



September 6, 2013

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

*Re: Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule and Other Revisions to Part B for CY 2014; Proposed Rule*

Dear 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) 2014.

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 430 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 policy 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.

### **Telehealth Services**

AMGA supports the expansion of telehealth services to include transitional care management services, in addition to revisions regarding telehealth originating sites in order to define rural health professional shortage areas to include rural census tracts, as determined by the Office of Rural Health Policy. We believe that the inclusion of these telehealth services, and originating sites, will help strengthen the primary care fabric for patients living in rural and medically underserved areas, and help to prevent unnecessary hospitalizations. We are pleased to see these provisions in the proposed rule for calendar year 2014.

## **Complex Chronic Care Management Services**

CMS proposes to establish separate payments for patients who require complex chronic care management services, beginning in CY 2015, as part of a multi-year strategy to appropriately recognize and value primary care and care management services, and AMGA applauds this proposal. AMGA member medical groups have long provided such services to their Medicare patients who require them in order to improve the overall health of their patient population and prevent unnecessary hospitalizations, and have done so without compensation. We believe that shifting resources into complex chronic care management services will help preserve Medicare expenditures over time by keeping patients who are at-risk of being hospitalized healthier, and out of the hospital.

AMGA has some recommendations for how to identify the appropriate patients to receive complex chronic care management services, however. We believe that CMS should establish a nationally standardized assessment and patient identification process that is focused on patients with moderate to severe chronic conditions, which would provide clarity on what defines “significant” risk. This would help to focus the available resources on the patients with the greatest need for these services rather than diffusing payments across a larger patient population, some of whom may not benefit from the services.

AMGA also believes that CMS should consider increasing the payment for subsequent Annual Wellness Visits, since patients with multiple chronic conditions are expected to become more complex over time, not less so. In addition, the time requirement of one hour over a 90-day period should include time spent in contact with family and caregivers, and not just the patient. CMS should also consider payment for non-traditional face-to-face time that would support chronic care management such as group visits, and visits to the home conducted by the clinic’s care management staff, since these can be successful methods to support patients who have multiple chronic conditions.

Lastly, the AMGA does not support the requirement that advanced practice nurses or physician assistants be employed by the medical practice. We believe that these services can be effectively and efficiently performed by nurses under the direction and supervision of physicians.

## **Coverage of Investigational Device Exemption (IDE)**

AMGA supports the proposal to establish criteria to centralize the IDE coverage process in order to reduce the variation of coverage and increase efficiency by eliminating the need for duplicative reviews by Medicare local contractors. We believe that the proposals will result in approved studies being brought to market more quickly, and reduce the overall administrative burdens for stakeholders. We also agree that clinical trials should have appropriate scientific and ethical standards to protect every study participant.

## **Liability for Overpayments: Extension of “Look-Back” Period**

CMS proposes implementation of changes enacted by the American Taxpayer Relief Act of 2012 that provide the agency more time to recover overpayments made to providers without fault, extending the three-year “look back” time frame to five years.

AMGA opposes extension of this time period. At a time when medical groups are implementing other federal initiatives, such as the electronic health records incentive program and working to implement increasingly complex quality reporting initiatives, extending the recovery period for claims with overpayments to five years is yet another burden. Medical groups already devote significant resources to records management and concurrently face the demands of many other federal programs and mandates.

AMGA therefore urges CMS to use any available administrative discretion to revise the look-back period to three years. This period of time aligns more closely with previously established programs such as the Recovery Audit Contractor program, and others.

### **Electronic Health Record Incentive Program**

CMS proposes to align the requirements among various quality reporting and payment programs that include the submission of clinical quality measures (CQMs). AMGA and its members greatly appreciate the continued alignment of reporting requirements across programs.

Given the complexity of requirements, in totality, of the various quality measurement programs, we also welcome the expansion of registry reporting options, including the integration of reporting on quality measures under the Physician Quality Reporting System and the reporting requirements relating to meaningful use in the Electronic Health Record Incentive Program.

### **Medicare Shared Savings Program-Establishing the Quality Performance Benchmark**

AMGA supports the use of recent empirical data for the proposed data sources for the 2014 reporting period, as outlined in the proposed rule. In this proposal, CMS includes historical ACO quality performance data, available Medicare fee-for-service (FFS) data, and Medicare Advantage data sources to set quality benchmarks. We also appreciate the CMS plan to publish the quality benchmarks based upon these data prior to the beginning of the 2014 reporting period.

However, AMGA has significant concerns with the CMS proposal to retain the option of using flat percentages to set quality benchmarks when these data are unavailable, inadequate, or unreliable, and we would urge CMS to reconsider this approach. Use of arbitrary flat percentages would have the potential to harm high-performing ACOs, and discourage future participation in the program.

We understand the need for CMS to develop quality benchmarks, and appreciate the complexity involved in doing so, but we would like to make recommendations on other potential options to the use of flat percentages. CMS should consider, in order of preference: (1) allowing another year of pay for reporting until adequate and accurate empirical data are available, (2) using a flat percentage that is low to begin with, and adjusting it as more data becomes available, or (3) using a methodology that includes scoring based upon either an "attainment score" or an "improvement score" like the methodology CMS developed for its Hospital Value Based Purchasing program<sup>1</sup>, and adopted for use in California's Pay for Performance Program.<sup>2</sup> This methodology would evaluate performance based on either an "attainment score" or an "improvement score," whichever is

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<sup>1</sup> U.S. Department of Health and Human Services Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program, November 21, 2007.

<sup>2</sup> Integrated Healthcare Association, *The California Pay for Performance Program, The Second Chapter Measurement Years 2006-2009*. June 2009.

higher, until such time that the data sources are adequate to set accurate quality benchmarks. This approach would encourage Accountable Care Organizations to continue their participation in the program.

### **Medicare Shared Savings Program-Ensuring Meaningful Differences in Performance Rates**

AMGA member medical groups who are participating in the Medicare Shared Savings Program (MSSP) share the CMS concern regarding clustered measures. As the proposed rule illustrates, in such instances, a small distinction in actual performance rates on measures can result in a significant difference in the number of quality points an ACO can obtain. Allowing clustered performance rates for a measure may therefore result in payment differences that are not associated with clinically meaningful differences in patient care.

The methodology in the proposed rule that would spread, or separate, the performance rates within the measure raises concerns for our members who are participating the MSSP because it has the potential to penalize higher performing ACOs. AMGA would therefore recommend a methodology that is similar to the one used in the Physician Group Practice Transition Demonstration (PGP-TD) in cases of measure performance rates that are too tightly clustered. In this methodology, benchmarks were set on empirical data based on the participating medical group's performance, with the percentage of quality points calculated as the individual group's performance, divided by the benchmark. The following example illustrates how this methodology would more accurately recognize clinical excellence when there is little difference in clinical performance between the 30<sup>th</sup> and 90<sup>th</sup> percentiles of performance:

- 90<sup>th</sup> percentile = 99%
- 30<sup>th</sup> percentile = 97%

If an ACO achieves 97% (30<sup>th</sup> percentile), this methodology would award the ACO 98% of the quality points (97% divided by 99% = 98%). We therefore urge CMS to consider adoption of this methodology in cases where there is little clinically meaningful difference in performance between the 30<sup>th</sup> and 90<sup>th</sup> percentile.

### **Medicare Shared Savings Program-Scoring CAHPS Measures within the Patient Experience of Care Domain**

AMGA member medical groups participating in the MSSP strongly value the experiences their patients have while obtaining medical care in their facilities, and agree with recognizing performance in this area. AMGA supports the proposal to phase-in pay-for-performance for six Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, while retaining the pay-for-reporting status of the "Health Status/Functional Status" measure, given that the measure is so new. However, our medical groups that are participating in the MSSP are concerned about the changes in weighting of these measures that are outlined in the proposed rule, and we urge CMS to wait until the end of the three year agreement period to assess whether this change is appropriate.

AMGA notes that there are other survey tools available to assess patient experience, and that CMS should allow health care providers to choose the survey instrument of their choice in meeting this requirement.

AMGA appreciates CMS' careful consideration of our comments, and stands ready to serve as a resource 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](mailto:kferguson@amga.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Donald W. Fisher". The signature is fluid and cursive, with a prominent initial "D" and "W".

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