



September 4, 2012

Ms. Marilyn Tavenner
Acting Administrator & Chief Operating Officer
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule (CMS-1590-P), published in the July 30, 2012, *Federal Register*.

Submitted Electronically

Dear Acting Administrator Tavenner:

On behalf of the American Medical Group Association (AMGA), thank you for the opportunity to provide comments on the above-referenced proposed rule regarding revisions to the payment policies under the Medicare Physician Fee Schedule for Calendar Year (CY) 2013.

As you may know, 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 415 medical groups in 49 states that employ nearly 125,000 physicians who treat over 130 million patients. Our member medical groups are working diligently to provide innovative, patient-centered medical care and are strongly committed to protecting the Medicare Trust Funds. Therefore, we have a strong interest in the physician payment and quality proposals that the Centers for Medicare and Medicaid Services (CMS) has put forward in its proposed regulation. AMGA's specific comments on various areas of the proposed regulations follow in the paragraphs below.

Primary Care and Care Coordination

CMS proposes a new G-code for non-face-to-face post-discharge transitional care management to cover the transition of a beneficiary from care furnished by a treating physician during a hospital stay (inpatient, outpatient observation services, or outpatient partial hospitalization), skilled nursing facility stay, or community mental health center partial hospitalization program, to care furnished by the beneficiary's primary physician in the community. This code will recognize telephone and e-mail contact between patients and/or caregivers and other health care providers to help ensure a smooth transition into post-discharge settings. The code is payable to a physician who has seen the beneficiary in the 30 days prior to the hospital discharge and

conducts an evaluation and management visit within the first 14 days of the post-discharge period.

AMGA members are constantly working to meet the needs of patients during transitions in care. Some AMGA members have care managers who visit patients face-to-face prior to hospital discharge. Care managers review home care instructions and prepare patients for the post-discharge contact and follow-up they will be receiving from the medical group.

In one member group, initial telephone contact with the patient is made within 24 to 48 hours upon discharge, followed by a face-to-face visit with a physician within five days of discharge. This telephone communication engages the patient early in the process. The telephone contact also serves to maximize the quality of the time the physician spends with the patient, since the logistical part of the post-discharge care has already been covered. After the initial post-discharge face-to-face visit with the physician takes place, weekly telephone contact with care managers is initiated. This follow-up allows care managers to identify early signs of complications and schedule physician appointments or initiate other intervention, if needed. Many AMGA member groups have similar post-discharge protocols in place to prevent unnecessary readmissions to the hospital and improve the patient experience. **AMGA supports the concept behind the establishment of this code to improve transitions in care settings and reduce the unnecessary expense associated with preventable hospital readmissions.**

AMGA believes in using a team-based, collaborative approach that engages the physician, the care manager, and other members of the health care team to significantly improve the patient's well-being. Many AMGA members participate in the medical home model. Under this concept, the patient, multiple physicians, nurse practitioners, lab technicians, and other health care professionals all work together as a team to help patients improve their understanding of the medical condition and comply with their plan of care. Patient information is reviewed by their care team prior to patient appointments for unmet health care needs. Accordingly, patients see the care team physician or other health care professional that is available and well-informed of the patient's clinical status and medical history for their post-discharge visit. **In a multi-specialty medical group or other organized system of care, health care services are furnished in a collaborative manner. AMGA therefore suggests that, for larger medical groups, CMS consider providing reimbursement for the new post-discharge transitional care code according to a group's Tax Identification Number, rather than a single physician's National Provider Identifier.**

CMS requests comments regarding the care plan and whether it would be more accurate for the face-to-face visit to take place the same day of discharge. There are several reasons why a same-day of hospital discharge visit could be problematic for patients and physicians. In a perfect world, all patients would be seen in highly integrated, high-performing health care systems, but that is not always the case. Unless the physician shares electronic health records (EHRs) with the discharging hospital, the physician may not have access to discharge summary information on the day of discharge. Without having complete and necessary information from the hospital, clinical decision-making would be hindered. It could also be difficult for newly discharged patients to visit their physician the very same day of discharge, due to the patient's condition and levels of fatigue or pain. **Therefore, should CMS ultimately decide in its forthcoming final**

regulation to compress the post-discharge visit, we believe the window should be at least five days, especially if telephone outreach to the patient has taken place within the first 24-48 hours. Doing so would ensure that the patient's community physician would have the appropriate discharge information and the patient would receive the most appropriate post-discharge care plan.

CMS also requests stakeholder input on how to establish relevant parameters to determine whether a clinical practice should be considered an advanced primary care practice (medical home), in order to receive enhanced payments for primary care services in the Medicare Physician Fee Schedule. CMS contemplates a number of options that could be used to make this determination, including the development of CMS standards.

Since many AMGA members have made significant investments undertaking the rigorous process of becoming accredited through the National Committee for Quality Assurance (NCQA) to become a Patient-Centered Medical Home, **we support the use of NCQA standards.** These standards could readily serve as an alternative to standards that CMS would develop. CMS-developed standards would likely be quite similar to those of the NCQA, but would represent yet another compliance issue, and would therefore increase administrative burden. As CMS considers ways to simplify compliance and quality activities for physicians, using such an existing set of standards makes practical sense. **Moreover, multi-specialty medical groups and other organized systems of care that have attained certification through NCQA, at any level, have already demonstrated a commitment to providing high-quality health care to patients through improved care processes and respectful use of health care resources.**

Expansion of Medicare Telehealth Services

AMGA is very supportive of the expansion of Medicare telehealth services that is being proposed for several behavioral interventions and furthermore supports the inclusion of alcohol and/or substance abuse assessment and intervention services in this new category of covered telehealth services. The inclusion of the new telehealth services will help strengthen the primary care fabric for patients living in rural and medically underserved areas.

Physician Quality Reporting System (PQRS)

AMGA greatly appreciates CMS' efforts to align PQRS reporting requirements with those of other quality improvement programs, including the Medicare Shared Savings Program (MSSP). We urge the conduct of extensive education and outreach to the health care provider community as quickly as possible, and as far ahead of 2013 as feasible. Ultimately, the alignment of reporting requirements across programs will save providers--and hopefully the Medicare program as well--both time and expense. We are grateful for these efforts; however, as reporting requirements evolve into a single set of quality metrics, this evolution will certainly present operational challenges and be labor intensive, and costly to implement. Undoubtedly, multi-specialty medical groups and other organized systems of care will require substantial guidance from CMS during this time of transition.

AMGA notes that for CY 2013, CMS is proposing that medical group practices that have between 100 and 249 physicians would be required to utilize the Group Practice Reporting Option (GPRO) web-interface to report quality data for the PQRS program. Smaller group practices that have between 2 and 99 physicians would retain the claims and qualified registry or EHR-based reporting options. CMS states that physician groups with more than 100 physicians are sufficiently large enough to account for the variety of measures required for reporting under the GPRO, although medical groups were just introduced to this process in 2012.

After discussing this proposal with several representatives of our multi-specialty medical groups and other organized systems of care, it is apparent that not all medical groups that have between 100 and 249 physicians are familiar with reporting that utilizes the GPRO web-interface process. Implementation of the GPRO web-interface will require extensive technical resources for medical groups that do not have previous experience with the tool either through the PQRS or the MSSP or its predecessor programs. Completion of the GPRO web-interface requires manual abstraction for data that does not appear in distinct data fields for each of the 411 individual patients represented in the tool. **We therefore urge CMS to reconsider this proposal, and allow larger medical groups that have between 100 and 249 physicians to continue reporting PQRS data in the manner they have previously chosen, rather than being forced to switch, particularly given that the PQRS is just one of many programs with which medical groups must comply.** For example, medical groups that have Ambulatory Surgical Centers will begin reporting five measures, using G-codes, starting in October of this year. Taken together, current quality reporting requirements, while vitally important, present a complex tapestry of compliance issues, and medical groups should be given choices whenever possible. **Moreover, since CMS proposes to utilize 2013 PQRS data to determine 2015 performance in the Value-Based Payment Modifier (VBM) program, it becomes even more important for groups to utilize a reporting method with which they are familiar in order to increase their chances of success.**

E-Prescribing (eRx) Incentive Program

CMS has used its administrative discretion to propose two additional and significant hardship exemption categories for the 2013 and 2014 eRx payment adjustment: 1) eligible professionals or group practices who achieve meaningful use during certain eRx payment adjustment periods; and 2) eligible professionals or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology.

These two additional significant hardship exemption categories will greatly assist eligible professionals in focusing their energies on achieving meaningful use of EHR in 2013 and 2014 without diluting their efforts, or resources, to comply with a separate program whose aim is to incentivize the same behavior. **AMGA greatly appreciates, and supports, the two additional significant hardship exemption categories that CMS has proposed.**

Medicare Shared Savings Program (MSSP)

AMGA appreciates the thoughtful approach taken by CMS to align MSSP quality reporting requirements for Accountable Care Organizations (ACOs) with those of the PQRS. Multi-

specialty medical groups and other organized systems of care that have taken the steps to apply for participation in the MSSP and form ACOs have demonstrated willingness to make significant investments to embark upon quality improvement and care coordination activities. **We greatly appreciate efforts to minimize the reporting burdens imposed on medical groups that are actively involved in transforming health care delivery to a high-quality system that reduces expenditures over time.**

Physician Value-Based Payment Modifier (VBM)

A requirement of the Affordable Care Act, implementation of the VBM, will allow CMS to measure the quality of health care as compared to its cost. It also offers incentives to health care providers to improve the quality and value of the health care services that are furnished to Medicare beneficiaries. CMS proposed to apply the VBM, at least initially, to medical groups of 25 or more eligible professionals. These medical groups – which have satisfactorily reported PQRS- will have their 2013 PQRS data analyzed to determine whether a payment adjustment will apply in 2015, if the group chooses to opt-in to the quality-tiering methodology that CMS has proposed. **While AMGA supports efforts to enhance the overall quality and value of our health care delivery system, we believe that the proposed rule outlines a framework that will discourage medical groups from electing to participate in the VBM program in 2013.**

Physician groups that decide to be measured via the quality-tiering methodology CMS has put forward in its rule will base performance on PQRS measures from high-quality and low-cost all the way to low-quality and high-cost, will receive an as yet unknown payment incentive for being in the high-quality and low-cost category. Because CMS must implement the VBM in a budget neutral manner, the upside gain for these high-performing medical groups is unknown until the 2013 quality data is analyzed and the Agency can determine the amount of funds available for incentive payments. Alternatively, medical groups who are classified in the low-quality and high-cost category will receive a downward payment adjustment of a flat one percent. Presumably the money from this downward adjustment will be used to fund those who earn incentives. Those medical groups that are classified at the halfway point, and groups who simply choose to satisfactorily report PQRS data and do not opt to be measured by the quality-tiering methodology will see no payment adjustment up or down.

Under the proposed implementation of the VBM, many AMGA groups have indicated that without a greater sense of how to predict the risks or the benefits involved, they will opt-out of the quality-tiering approach, and will simply continue to report PQRS data in order to inoculate themselves from the risk of a potential downward adjustment in reimbursements. **In short, there is simply not enough of an incentive built-in to the VBM program to stimulate widespread measurement under the quality-tiering approach, as proposed.**

In addition, AMGA members have noted that participation in the VBM program should be available to other types of entities, including ACOs, Rural Health Clinics, and hospital-based physicians in order to drive greater transformation of the health care delivery system. One

AMGA members even went so far as to say that under the proposed framework, the VBM could dis-incentivize medical group formation. **As such, we urge CMS to reconsider its approach to implementing the VMB in order to make it a more meaningful adjuster so it can realize its promise to truly incentivize behaviors that will enhance value in the health care delivery system.**

AMGA appreciates CMS' careful consideration of our comments, and stands ready to serve as a resource to the Agency as it continues to promulgate regulations that will change our health care delivery system to one that is driven by value. Should you have questions, please do not hesitate to contact Karen Ferguson of my staff at kferguson@amga.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Donald W. Fisher".

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