many private insurers have made the decision to roll the PCMH model out based on their experience to date with pilot programs, as well as the substantial evidence that health systems with a strong primary care foundation deliver higher-quality, lower-cost care overall and greater equity in health outcomes; and that patient-centered primary care is best delivered in a medical home.<sup>5,6</sup> However, it is important to note that peer-reviewed academic studies evaluating the medical home model in its full implementation are limited.<sup>7,8,9</sup> But, there is still much to be learned from the numerous PCMH evaluations that have considered individual components of the PCMH model in specific settings, including a recent Institute of Medicine report that evaluated methods of care for those who are chronically ill.<sup>10</sup>

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<sup>5</sup> Commonwealth Fund (2012, March 12). Patient-Centered Coordinated Care. Program Description. [http://www.commonwealthfund.org/~media/Files/Programs/2012/Program%20PDFs/2011\\_PatientCentered\\_Coord\\_Care\\_with\\_caption.pdf](http://www.commonwealthfund.org/~media/Files/Programs/2012/Program%20PDFs/2011_PatientCentered_Coord_Care_with_caption.pdf).

<sup>6</sup> Johns Hopkins Bloomberg School of Public Health. Publications of the bureau of primary health care and primary care policy center. (2012). Available at: <http://www.jhsph.edu/pcpc/publications.html>.

<sup>7</sup> Peikes, D., Genevro, J., Scholle, S. H., Torda, P. (2011, Feb). The patient-centered medical home: Strategies to put patients at the center of primary care. Agency for Healthcare Research and Quality. AHRQ No. 11-0029. Rockville, MD. Retrieved from [http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh\\_home/1483/pcmh\\_tools\\_resources\\_patient-centered\\_v2](http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_tools_resources_patient-centered_v2).

<sup>8</sup> Jaén C. R., Ferrer R. L., Miller W. L., Palmer R. F., Wood R, Davila M, et al. (2010, May 1). Patient outcomes at 26 months in the patient-centered medical home national demonstration project. *Ann Fam Med*, 8(1 Suppl):S57–S67; S92.

<sup>9</sup> Reid, R. J., Coleman, K., Johnson, E. A., Fishman, P. A., Hsu, C., Soman, M. P., Trescott, C. E., et al. (2010, Mar) The group health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Affairs*, 29(5):835–43.

<sup>10</sup> Institute of Medicine. (2012). *Living well with chronic illness: A public health call to action*. Washington, DC: National Academy Press.

- The need for care coordination across settings and the continuum of patient care.  
This challenge is beginning to be addressed via the development and implementation of the PCMH-Neighborhood model. There has been significant and rapid growth of activity to advance this concept. ***ACP believes that the PCMH-Neighborhood model will be ready to be scaled up for implementation throughout Medicare in the near future.***
- Need for improved data alignment and timeliness of data use and sharing.  
This is related to the issue of care coordination and makes it extremely challenging for practices to provide proactive, patient-centered care. It is exacerbated by the lack of effective data and information sharing across sites of care. ***In the College's most recent comments on the notice of proposed rulemaking from both CMS<sup>11</sup> and ONC<sup>12</sup> on Stage 2 Meaningful Use, we highlighted our support of the government's vision to use EHRs and health IT to improve care, but believe that more needs to be done to align the measures across all of the initiatives currently underway including CMS PQRS and e-prescribing programs.*** While CMS has made strides in aligning the measures, at a high level, the technical requirements within each of the programs are different enough that dual processes must be undertaken. We are also concerned about the approach that CMS has taken when structuring the penalty phases of the EHR Incentive Programs, e-Prescribing Incentive Program, and Physician Quality Reporting System (PQRS) by requiring that the activity to avoid the penalty must be completed in the prior year or even two years in advance of the legislated deadline. As a result, CMS has effectively moved up the legislated deadline beyond what the market can bear. However, ACP is encouraged that the CPC Initiative program within the Innovation Center (as well as other Innovation Center programs) does include a commitment by CMS to share data in a more frequent and consistent manner and hope that it will provide an opportunity learn the most efficient and effective means of regular data sharing with practices.
- Lack of timely payments for PCMH activity.  
Practices that are trying to transform and that are actively engaging in or pursuing PCMH recognition/accreditation, meaningful use for their electronic health records, e-prescribing, etc. also struggle when they do not receive timely payments from their payers for these activities.

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<sup>11</sup> These comments can be found at:  
[http://www.acponline.org/advocacy/where\\_we\\_stand/health\\_information\\_technology/cms\\_nprm.pdf](http://www.acponline.org/advocacy/where_we_stand/health_information_technology/cms_nprm.pdf).

<sup>12</sup> These comments can be found at:  
[http://www.acponline.org/advocacy/where\\_we\\_stand/health\\_information\\_technology/onc\\_nprm.pdf](http://www.acponline.org/advocacy/where_we_stand/health_information_technology/onc_nprm.pdf).

- Lack of full payment for PCMH activity.  
Finally, in many cases practices are transforming to provide services to their patients in line with the PCMH model, but are only paid to do so for a subset of their patient population (e.g., WellPoint and Aetna are paying practices a per-member per-month fee for their beneficiaries, but those same practices are not receiving payment from CMS for Medicare beneficiaries). This issue is being addressed in some areas of the country, particularly those that were selected to participate in the CPC Initiative, discussed above, but many other practices across the country are not being “made whole” in terms of payment for the work they are doing. ***The College is extremely encouraged by the inclusion of this discussion by CMS in the proposed rule.***

ACP believes that the advancement of the PCMH model is being facilitated through several recognition and accreditation programs. These programs help provide roadmaps for practices that are interested in providing care that is high quality, efficient, and patient-centered—or, in other words, aligned with the PCMH model. Some examples of these programs include:

- The National Committee for Quality Assurance’s (NCQA) Patient-Centered Medical Home Recognition Program (2011)<sup>13</sup>
- URAC’s Patient-Centered Health Care Home’s Accreditation Program<sup>14</sup>
- The Joint Commission’s Primary Care Medical Home Option<sup>15</sup>

***ACP supports the idea of CMS basing its determination of accreditation as a PCMH through a national accreditation organization (via a deeming approach for the purposes of Medicare payment, discussed further below).*** The standards included in each of these programs are already well known and widely used and, while not identical, do include very similar concepts and address much of what CMS is interested in recognizing.

***At this time, ACP recommends against CMS developing its own comprehensive recognition program, including its own processes for reviewing whether practices have met those program’s standards.*** While that approach would likely be less costly for practices and could have greater transparency, the administrative costs and other hassles that would be involved for CMS to develop and carry out its own program would be enormous. There is no guarantee that the CMS standards would be more appropriate or acceptable than those already in use by the existing programs. ACP believes that the

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<sup>13</sup> More information available at: <http://www.ncqa.org/tabid/631/Default.aspx>.

<sup>14</sup> More information available at: [https://www.urac.org/healthcare/prog\\_accred\\_pchch\\_toolkit.aspx](https://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx).

<sup>15</sup> More information available at: <http://www.jointcommission.org/accreditation/pchi.aspx>.

better approach would be for CMS to develop a set of deeming criteria and use the existing accrediting bodies to measure compliance.

ACP agrees with CMS that the cost and processes required by practices to achieve accreditation from one of these organizations are not insignificant, and should be considered within the payment approach used to recognize these practices. ACP also agrees that CMS would face challenges in terms of balancing the interests of these private organizations in their accreditation models with CMS' responsibility to establish and maintain appropriate transparency in its decision-making processes.

We note, though, that the Department of Health and Human Services has a long history and tradition of deeming non-profit private sector accreditation organizations to satisfy compliance with federal regulations in a way that relies on the accreditation organization's expertise, while still ensuring that the process meets federal standards relating to transparency. Examples include the deemed accreditation programs authorized by the Clinical Laboratory Improvement Act and the Medicare and Medicaid conditions of participation for hospitals. We believe that CMS can learn from those relationships and work with the accreditation organizations and national specialty societies, including ACP, to design a PCMH and PCMH-N recognition program that appropriately balances the interests of the non-profit private sector accreditation organizations and CMS's responsibility to establish and maintain transparency in its decision-making processes.

ACP, along with AAFP, AAP, and AOA, has offered a number of guidelines that address these issues, as well as others, to be taken into account when considering using a PCMH recognition or accreditation program.<sup>16</sup> In brief, these are:

1. Incorporate the joint principles of the patient-centered medical home, which were discussed earlier.
2. Address the complete scope of primary care services—comprehensiveness, coordination, continuity, accessibility, and patient engagement and experience.
3. Ensure the incorporation of patient and family-centered care emphasizing engagement of patients, their families, and their caregivers.
4. Engage multiple stakeholders in the development and implementation of the program.
5. Align standards, elements, characteristics, and/or measures with meaningful use requirements.

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<sup>16</sup> Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs. February 2011. Accessed at: [http://www.acponline.org/running\\_practice/pcmh/understanding/guidelines\\_pcmh.pdf](http://www.acponline.org/running_practice/pcmh/understanding/guidelines_pcmh.pdf)



6. Identify essential standards, elements, and characteristics—including, but not limited to: advanced access principles; comprehensive practice-based services; effective care management; care coordination; practice-based team care; and guarantees of quality and safety.
7. Address the core concept of continuous improvement that is central to the PCMH model.
8. Allow for innovative ideas.
9. Ensure care coordination within the medical neighborhood.
10. Clearly identify PCMH recognition or accreditation requirements for training programs.
11. Ensure transparency in program structure and scoring.
12. Apply reasonable documentation/data collection requirements.
13. Conduct evaluations of the program's effectiveness and implement improvements over time.

While the current recognition and accreditation programs available today align well with many of these guidelines—and should be used by CMS—there is certainly room for ongoing improvement.

***ACP specifically recommends that CMS adopt a deeming approach for Medicare payments of services associated with PCMHs and PCMH-N that facilitates the improvement of the existing accreditation programs as described below.***

CMS could use the PCMH and PCMH-N recognition guidelines outlined above, with the five functions of comprehensive primary care used in the CPC initiative, as a starting point to develop its own standards that would have to be met for a recognition and accreditation program to achieve deemed status. These criteria could apply to both the overall program structures and processes (building on the guidelines above), as well as to elements within the program that serve to define what makes up a patient-centered medical home/advanced primary care practice (building on the CPC initiative functions).

ACP understands the need for CMS to determine an attribution method for beneficiaries to patient-centered medical homes/ advanced primary care practices. The two attribution methods currently under consideration by CMS are:

- Each beneficiary prospectively chooses an advanced primary care practice.
- To examine the quantity and type of E/M or other designated services furnished to that beneficiary by the practice.

Because a key element of the PCMH models is an active, engaged and empowered patient, there is an advantage to having beneficiaries prospectively choose the practice, so

that they are aware of—and more committed to contributing to—the success of the model. A prospective selection process, though, has the disadvantage of potentially reducing the numbers of practices that would receive recognition as being an advanced primary care, or PCMH, practice.

One option would be to combine a prospective beneficiary selection process with examination of the quantity and type of E/M and other designated services furnished to the beneficiary by the practice. In this way, beneficiaries would be encouraged to choose an advanced primary care practice for engagement and attribution purposes. At the same time, Medicare beneficiaries who are seen by practices that have met all of the standards of a PCMH would not be excluded from attribution, even though some of those beneficiaries may not have formally designated the practice as their patient-centered medical home. (In essence, the beneficiary would still have chosen the practice as the source of care, simply by virtue of the fact that the beneficiary chose to receive care from that practice.)

The College recognizes that this is a challenging issue and would like to work with CMS and other stakeholders to further develop the methods to determine which advanced primary care practice is providing PCMH services to each beneficiary. The approach being utilized by CMS in the CPC Initiative—determining which primary care practice billed for the plurality of a beneficiary’s primary care allowed charges during the most recent 24-month period—aligns more with the second attribution methodology under consideration by CMS. Therefore, CMS should use the opportunity provided by the CPC Initiative to more fully understand the advantages and disadvantages of that approach, as well as consider additional pilot tests of both approaches through the projects of the CMS Innovation Center to determine whether one is more effective—or whether a combination of the two approaches would be more appropriate. In addition, there are a number of private sector PCMH demonstration projects and rollouts that have used several different attribution approaches from which CMS could learn.

#### Hospital, SNF, or CMHC Post-Discharge Care Management

ACP is extremely pleased that CMS has chosen to move forward on creating pathways for payment of non-face-to-face, transition care management—through their proposal to create a new HCPCS G-code to describe care management for the transition of a beneficiary from care furnished by a treating physician during a hospital stay, SNF stay, or community mental health center to care furnished by the beneficiary’s primary physician in the community. This proposal has long been sought by the College, particularly on behalf of our members that are internal medicine specialists in the primary and comprehensive care of adults, as well as by a number of other specialties such as family physicians, and geriatricians. We also recognize and appreciate that this proposal

would be beneficial to our internal medicine subspecialty members in cases where they are providing comprehensive care for their patients.

The proposed rule states that CMS is continuing to monitor the progress of the AMA CPT/RUC Chronic Care Coordination Workgroup (C3W). The College is involved in the efforts of this workgroup and has therefore considered a number of comparisons that can be made between the CMS proposal and the codes that have been proposed by the C3W. The Relative Value System Update Committee (RUC) is currently surveying the C3W-proposed codes, and their recommendations are expected to be sent to CMS after the October 2012 RUC meeting.. Therefore, while many elements of the CMS proposal are desirable and in line with what the College and other specialty societies have sought, ***ACP recommends that CMS await the recommendations of the RUC and, if deemed appropriate, accept the values, so that they can fully take into account feedback from practicing physicians of all specialties before finalizing the descriptors of and values for these non-face-to-face, care management services.*** ACP believes that the development of billing codes and their assigned relative values must be done with input from the practicing medical community.

If CMS decides to move forward with implementing the proposed post-discharge, non-face-to-face, transitional care service HCPCS G-code, then ACP would like CMS to take into consideration the following, more specific, recommendations:

- CMS proposes that the post-discharge transitional care HCPCS code (GXXX1) would be payable only once in the 30 days following a discharge, per patient per discharge, to a single community physician or qualified non-physician practitioner (or group practice) who assumes responsibility for the patient's post-discharge transitional care management. The claim would be paid at the conclusion of the 30-day post-discharge period. ***ACP agrees that this code should be billed at the end of the transition period, after the services have been provided.***
- However, CMS also states that they "...believe it is unlikely that two or more physicians or practitioners would have had a face-to-face E/M contact with the beneficiary in the specified window of 30 days prior or 14 days post discharge and have furnished the above-listed post-discharge transitional care management services." CMS does not believe it is necessary to take further steps to identify a beneficiary's community physician or qualified non-physician practitioner who furnishes the post-discharge transitional care management services. ACP understands this to mean that CMS will not attempt to identify the community physician or qualified non-physician practitioner immediately after the patient's discharge from the facility. ***ACP asks that CMS make a careful examination of this provision, and consider ways to avoid the administrative burden of***

*providing detailed documentation of non-face-to-face services that will meet physicians and qualified NPPs if more than one submits a claim for the post-discharge transitional care coordination code. We suggest that CMS consider other options, such as using a plurality of care—similar to that used in ACOs and the Innovation Center’s CPC Initiative—to decide the payment in such cases.*

#### **Payment for New Preventive Service HCPCS G-Codes**

*ACP supports the proposal to add these newly created preventive services (HCPCS codes G0442 through G0447) to the telehealth benefit, as Category 1 services.* These services are: alcohol misuse screening, depression screening, STI screening and counseling, intensive behavioral therapy for cardiovascular disease, and intensive behavioral therapy for obesity. The services’ codes are HCPCS G0442 through G0447. The rule also proposes expanding the telehealth benefit by adding HCPCS code G0396 (alcohol and/or substance [other than tobacco] abuse structured assessment [for example, AUDIT, DAST] and brief intervention, 15 to 30 minutes) and HCPCS code G0397 (alcohol and/or substance [other than tobacco] abuse structured assessment [for example, AUDIT, DAST] and intervention greater than 30 minutes).

#### **Potentially Misvalued Codes Under the Physician Fee Schedule**

##### **Payment for Global Surgical Packages**

CMS proposes to take a close look at the volume of E/M services that are included as part of many surgical procedures’ global payment packages. The agency has initial evidence that the global payment packages’ requisite number of E/M visits are not always provided, with the outcome that those surgeries are overpaid. ACP has been working for several years to bring this issue to the attention of Medicare, in the on-going effort to ensure that fee schedule services are appropriately valued and paid.

*ACP suggests two modifications of this proposal: 1) CMS should implement a requirement that each face-to-face visit provided within a global package be documented in the medical record. Accordingly, if the provided E/M services are not in accord with the service levels specified in the global package, the excess payment should be recouped by CMS and redistributed to the overall physician payment/RVU pool. This option would also provide CMS with data for its future reviews of global E/M services. 2) Alternatively, CMS should require that the surgeon report a HCPCS code to indicate that the visit took place. The surgeon would not be held to the CMS E/M documentation standards for the E/M global visits. For both of these suggested modifications, the face-to-face E/M visit could be provided by a physician or by a mid-level practitioner.*

### **Medicare Coverage of Hepatitis B Vaccine**

Currently, Medicare coverage of preventive immunizations is divided between Medicare Part B (limited to influenza, pneumococcal and a subset of hepatitis B vaccinations) and Medicare Part D (remaining recommended immunizations). This division of coverage for vaccines creates administrative challenges for patients, physicians, and pharmacists. Since the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, CMS has been required to cover all preventive services the United States Preventive Services Task Force (USPSTF) recommends with a Grade of A or B with no cost-share burden to patients. Unfortunately, in 1996, the USPSTF ceded its authority over vaccine recommendations to the Advisory Committee on Immunization Practices (ACIP). Since that time, only ACIP has made vaccine recommendations. This has placed vaccines outside of the preventive service mandate for CMS. Furthermore, because vaccines are not included as USPSTF preventive services, patients face challenges in accessing vaccines, whether through Part B or Part D.

Ironically, under Section 1001 of the ACA, most private health plans are required to cover all vaccines recommended by ACIP, and typically do so with no cost-share burden to patients if provided by in-network providers. Therefore, with vaccines not considered under preventive services for Medicare coverage, yet covered by mandate under private plans at no cost to patients if provided by in network providers, we have a different standard applied to private plans than that of Medicare beneficiaries. This results in a gap in care for Medicare beneficiaries while their privately insured counterparts enjoy the benefits of mandatory coverage of preventive vaccines.

***ACP commends CMS for using the (ACIP) recommendation for hepatitis B vaccine, and for acknowledging the risk of infection to diabetic persons.*** ACP supports the proposed expansion of coverage for hepatitis B vaccine and its administration to all individuals diagnosed with diabetes mellitus (not only those individuals with diabetes who are receiving glucose monitoring in facilities). With this proposal, CMS demonstrates that it does not require a USPSTF Grade A or B designation of this service for reimbursement. For that reason, ***ACP recommends that CMS also consider including coverage for all ACIP-recommended vaccines to the preventive services benefit. In particular, due to the multi-state pertussis outbreaks, ACP recommends that CMS add coverage of the diphtheria, tetanus, and pertussis (DTaP) vaccine for all beneficiaries, at the appropriate intervals. In addition, inclusion of the herpes zoster vaccine under the Part B preventive services benefit will significantly increase beneficiary access to the important intervention.***

### **Part B Drug Payment: Average Sales Price (ASP) Issues**

The rule proposes a change in the Part B drug pricing policy, to diminish concerns regarding drug shortages. CMS proposes that the AMP price substitution policy would not take effect if the drug and dosage form represented by the HCPCS code are reported on the FDA Current Drug Shortage list (or other FDA reporting tool that identifies shortages of critical or medically necessary drugs). The rule also clarifies that drugs used by a physician to refill an implantable item of DME to be within the “incident to” benefit category and not the DME benefit category. Consequently, the physician must buy and bill for the drug, and a non-physician supplier that has shipped the drug to the physician’s office may not do so (except as may be permitted pursuant to a valid reassignment).

*The College supports the proposal that restricts the implementation of an "AMP Price Substitution" for a drug and dosage form that is represented by a HCPCS code reported on the FDA Current Drug Shortage list. Many of our members are in small practices, without the purchasing power of larger organizations. We believe that this change would make it more affordable for those physicians to purchase these limited-supply drugs and would improve beneficiary access to medications.*

### **Physician Value-Based Payment Modifier (VBPM) and the Physician Feedback Reporting Program**

ACP is a strong advocate for transitioning to a value-based payment and delivery system and the steps necessary to get there. *Therefore, ACP is supportive of the goals behind the value-based payment modifier program. However, linking payment to reporting and performance on specific quality and cost measures must be done carefully.* The measures should be evaluated through and collected in a consistent, reliable, feasible, and transparent manner; thoroughly tested prior to full implementation to the extent possible; and applied as part of overall payment and delivery system reform emphasizing collaborative system-based health care. When linking payments to reporting and performance on specific quality measures, such incentives must take into consideration the potential adverse consequences (e.g., “deselection” of difficult patients with complex health care needs; “gaming of the system” or providing services based solely on performance measures rather than evidence-based services that might not be measured; undermining trust between the patient and physician; and unjustified increases in unnecessary or costly care) and steps should be taken to mitigate any of these potential unintended consequences and/or reconfigure the program if such adverse effects are recognized.

In addition, the College calls for programs that link rewards and/or penalties to performance to be incorporated into systems-based payment reforms designed to permit

and facilitate broad-scale positive behavior change and achievement of performance goals within targeted time periods. Potential rewards should be:

- Significant enough to drive desired behaviors and support continuous quality improvement;
- Reflective of the cost and other resources needed to participate in a performance assessment-based payment program, including the cost to measure and design improvements that will take, for example, system supports and program management;
- Balanced between rewarding high performance and rewarding substantial improvement over time;
- Graduated to create stronger incentives for physicians to participate in performance improvement programs and to ensure that a physician's level of commitment to quality improvement activities is recognized;
- Directed at positive rather than negative rewards;
- Timely and followed closely upon the achievement of performance;
- Designed to encourage physicians and health care systems to care for vulnerable patients with complex health care needs, reflect the level of care required, and avoid adverse, unintended consequences resulting from performance assessment-based payment program implementation; and
- Adjusted as the complexity of performance measure requirements change.<sup>17</sup>

One of the most critical issues that should be addressed in the implementation of the VBPM program is the use of timely data to calculate the modifier. In the rule, CMS proposes to use CY 2014 as the performance period for 2016 value-based payment modifier. ***ACP strongly encourages CMS to use more timely data to calculate the modifier for the participating physicians, in order to provide them with meaningful and actionable information that will enable them to improve the overall value of the care they furnish.*** Basing payments off data from two years prior does not allow practices the opportunity to use the performance and cost data they receive to make meaningful changes and then be rewarded appropriately for those improvements. Effective, regular communication between payers and physicians—of which data sharing is a key component—is vital to a successful pay for performance (and value) program. If CMS is not able to determine a means of providing more timely data and feedback to physicians, then it is likely that this program will fall far short of its goals of improved performance

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<sup>17</sup> More information on ACP's recommendations for performance assessment programs can be found in our position paper titled, "The Role of Performance Assessment in a Reformed Health Care System". November 2011. Accessed at: [http://www.acponline.org/advocacy/where\\_we\\_stand/policy/performance\\_assessment.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/performance_assessment.pdf).

and reduced cost; and could become an unfortunate setback in the movement toward a true value-based payment and delivery system.

*ACP is supportive of CMS' proposal to initially apply the VBPM to all groups of physicians with 25 or more eligible professionals in the program for 2015.* However, the College strongly encourages CMS to engage in significant education and outreach efforts to those groups so that they are:

- Aware of the program;
- Understand what it involves and how it will have an effect on them;
- Feel they can make informed decisions about their participation in this initial year, as well as in future years; and
- Able to provide meaningful feedback to CMS throughout the implementation of the VBPM.

This education and outreach, paired with the ability to accept and act on ongoing feedback, should be a top priority of CMS, working collaboratively with the physician societies, if they truly intend to meet their goals of improved performance and reduced cost.

ACP understands that CMS proposes to further separate all groups of physicians with 25 or more eligible professionals into two categories based on PQRS participation, with the first category including groups of physicians that have satisfactorily reported PQRS quality measures or that have satisfactorily reported using the administrative claims-based reporting. This satisfactorily reporting category will then have its value-based payment modifier set at 0 percent, which therefore would not affect their payment under the fee schedule. The second category would then include groups of physicians with 25 or more eligible professionals that have not satisfactorily met the PQRS reporting criteria. This second category's VBPM would be set at negative 1.0 percent—and would be in addition to the negative 1.5 percent payment adjustment assessed under the Act for failing to meet the satisfactory reporting criteria under PQRS.

The College appreciates that CMS is proposing to align this program with the PQRS program to the extent possible. ACP also understands that the program, by law, must be implemented in a budget neutral manner. This makes it all the more important, though, that CMS ensure that there is timely, effective, and regular communication and data sharing between CMS and the groups that are to be included in the program—so that they clearly understand what the impact of their participation, or lack thereof, in PQRS will be on their practices, and have as many opportunities as possible to successfully participate.



In addition, CMS' education outreach, discussed above, should make it clear that groups of 25 or more eligible professionals that report PQRS individually—rather than as a group—will now need to report as a group or they will be put into the non-satisfactory PQRS reporter category and will receive a negative 1 percent payment adjustment. ***Some alternatives that CMS could consider include: (1) offering physicians within a group the option of avoiding a VBPM penalty by participating in PQRS as individuals rather than as a group and/or (2) allowing groups not currently reporting via GPRO (i.e., participating in PQRS as individuals) to avoid the VBPM penalty by using the administrative claims mechanism or another approved approach, while still allowing the physicians within the group to participate in PQRS as individuals.***

Further, the College reiterates how important it is that CMS fully consider the potential adverse consequences and unintended consequences of the VBPM and other pay-for-performance programs as discussed above, particularly when making negative payment adjustments, carefully assess their impact over time, and be prepared to take steps to mitigate potential unintended consequences and/or reconfigure the program if such adverse effects are recognized.

ACP further understands that within the satisfactorily reporting category, CMS proposes to offer physician groups an option that calculates the value-modifier using a quality-tiering approach. Therefore, groups of physicians could elect to earn an upward payment adjustment for high performance (i.e., the high quality and low cost tier), but would be at risk for a downward payment adjustment for poor performance (i.e., low quality and high cost tier). ***The College appreciates that CMS is proposing to give physician groups the option of participating in the quality-tiering approach during this first year. However, the College has some specific concerns and recommendations about the proposed approach:***

- First, during the initial year, the College strongly recommends that the practices that opt into the quality tiering not be at risk for a negative adjustment. Putting practices that voluntarily opt in to the quality-tiering approach at risk will be a significant disincentive—even for practices that believe themselves to be high performers—and will also limit the ability of CMS and other stakeholders to learn from this initial round of implementation and to improve upon the program before it rolls out more broadly.
- Second, particularly due to the potential for a negative adjustment, the College is concerned that only those practices that clearly demonstrate high-quality/low-cost performance will opt into the quality tiering, resulting in a narrow range of comparisons that can be made and/or truly high performing practices being

classified as low performing relative to their colleagues. Again, this will severely limit the ability to learn from and improve upon the program.

- Third, ACP strongly recommends that CMS apply their risk adjustment methodology to all practices that participate in the quality-tiering approach—not just those that fall into the high-quality/low-cost, high-quality/average-cost, and average-quality/low-cost tiers. The current proposal would not risk adjust the payments for those practices in the lowest performing tier. This is of particular concern if the potential of a negative adjustment for practices falling into the lower-quality/higher-cost tier is not removed—then there would simply be no opportunity for those practices, particularly those with a high-risk patient population, to come out of the “penalty box”. It would also be a further disincentive for practices to participate in quality-tiering.
- Finally, ACP recognizes the importance of phasing in a program like this—and is again appreciative of CMS’ proposal to apply it only to practices of 25 or more eligible professionals in the first year. However, the College strongly encourages CMS to begin sharing the quality and resource use data with all satisfactory PQRS reporters—both individuals and groups—within the coming year, and to seek feedback on those reports. This will allow CMS, as well as physicians, group practices, and other stakeholders to better understand what data are being used within the VBPM program and what needs improvement in terms of the data used and how it is presented, as well as provide greater opportunities for improvement by all participants.

With regard to how groups of 25 or more eligible professionals indicate their willingness to participate in the quality-tiering approach, the College appreciates that CMS is seeking to reduce administrative burden. ***Therefore, ACP supports using a web-based registration system or other simple online approach to opting into the quality-tiering that allows for ongoing registration by groups throughout the relevant calendar year.*** However, it is again important to note the critical need for education and outreach by CMS, working collaboratively with the physician societies, so that practices are aware of the program; understand what it involves and how it will impact them; feel they can make informed decisions about their participation in this initial year, as well as in future years; and are able to provide meaningful feedback to CMS throughout the implementation of the VBPM.

CMS also proposes that groups with 25 or more eligible professionals that are participating in the Medicare Shared Savings Program or the Pioneer ACO program, assuming they are satisfactory PQRS reporters, should be given the option of having their value-based payment modifier calculated using the quality-tiering approach. The College shares CMS’ concerns about ensuring that the structure of the VBPM program not

conflict with the structures being established within the Medicare Shared Savings Program and other ACO initiatives. *Therefore, while ACP is supportive of Medicare ACO-participating practices with 25 or more eligible professionals being given the option of having their value-modifier calculated, it would preferable to wait to apply the modifier to their payments until after the first year of the VBPM program.* That will allow both CMS and the ACO-participating practices to make more informed decisions and to better understand any potential conflicts in the designs of the programs.

Finally, CMS seeks feedback on a proposal to develop a value-based payment modifier for hospital-based physicians that will assess their performance using the measure sets for their hospital as a whole (i.e., the Inpatient Quality Reporting (IQR) and the Outpatient Quality Reporting (OQR) programs). *While ACP does encourage CMS to develop a value-based payment modifier option for hospital-based physicians, the College is concerned that the proposed approach would result in hospitalists being inaccurately measured, as they would be attributed to the total cost of the patients' stay at a hospital, when they may have only been responsible for discharging the patient.* Therefore, ACP recommends that attribution methodology be developed to accurately capture the role of hospitalists in patient care. Since hospitalists are typically part of a group practice, CMS could consider implementing the modifier for hospitalists at the group practice level—as it is being applied to other physicians for 2015—which would be a more appropriate locus to use in assessing their collective performance.

#### Proposed Quality Measures

ACP supports the use of performance measures that help to measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems associated with the ability to provide high-quality healthcare. In addition, the College believes that programs that link payment to assessment of performance should incorporate periodic, objective assessments of measurement, data collection, scoring, and incentive systems to evaluate their effects on achieving improvements in quality, including any unintended consequences. The College has critically reviewed and evaluated the proposed performance measures for the VBPM program to determine if they are based on high-quality clinical evidence and are methodologically sound. (See attached table.)

In general, ACP provides the following comments on the proposed quality measures:

- **Use of High-quality, Evidence-based Measures** - The College supports the use of performance measures that are based on high-quality clinical evidence and are derived from clinical guidelines that are developed from a systematic review of the evidence.

- **Requirement for National Quality Forum (NQF) Endorsement** – The College believes that CQMs that have not been endorsed by NQF should not be accepted by Medicare, and suggests that the measures that are not NQF-endorsed be submitted for endorsement. The College also suggests that the CQMs be updated to include the latest specifications when measures are updated as part of the NQF-endorsement maintenance effort.
- **Alignment of Quality Improvement Programs** - The College supports alignment across the following federal programs, the Value-Based Payment Modifier, Medicare Star Advantage Program, Physicians Quality Reporting System, and Meaningful Use through the use of the same or harmonized measures.
- **Documentation of Patient Exclusion and Exceptions** - The College feels it is important to create ways to document when patients are excluded or should be exempted from CQMs.
- **Appropriate Risk Adjustment** - The College supports the risk adjustment of CQMs when applicable to take into account differences in patient populations and healthcare settings.
- **Readiness of E-Measures** – The College would also like to note our concern that e-measures are not sufficiently mature for use in actual pay-for-performance programs, as they have not yet been properly evaluated in pay-for-reporting programs. There must be thorough evaluation of the validity and reliability of e-measure reporting before they are used in any program that will directly impact physician revenues.

### **Ordering Portable X-ray Services**

*ACP supports the CMS proposal to revise its current regulations, which limit ordering of portable x-ray services to only an MD or a DO, to allow other physicians and non-physician practitioners acting within the scope of their Medicare benefit and State law to order portable x-ray services.*

This proposed regulatory change would allow a MD or DO, as well as an nurse practitioner, clinical nurse specialist, physician assistant, certified nurse-midwife, doctor of optometry, doctor of dental surgery and doctor of dental medicine, doctor of podiatric medicine, clinical psychologist, and clinical social worker to order portable x-ray services within their State scope of practice and the scope of their Medicare benefit. Although all of these physicians and non-physician practitioners are authorized to order diagnostic services, the existing Medicare benefit limits the services that they can provide. Correspondingly, CMS also proposes to revise the language included in §410.32(c) to recognize the same authority for physicians and non-physician practitioners to order diagnostic tests as is prescribed for other diagnostic services.

### **Durable Medical Equipment (DME) Face-to-Face Encounters and Written Orders Prior to Delivery**

The proposed rule clarifies and expands requirements for a physician order prior to a beneficiary receiving various Durable Medical Equipment. This proposal is consistent with the Medicare and Medicaid home health face-to-face requirement that increases physician accountability.

The proposal for 2013 would change the timeframe for the written order and the face-to-face visit. CMS proposes that a physician must have documented and communicated to the DME supplier that the physician or a PA, an NP, or a CNS has had a face-to-face encounter with the beneficiary no more than 90 days before the order is written or within 30 days after the order is written. The order itself would need to be relevant to the reason for the beneficiary's need for the item of DME; the face-to-face encounter would substantiate that the beneficiary's condition warrants the covered item of DME and be sufficient to meet the goals of this statutory requirement.

CMS recognizes that there may be circumstances when it may not be possible to meet this general requirement of "prior to the written order," and that in such cases, beneficiary access to needed items must be protected. If a face-to-face encounter occurs within 90 days of the written order, but is not related to the condition warranting the need for the item of DME, or if the beneficiary has not seen the physician or PA, NP, or CNS within the 90 days prior to the written order, the agency proposes to allow a face-to-face encounter up to and including 30 days after the order is written in order to ensure access to needed items. "Incident to" services would not satisfy the proposed requirement. This proposal does not apply to prosthetics, orthotics, or supplies (POS).

*ACP agrees with CMS, and supports these proposed changes for DME orders.*

### **Electronic Prescribing (eRx) Incentive Program**

CMS proposes these changes to the 2013-2014 eRx Program:

- Establish an alternative submission mechanism for self-nomination by those wishing to participate in the MSSP, Pioneer ACP, or PGP demonstration. They would also need to submit an XML file (not a web-based submission) that describes the eligible professionals included in the group practice.
- Define a group as a single TIN with two or more eligible professionals, as identified by their NPIs, who have reassigned their Medicare billing rights to the TIN.
- Define success in the GPRO program as reporting the electronic prescribing measure's numerator code during a denominator-eligible encounter for at least

- 225 times during the 12-month period (January 1, 2013 to December 31, 2013).
- Not allowing claims to be reprocessed for the sole purpose of attaching a reporting G-code on a claim.
  - Adding two significant hardship exemptions:
    - Eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment reporting periods could be exempted.
    - Eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology could be exempted.

*The College supports the provisions regarding the eRx Incentive Program included in the propose rule. We particularly want to commend CMS for adding the two hardship exemption categories related to participation in the "meaningful use" electronic medical record (EHR) incentive program and the establishment of an informal review process for eRx program participants to request reconsideration by CMS regarding determination of successful reporting for the 2013 incentive and application of the 2014 payment adjustment.*

#### **Medicare Shared Savings Program**

CMS proposes to better align the program criteria with the PQRS criteria. For purposes of the payment adjustment, CMS proposes to incorporate the same PQRS GPRO under the Shared Savings Program that is currently used for purposes of the PQRS incentive under the Shared Savings Program. Under this proposal, eligible professionals who are ACO providers or suppliers would constitute a group practice that would report quality measures via the group practice reporting option (GPRO) data collection tool for purposes of both the PQRS incentive under the Shared Savings Program and of the PQRS payment adjustment under the Shared Savings Program.

The agency proposes to use the final GPRO quality measures adopted under the Shared Shavings Program and to incorporate the same criteria for satisfactory reporting that were finalized for the PQRS incentive under the Shared Savings Program, both of which are described in the Shared Savings Program final rule.

*The College supports this provision in the proposed rule; we understand that it is an attempt to align both quality reporting processes and measures within the Shared Savings Program and the PQRS initiative. We strongly support the alignment of quality assessment efforts used among the multiple quality initiatives currently being implemented within the public and private sectors.*

## **Physician Payment, Efficiency, and Quality Improvements — Physician Quality Reporting System**

ACP agrees with CMS that alignment of their quality improvement programs will decrease the burden of participation on physicians, thus allowing them more time and resources to use caring for patients. The College also agrees that if physicians wish to improve the quality of the care they provide, they must engage in quality measurement and reporting. Therefore, the College appreciates the efforts that CMS has made in the proposed rule to move these efforts toward greater alignment, but would also like to make some specific comments and recommendations regarding CMS' proposal.

***ACP strongly supports CMS' proposal to initiate an administrative claims reporting mechanism for PQRS (as well as for the value-based payment modifier program) in 2015 and 2016.*** This option provides a feasible alternative for physicians and groups to participate in the program, particularly if they have not yet been able to effectively use the traditional reporting mechanisms (claims, registries, or electronic health records [EHRs]) for this purpose or have otherwise not been able to meet the criteria for successful reporting for the 2013 and/or 2014 incentives. Further, the proposal to require that eligible professionals and groups elect to use that option by a pre-determined deadline is reasonable and ACP is supportive of using a web-based and/or G-code approach for this purpose.

CMS proposes to change the number of eligible professionals comprising a PQRS group practice from 25 to 2. While the intent of this proposal is to give more groups the opportunity to report using the group practice reporting option (GPRO), potentially leading to greater overall program participation, it is unclear if such a change is appropriate at this time. A small practice of one physician and one nurse practitioner, which is typically considered a solo physician practice and not a group, would then qualify for this new group reporting option. This also confuses the alignment of the PQRS program with the VBPM program, which is planning to use the current PQRS definition of 25 or more eligible professionals for the initial round of implementation. ***ACP recommends that CMS reconsider this change in the definition of a group practice from 25 to 2 for the coming year until the implications of such a change are more clearly understood. However, the College does support CMS' proposal to allow a greater number of reporting mechanisms to be used by groups, including claims, registry, EHR, GPRO, and administrative claims. ACP agrees that this will lead to greater overall program participation, even if the definition of a group practice is not changed at this time.***

CMS' proposal of new criteria for registry-based reporting by individual eligible professionals on measures groups is also of interest—specifically that EPs would be able

to include non-identifiable data for non-Medicare beneficiaries in the denominators for these measures, as long as Medicare Part B patients make up the majority of their 20 patient cohort for the measures group (which is a reduction in the previous requirement of 30 Medicare Part B patients in the cohort). ACP is encouraged that CMS is considering alternative reporting criteria that are potentially more aligned with other quality improvement and reporting programs that are inclusive of non-Medicare patients. The inclusion of non-Medicare patients in the denominator may also provide more accurate overall assessments of the quality of care provided by physicians and that approach, when combined with the reduced number of required cohort patients, may increase the likelihood of more physicians being able to meet the PQRS reporting requirements.

While the effort to improve registry-based reporting criteria described above is encouraging, ACP does not feel that the measures can be truly aligned as long as different populations are being measured. ***ACP recommends that CMS take these efforts further and make a reasonable assessment of their ability to align measures, and then develop and publish a concrete plan to address that alignment.***

Related to the proposed criteria changes for registry-based reporting is CMS' proposal to change the minimum sample size on the Physician Compare website from 25 patients to 20 patients, beginning in 2013. ACP understands the reason for this would be to better align with the proposed minimum patient reporting thresholds for PQRS measures group reporting—and, as indicated earlier in this letter, ACP is strongly supportive of greater alignment across all of the programs. However, since these data will be used for public reporting via the Physician Compare website, it is critical that the sample size is statistically valid and reliable. ***ACP requests that CMS provide the public with evidence supporting this change in sample size from 25 to 20 so that it is clear the information being publicly reported on physician performance is meaningful.***

Finally, the College would like to note that many of our members participate in the American Board of Internal Medicine's Maintenance of Certification (MOC) program, which is a rigorous, multi-faceted, voluntary process that can provide participants with a robust picture of the quality of care they are providing. The program's quality assessments include clinical and practice data collection, patient experience surveys, and a quality improvement activity. The program also provides near real-time feedback to physicians, which, as we have noted throughout these comments, is critical to enable them to identify and act on those opportunities for improvement. ***Therefore, ACP requests that CMS explore opportunities to leverage the MOC infrastructure that exists within the specialty boards in order to reduce redundant reporting requirements and enhance the value of PQRS for physicians and their patients.***



Thank you for considering ACP's comments. Please contact Shari Erickson, Director, Regulatory and Insurer Affairs, by phone at 202-261-4551 or e-mail at [serickson@acponline.org](mailto:serickson@acponline.org) if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read 'RAG', written in a cursive style.

Robert A. Gluckman, MD, FACP  
Chair, Medical Practice and Quality Committee



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**ATTACHMENT**  
**ACP Comments on Proposed Measures for 2013 Physician Fee Schedule**  
**Value-Based Payment Modifier**

| American College of Physicians Review (2013 Medicare Physician Fee Schedule)                        |  |
|---|--|
| TABLE 64: Proposed Measures for the Administrative Claims Option for 2015 and 2016                  |  |
| Measure   | ACP Review   |
| 0021<br><b>Annual Monitoring for Beneficiaries on Persistent Medications</b><br>NCQA Patient Safety | <p>The College suggests updating this measure to align with the latest clinical recommendations. Ongoing ALT and AST liver enzyme tests for all patients on HMG CoA Reductase Inhibitors is no longer recommended because of the low risk of enzyme elevation for patients on stable dosing and the lack of evidence that the rate of elevation is higher than in patients who are not on an HMG CoA Reductase Inhibitor.</p> <p>The US Food and Drug Administration (FDA) had previously recommended liver function testing following the initiation of statins and periodically thereafter. In 2012, the FDA revised its labeling information on statins to only recommend liver function testing prior to initiation of statin therapy and to only repeat such testing for clinical indications .<br/><a href="http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm293623.htm">http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm293623.htm</a></p> |
| 0555<br><b>Lack of Monthly INR Monitoring for Beneficiaries on Warfarin</b><br>CMS Patient Safety   | <p>The College suggests that the measure is out of date with latest research which has shown that less frequent monitoring of INR at 3 month intervals may be clinically equivalent to monthly INR monitoring. The measure should be updated to allow for less frequent INR monitoring.</p> <p><b>Citation:</b> Warfarin Dose Assessment Every 4 Weeks Versus Every 12 Weeks in Patients With Stable International Normalized Ratios: A Randomized Trial<br/><a href="http://annals.org/article.aspx?volume=155&amp;page=653">http://annals.org/article.aspx?volume=155&amp;page=653</a></p>   |
| 0577<br><b>Use of Spirometry Testing to Diagnose COPD</b><br>NCQA Clinical Care                     | <p>The College supports this measure under the assumption that the COPD diagnosis was obtained by diagnosing <i>airflow obstruction in patients with respiratory symptoms</i>.</p>   |
| 0549<br><b>Pharmacotherapy Management of COPD Exacerbation</b><br>NCQA Clinical Care                | <p>The College does not support the measure for two reasons: 1) the measure does not take into account if a patient has possession of the medication at home from a previous prescription and 2) not all patients should be prescribed a corticosteroid for COPD treatment.</p>  |

**American College of Physicians Review (2013 Medicare Physician Fee Schedule)**

**TABLE 64: Proposed Measures for the Administrative Claims Option for 2015 and 2016**

| Measure   | ACP Review  |
|---|---|
| 0543<br><b>Statin Therapy for Beneficiaries with Coronary Artery Disease</b><br>CMS Clinical Care                           | The College agrees that the measure is a clinically important measure of quality; however, the PMC has concerns that this measure is out of physician control. There are a lot of reasons why a patient may not get the medication including cost, co-pay, access to pharmacies, or pharmacies within a health plan network. This measure would be better off used to assess health plans that have control over these particular factors.              |
| 0583<br><b>Lipid Profile for Beneficiaries Who Started Lipid-Lowering Medications</b><br>Resolution Health<br>Clinical Care | The College supports this measure and agrees that obtaining a lipid profile shortly after the start of treatment is evidence based. However some committee members had a concern that the 3 month time frame is too short and should be extended to 4 or 6 months.  |
| 0053<br><b>Osteoporosis Management in Women <math>\geq 67</math> Who Had a Fracture</b><br>NCQA Clinical Care               | The College supports this measure.  |
| 0055<br><b>Dilated Eye Exam for Beneficiaries <math>\leq 75</math> with Diabetes</b><br>NCQA Clinical Care                  | The College supports this measure, but suggests that a retinal exam performed by retinal camera should also qualify as fulfilling the measure. This is important in order for physicians to have the ability to qualify for the measure in underserved rural/urban areas where there may a shortage of ophthalmologists or optometrists to perform the exams.   |
| 0057<br><b>HbA1c Testing for Beneficiaries <math>\leq 75</math> with Diabetes</b><br>NCQA Clinical Care                     | The College supports this measure.  |
| 0062<br><b>Urine Protein Screening for Beneficiaries <math>\leq 75</math> with Diabetes</b><br>NCQA Clinical Care           | The College supports this measure with the addition of an exclusion criterion for patients that are currently on preventative therapy such as ACE inhibitors or ARBs. The value of repeat testing for patients treated with ACE inhibitors or ARBs is unclear. We also believe that the definition of nephropathy screening requires clarification. Measurement of creatinine alone without testing for microalbuminuria is not adequate for screening. |
| 0063<br><b>Lipid Profile for Beneficiaries <math>\leq 75</math> with</b>  | The College supports this measure.  |

**American College of Physicians Review (2013 Medicare Physician Fee Schedule)**

**TABLE 64: Proposed Measures for the Administrative Claims Option for 2015 and 2016**

| Measure  | ACP Review   |
|--|--|
| <p><b>Diabetes</b><br/>NCQA Clinical Care</p>  |  |
| <p>0075<br/><b>Lipid Profile for Beneficiaries with Ischemic Vascular Disease</b><br/>NCQA Clinical Care</p> | <p>The College supports the idea of the measure, but suggests the VA measure be used instead.</p> <p><b><u>VA Measure:</u></b><br/>Lipid control will be deemed appropriate if either of the following criteria are met:</p> <ol style="list-style-type: none"> <li>1) The patient is receiving at least a moderate dose of a statin drug, as defined as : <ul style="list-style-type: none"> <li>· atorvastatin 10 mg/day or higher</li> <li>· fluvastatin 80 mg/day or higher</li> <li>· lovastatin 40 mg/day or higher</li> <li>· pravastatin 40 mg/day or higher</li> <li>· rosuvastatin 5 mg/day or higher</li> <li>· simvastatin 20 mg/day or higher or</li> </ul> </li> <li>2) LDL-cholesterol (LDL-C) value is 100 or less</li> </ol> <p>The technical specifications for these revised performance measures are available at:<br/><a href="http://secure.wvmi.org/Questions/Specifications/Technical%20Manual/fy2012q3/dmg25hs.pdf">http://secure.wvmi.org/Questions/Specifications/Technical%20Manual/fy2012q3/dmg25hs.pdf</a></p> <p><b>Three Reasons to Abandon Low-Density Lipoprotein Targets, An Open Letter to the Adult Treatment Panel IV of the National Institutes of Health</b><br/><a href="http://circoutcomes.ahajournals.org/content/5/1/2.full">http://circoutcomes.ahajournals.org/content/5/1/2.full</a></p> <p><b>ACCF/AHA/AMA–PCPI 2011 Performance Measures for Adults With Coronary Artery Disease and Hypertension:</b><br/><a href="http://circ.ahajournals.org/content/early/2011/06/13/CIR.0b013e31821d9ef2.full.pdf">http://circ.ahajournals.org/content/early/2011/06/13/CIR.0b013e31821d9ef2.full.pdf</a></p> |
| <p>0105<br/><b>Antidepressant Treatment for Depression</b><br/>NCQA Clinical Care</p>                        | <p>The College supports this measure.</p>  |
| <p>0031<br/><b>Breast Cancer Screening for Women ≤ 69</b><br/>NCQA Clinical Care</p>                         | <p>The College supports this measure.</p>  |

**TABLE 65: Remaining Measures Not Proposed for the Administrative Claims Option**

\*\*These measures are not proposed for the Value Modifier, but will be included in Physician Feedback Report and posted on the CMS Physician Compare Website <http://www.medicare.gov/find-a-doctor/provider-search.aspx?AspxAutoDetectCookieSupport=1> \*\*

| Measure  | Evidence Base and Comments  |
|--|---|
| <p>Not NQF Endorsed<br/><b>Potentially Harmful Drug-Disease Interactions in the Elderly</b><br/>NCQA Patient Safety</p>  | <p>The College agrees with the idea of tracking high risk medication use in the elderly. We recommend the use of the most updated 2012 Beers list published by the American Geriatric Society. <a href="http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03921.x/full">http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03921.x/full</a></p>  |
| <p>0071<br/><b>Acute Myocardial Infarction (AMI): Persistence of Beta-Blocker Treatment After a Heart Attack</b><br/>NCQA Clinical Care</p>  | <p>The College supports this measure.</p>   |
| <p>0022<br/><b>Use of High-Risk Medications in the Elderly: (a) Patients Who Receive At Least One Drug To Be Avoided (b) Patients Who Receive At Least Two Different Drugs To Be Avoided</b><br/>NCQA Patient Safety</p> | <p>The College agrees with the idea of tracking high risk medication use in the elderly and recommends the use of the most updated 2012 Beers list published by the American Geriatric Society. <a href="http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03921.x/full">http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2012.03921.x/full</a></p> <p>The College also recommends the measure aligns with the metric defined for the Medicare Advantage STAR rating program.</p> |
| <p>0556<br/><b>INR for Beneficiaries Taking Warfarin and Interacting Anti-Infective Medications</b><br/>CMS Patient Safety</p>   | <p>The College supports this measure.</p>   |
| <p>0568<br/><b>Appropriate Follow-Up for Patients with</b></p>   | <p>The College supports this measure.</p>   |

**TABLE 65: Remaining Measures Not Proposed for the Administrative Claims Option**

\*\*These measures are not proposed for the Value Modifier, but will be included in Physician Feedback Report and posted on the CMS Physician Compare Website <http://www.medicare.gov/find-a-doctor/provider-search.aspx?AspxAutoDetectCookieSupport=1> \*\*

| Measure  | Evidence Base and Comments  |
|--|---|
| <b>HIV</b><br>Health Benchmarks<br>Clinical Care   |   |
| 0623<br><b>Breast Cancer – Cancer Surveillance</b><br>Active Health Management<br>Clinical Care                              | The College does not support the measure as written. Since Medicare covers a mammogram one time every 12 months, the 12 month time frame is too strict. The College suggests the time window be extended to 14 months.<br><a href="http://www.medicare.gov/publications/pubs/pdf/10050.pdf">http://www.medicare.gov/publications/pubs/pdf/10050.pdf</a> |
| 0625<br><b>Prostate Cancer – Cancer Surveillance</b><br>Active Health Management<br>Clinical Care                            | The College does not support this measure and suggests that it be removed.  |
| 0054<br><b>Arthritis: Disease Modifying Antirheumatic Drug (DMARD) Therapy in Rheumatoid Arthritis</b><br>NCQA Clinical Care | The College supports this measure.  |
| 0581<br><b>Deep Vein Thrombosis Anticoagulation At Least 3 Months</b><br>Resolution Health<br>Clinical Care                  | The College supports this measure.  |
| 0593<br><b>Pulmonary Embolism Anticoagulation At Least 3 Months</b><br>Resolution Health<br>Clinical Care                    | The College supports this measure.  |

**TABLE 65: Remaining Measures Not Proposed for the Administrative Claims Option**

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| <b>Measure</b>  | <b>Evidence Base and Comments</b>  |
|---|------------------------------------|
| 0614<br><b>Steroid Use – Osteoporosis Screening</b><br>Active Health Management Clinical Care | The College supports this measure. |
| 0584<br><b>Hepatitis C: Viral Load Test</b><br>Resolution Health Clinical Care                | The College supports this measure. |