August 30, 2011

Donald M. Berwick, MD, MPP
Administrator, Centers for Medicare and Medicare Services
7500 Security Boulevard
Baltimore, MD 21244-8013

Re: Medicare Program: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012 (CMS-1524-P)

Submitted Electronically

Dear Dr. Berwick:

On behalf of the American Medical Group Association (AMGA), thank you for the opportunity to comment on the notice of proposed rulemaking (NPRM), CMS-1524-P. AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA represents the interests of nearly 400 such groups and systems that employ approximately 117,000 physicians who provide services to an estimated 110 million patients. Our comments follow in the paragraphs below.

Expanding the Multiple Procedure Payment Reduction (MPPR) Policy: ***AMGA opposes the expansion of the MPPR. The concerns over imaging growth are based on old information and do not take into account nor reflect what is actually happening in imaging volumes.*** CMS proposes to expand the 50 percent payment reduction currently applied to the technical component (TC) to apply also to the professional component (PC) of the second and subsequent advanced imaging services furnished in the same session. Full payment would be made for the PC and TC of the highest paid procedure, and payment would be reduced by 50 percent for the PC and TC for each additional procedure furnished to the same patient in the same session. Advanced imaging is defined as ultrasound, computerized tomography (CT), and magnetic resonance imaging (MRI).

CMS bases its proposal on the assumption of expected efficiencies in the furnishing of multiple services in the same session due to duplication of physician work, primarily in the pre-service and post-service periods, with smaller efficiencies in the intra-service period. Furthermore, CMS cites the justification for this action as being the statutory requirement for the Secretary to identify, review, and adjust the relative

values of potentially misvalued services under the PFS as specified by section 3134(a) of the Affordable Care Act. CMS also notes it is responsive to concerns about growth in imaging spending as mentioned in MedPAC's (March 2010) and GAO (July 2009) recommendations regarding the expansion of MPPR policies. Final justification for the expansion of the MPPR policy rests on the statement that the proposal is consistent both with its longstanding policy on surgical and nuclear medicine diagnostic procedures, which apply a 50 percent reduction to second and subsequent procedures.

AMGA opposes the expansion of the MPPR. The concerns over imaging growth are based on old information and do not take into account nor reflect what is actually happening in imaging volumes. Over the past several years, legislative and regulatory changes have led to significant cuts in Medicare payments for advanced imaging and other diagnostic imaging procedures.

Payments for some services have been reduced more than 60 percent between 2006 and 2013 as shown in Attachment A. Continued reductions to imaging services cannot be absorbed by physician practices without affecting quality and access to high quality care. The volume of outpatient diagnostic imaging services began trending downward in 2007, and in 2010, volume for both standard and advanced imaging services per fee-for-service beneficiary actually fell below the 2009 level as presented by Attachment B. Both attachments are produced by the Coalition for Patient Centered Imaging of which AMGA is a member.

Not surprisingly, some of these services also had begun to shift out of physician offices and into more expensive alternative settings, suggesting that another round of imaging cuts is not only unnecessary but also counter-productive. As a result of these already implemented cuts, physicians are holding on to their old equipment longer, which means fewer patients have access to the newest technologies that are better at finding disease in its early stages, guiding life saving treatments in the most optimal and timely way. The problem is exacerbated in rural areas, as a loss of services often means patients may find themselves far from access to meet their clinical needs.

AMGA further opposes the proposal to expand the MPPR because CMS bases the expansion on a number of existing policies: The multiple procedure surgical payment reduction and the reduction associated with combination abdomen and pelvis CT codes, and because there are considerable differences in these payment policies, they are poor proxies upon which to justify the proposal.

The surgical payment reduction accounts for the fact that a surgical procedure includes significant physician work for opening and closing a surgical site as well as

90 days of follow-up care in the hospital or the office. The work values for imaging services primarily account for the review and analysis of the image and include negligible, if any amounts of duplicated work.

As CMS notes in the rule, a new code for a combination of an abdominal and pelvis CT was recently created and the work value for that code was approximately equal to a 50 percent reduction for the lesser valued code. CMS thinking is faulty in applying work value reduction for one commonly provided procedure using the same methodology on adjacent body parts as a template for a payment policy that applies to multiple modalities. CMS fails to account for the fact that there have been other combined codes created that did not reflect similar efficiencies in work values.

Although there is scant empirical evidence supporting CMS' assumption that there are considerable efficiencies within the professional component of advanced diagnostic imaging services, there is one study known to us. The results from this peer-reviewed study published online by the Journal of American College of Radiology in June 2011 clearly undermine support for imposing a 50 percent MPPR for the professional component.[1] CMS never conducted a similar statistical analysis and it is clear that the imposition of a 50 percent MPPR is nothing more than a normative policy in pursuit of expenditure reductions, based on beliefs rather than on data.

While the full repercussions of this proposal are difficult to gauge, it is certain that there will be negative results for patient access. Staging of multiple imaging services is a highly likely outcome, should this policy be implemented. Some providers will simply schedule two visits rather than conducting multiple services at the same session. In this era of CMS' emphasis on patient-centric and coordinated care, such policies, given the probable avoidance strategies mentioned, seem counterintuitive, and undesirable.

There are alternative approaches to assuring that imaging and other diagnostics are available and used appropriately, and many, if not most AMGA members use them. One such approach is the application of decision support systems, methods for assuring that physicians have the latest clinical guidelines at their ready disposal, a tool facilitated through application of electronic medical records and complimentary electronic infrastructure. CMS is testing this approach and should evaluate results before taking further actions of the sort proposed. CMS should also examine the

1 Allen B, Donovan WD, McGinty G, et. Al. Professional component payment reductions for diagnostic imaging examinations when more than one service is rendered by the same provider in the same session: an analysis. JACR In Press. Published online 29 June 2011. http://www.jacr.org/article/PIIS1546144011003310/abstract.

possibility of offering incentives and/or granting exemptions from payment reductions to those who use such systems or other means to operate effectively and efficiently.

We strongly urge CMS not to apply additional payment cuts and restrictions on these services without carefully studying their effects on Medicare patients and overall government spending and evaluating alternatives such as decision-support systems to assure appropriate application of advanced imaging and other diagnostics.

Physician Quality Reporting System (PQRS): ***AMGA supports the continued alignment of reporting requirements across PQRS and the EHR Incentive Program, a requirement of the Affordable Care Act. Improvements in future years should allow medical groups to passively report, through automated means, in order to streamline the administrative burdens associated with reporting for multiple programs***. AMGA is pleased to see the continuing evolution to more automated reporting methods taking place in the PQRS program. Developments such as the proposed PQRS-Medicare EHR Incentive Pilot that will allow physicians to qualify for Medicare EHR incentives by using technology for the PQRS will also serve to make reporting requirements more efficient and encourage physician participation. We also note, and support, the continuing efforts to align reporting requirements across the PQRS and the Medicare and Medicaid EHR Incentive Program through the use of common clinical quality measures; however, we would urge CMS to avoid increasing the number of measures and other requirements until fully automated reporting is a reality. Physicians are currently facing multiple reporting requirements, and penalties in the years ahead for lack of compliance. Therefore, any additions to program requirements must be carefully weighed before implementation.

We would also recommend that CMS, in taking steps to align program requirements between the PQRS and the Medicare and Medicaid EHR Incentive Programs, make consistent the certification requirements for both programs. Ideally, CMS would also consider implementing a single data submission process for use in both programs to further simplify the reporting process.

CMS proposes the use of a web interface that is pre-pre-populated with assigned beneficiaries' demographic and utilization information for use in the Group Practice Reporting Option (GPRO). Formerly, this tool was used for reporting in only the largest of group practices, and AMGA supports the expanded use of this interface. We caution, however, that use of this tool currently requires group practices to manually extract some of the patient data necessary to complete the web interface. CMS should consider modifying the tool to eliminate the manual processes required to populate the remaining data fields. Even for large medical groups and systems,

those deploying sophisticated electronic infrastructure, the gathering of data under present circumstances often requires considerable manual data abstraction and/or systems reprogramming with its inherent programming costs and staff training requirements. Program improvements in future years should allow medical groups to passively report, through automated means, in order to streamline the administrative burdens associated with reporting for multiple programs.

Value Modifier (VM): ***The emphasis must be on use of existing systems reporting, and that should be standardized, simplified, and harmonized for use in the VM program. AMGA agrees that high-cost, high-volume disease states are the best way to begin application of the VM.*** The Affordable Care Act requires the Department of Health and Human Services to develop a budget neutral payment modifier to provide differential payment to providers based on the cost and quality of care delivered to Medicare beneficiaries, and CMS solicits comments on a variety of matters related in this rulemaking. CMS notes that the modifier will be implemented for a select group of providers by January 1, 2015, and for all providers by January 1, 2017 and seeks comments on its early implementation.

The VM applied to 2015 payments will be based on performance in 2013. CMS proposes 62 quality measures for consideration and intends to coordinate performance measures related to the modifier with existing programs such as Physician Quality Reporting System.

CMS will be determining how to incorporate resource use/cost measures into the VM. CMS proposes to use total per capita costs and per capita costs for beneficiaries with four chronic conditions: diabetes, heart failure, coronary artery disease and COPD.

CMS is seeking comments on the use of an episode-based cost measure derived from the format of the Medicare Severity Diagnosis Related Group system (Parts A and B charges from day of service and through a specific number of days after discharge) until specific episode groupers are developed for the identified high-cost, high-prevalence conditions. CMS is also seeking comments on the use of resource and cost measures used in private sector quality improvement initiatives, and is exploring how to create composite measures that would allow comparison of quality in relation to cost. CMS is seeking comments on two additional areas: 1) How the modifier may be used in systems-based care settings; and 2) how to address the needs of physicians in rural areas and other underserved communities, which may have an impact on implementation of the modifier in such regions.

AMGA appreciates the challenges CMS faces in implementing the VM mandated in law. CMS is also required to harmonize data reporting in its various programs. We

must emphasize our concerns, however, at the seemingly endless growth of various data reporting requirements, noting that pursuit of data must not only be harmonized, it must be simplified and standardized.

As CMS advances to becoming a value-based purchaser and continues to support electronic data gathering for a number of purposes, it must be explicitly stated that increased requirements for data gathering are also increasingly burdensome. The demands for data, sometimes driven by law, often by the strategic directions of the agency, are additive, with more and more reporting forthcoming. The use of tools such as those which are "pre-populated" with data by CMS, while a significant step in the right direction, are not burden free.

Until CMS has developed capabilities to accept data via largely "passive" means, e.g., directly from electronic medical records or similar mechanisms, data submissions should not be expanded. The emphasis must be on use of existing systems reporting, and that should be standardized, simplified, and harmonized. Claims data are available, and are attractive only for that reason and the fact that information from them can be used by CMS without any burdens to the provider community. They are however grossly inadequate for the purposes under discussion, save their availability. Ideally, one set of data, one report, one mechanism should be used and this should be among the priorities CMS sets in its data gathering evolution. Until "direct data dumps" from providers to CMS are plausible for all, any associated bridging mechanism cannot be comprehensive and relatively burden free. Balance must be established, and thus ever-increasing data requirements must not be a facet of the evolution.

AMGA agrees that high-cost, high-volume disease states are the best way to begin assessing costs for the purposes of applying the VM. COPD, congestive heart failure, coronary artery disease and diabetes, the proposed measures, are a good starting point. As CMS' commentary in the NPRM suggests, other measures may apply and we believe that a good picture of costs and efficiencies can be drawn from the addition of transition of care data, patient experience results, and patient safety information, just to cite some examples. While we have taken no position on them, HEDIS quality metrics for these four disease states are widely accepted as useful process measures. Tracking total costs for cohorts of patients afflicted with these diseases, adjusted for case-mix, seems a reasonable approach.

Parenthetically, we would like to add that CMS should consult with a broad array of experts in the realm of quality measurement. Many among AMGA's membership have such capabilities, and we would be happy to provide our good offices to facilitate contacts with them. Additionally, we believe that, should CMS rely on an expert contractor to develop a VM methodology, the work not necessarily go to RTI.

This is not intended as criticism of RTI's work. It is however to suggest that CMS relies on the expertise of this contractor a good deal. In the long term, focused contracting of this sort, while perhaps providing assurance of technical skill and reliability, may lead to a narrowing of thinking, a predisposition of approach and analysis. Building on the experience and work of the past is understandable, but may also result in bias attendant, undesirable, and unintended. Much is to be said for new thinking, in particular in matters likely to affect virtually all physicians in Federal health care programs. To guard against such a possibility, others should be considered, e.g., experts from the National Academy of Science's Institute of Medicine.

In applying the VM selectively in years 2015 and 2016, CMS should consider these suggestions. First, as CMS has posited in its commentary in the NPRM, AMGA supports the idea of including outliers. Outlier status must not lead to a rush to judgment leading to premature negative payment adjustments. We offer that caution that before any action is taken. Outlier status must be verified to determine reasons for falling outside of normal distribution and allowing outliers to explain or justify their results.

We also suggest that CMS allow volunteers to participate in the VM program in the years prior to the statutory mandate and that they be allowed to participate without having the VM apply to payments. This would afford potentially large numbers of physicians to participate, learn from the process, with neither financial benefit nor detriment and would allow CMS the same learning opportunity.

CMS also asks for comments on the use of peer groups. Should peer groups of physicians be employed in the VM program, we suggest that any comparisons be done within geographic considerations. For example, if peer groups by medical subspecialty emerge, grouping these within a geographic region makes sense. The region must be large enough to capture sufficient numbers of participants, but not so large as to be a national comparison because there are legitimate regional variations in practice. We suggest that a metropolitan statistical area (MSA) might be considered.

Recognition of Multi-Specialty Groups/Organized Systems of Care: ***AMGA recommends that CMS recognize large multi-specialty medical groups and other organized systems of care based on certain characteristics, attributes, infrastructural elements, and desired actions in future rulemaking because these entities distinguish themselves by delivering high quality services to patients in the most cost-effective model of care currently available.*** Multi-specialty medical groups and other organized systems of care are the most effective and efficient vehicle to furnish the highest quality and most cost effective medical services to

patients. The strongest underpinning of truly integrated delivery systems is the multi-specialty medical group or other organized system of care.

Core values of this model of advanced practice include:

- Quality: continuous striving to improve patient care through measuring, reporting, and application of findings using evidence-based clinical and service quality measures and tools such as benchmarking, best practices, and peer review;
- Patient-centered care: timely information sharing by patients and physicians allowing patients to become active participants in their own care;
- Care coordination: supporting collaboration and communication among medical specialties and non-physician care givers;
- Accountability: shared physician responsibility and accountability for patient care;
- Innovation: openness to adoption and adaptation of evolving health care delivery models and a modern infrastructure (EHRs, patient registries);
- Physician self-governance: support of professionalism, physician participation in group governance and independence of clinical decision-making;
- Leadership development: creating a practice environment supportive of and seeking to enhance skills, knowledge, and experience of physicians' management and executive abilities.

Attributes of such advanced practice include: 1) a stable governance and financial structure; 2) centralized administration; and 3) a quality-driven mission statement. Recognition for multi-specialty medical groups, and other organized systems of care, would serve to promote coordinated care and provide a basis for payment differentials that would support infrastructure for patient safety, reduce costs, and improve patient communication and engagement. CMS currently has significant opportunities to create an environment that would foster this advanced model of practice.

Sustainable Growth Rate: ***AMGA urges CMS to continue working with Congress to address the flawed formula used to determine physician payments in Medicare.*** Unless Congress acts to avert it, a 29.5 percent reduction in Medicare payments to physicians will take place in January 2012. At the same time, physicians are being asked to make substantial investments in infrastructure and processes in order to bring about positive transformation of the health care delivery system. Understandably, ongoing concerns about reimbursement continue to create a climate of uncertainty. AMGA therefore asks CMS to continue working with Congress to develop a way to address the sustainable growth rate formula on a permanent basis.

Thank you for the opportunity to present AMGA's perspectives. As offered earlier, AMGA stands ready to facilitate contacts between CMS and its member experts on methodological matters pertaining to developing the VBM. If have questions or need additional information, contact my staff members, George Roman, Senior Director, Health Policy at groman@amga.org or Karen Ferguson, Associate Director, Regulatory Affairs at kferguson@amga.org.

Sincerely,

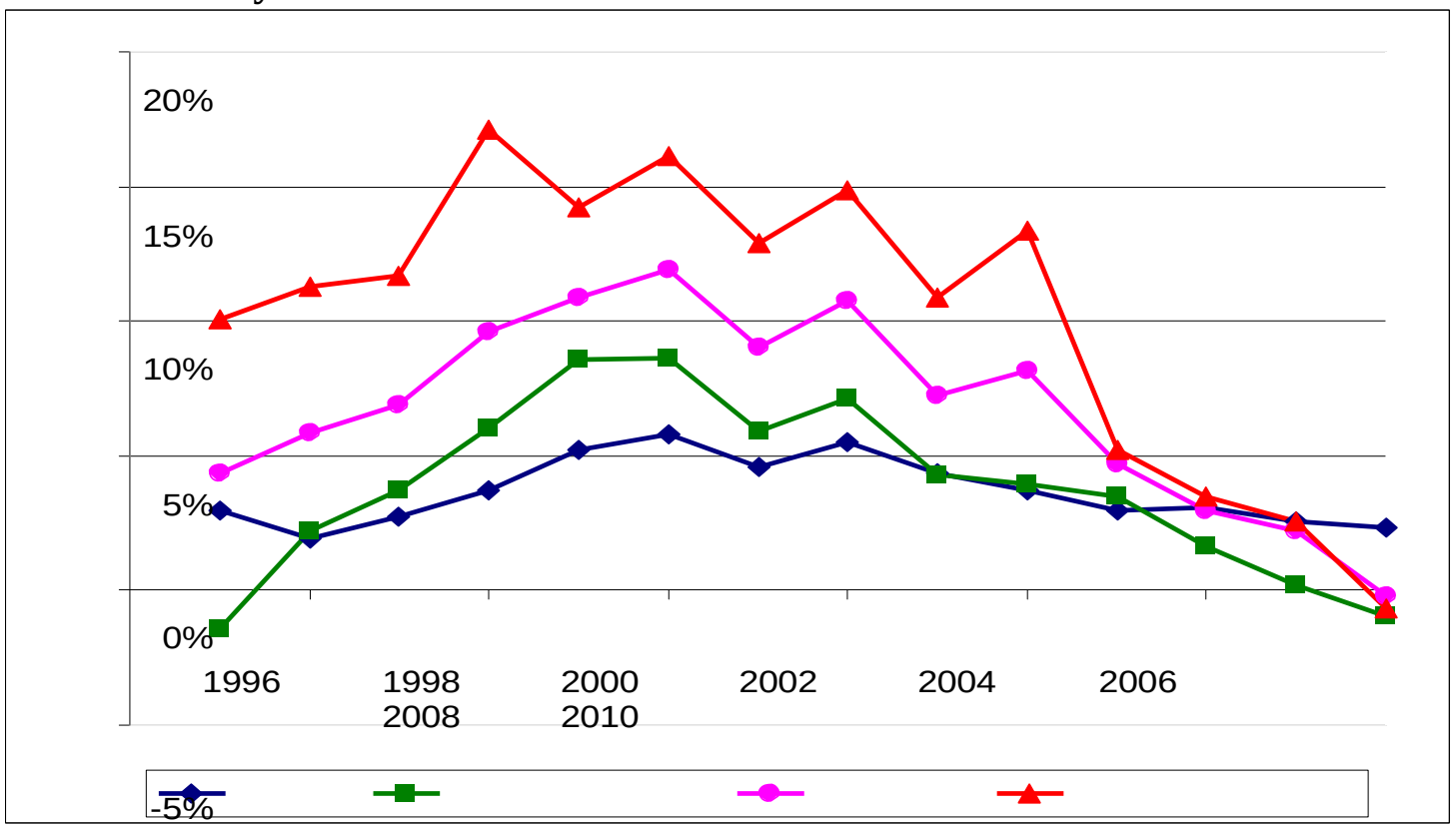
Donald W. Fisher, Ph.D.
President and CEO

Attachment A

Change in National Medicare Payment 2006 – 2011 High Volume Imaging Services with a 25% or Greater Decrease in Payment Examples						
CPT Code	**CPT Long Descriptor**	**2006 Medicare Non-Facility Payment**	**2011 Medicare Non-Facility Payment**	**Decrease**	**Percent Change**	**Estimated Medicare Utilization 2010**
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	$574.53	$417.23	-$157.30	-27%	1,149,351
71275	Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing	$585.52	$434.56	-$150.96	-26%	592,272
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	$657.90	$213.37	-$444.53	-68%	268,643
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material	$580.59	$423.01	-$157.58	-27%	182,707
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)	$125.06	$92.42	-$32.64	-26%	177,656
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	$564.29	$234.10	-$330.19	-59%	150,414
75962	Transluminal balloon angioplasty, peripheral artery other than cervical carotid, renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation	$658.28	$213.03	-$445.25	-68%	135,260
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	$563.54	$216.09	-$347.45	-62%	113,548
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	$572.25	$270.79	-$301.46	-53%	94,380
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection	$700.35	$477.71	-$222.64	-32%	2,559,717

Attachment B

Annual Change in Medicare Outpatient Imaging Volume Per FFS Beneficiary



Volume Growth for Medicare Physician Payment Schedule Services

- The volume and intensity of services covered under the Medicare physician fee schedule (MFS) grew at an annual rate of about 2% to 3% in the early years of the SGR, accelerated to 4.5% to 6% in 2000 to 2004, decelerated to 3% to 4% from 2005 to 2009, and dropped to an estimated 2.4% in 2010.

Volume Growth in Imaging

- Annual growth in imaging services volume and intensity has followed the same general pattern but with more dramatic fluctuations.
- Medicare spending on advanced imaging grew from $1.2 billion in 1996 to $5.1 billion in 2006, but had fallen back to an estimated $4.3 billion in 2010 due to significant pay cuts.

- Volume and intensity growth in standard imaging has been trending steadily downward since 2004 and growth rates for advanced imaging volume have trended downward since 2007.
- For both advanced and standard imaging, the estimated volume and intensity of services declined in 2010.
- PET scans and, since 2006, particularly PET scans for tumor imaging, have been a major factor in volume growth for advanced imaging, due to expanded Medicare coverage for PET scans and the high value of PET scans for tumor imaging in cancer care.