September 2, 2014

Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid 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, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models and Other Revisions for CY 2015, Proposed Rule

Submitted Electronically

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) 2015.

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 435 medical groups that employ nearly 150,000 physicians who treat more than 120 million patients. Our member medical groups are working diligently to provide innovative, patient-centered medical care while being respectful of federal health care expenditures. Many of them are also participating in alternative payment models such as the Medicare Shared Savings Program, the Pioneer ACO Program, the Comprehensive Primary Care Initiative, and bundled payments initiatives. 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.

Chronic Care Management Code

In 2014, CMS finalized its proposal to reimburse separately for the non-face-to-face chronic care management services furnished to patients with two or more chronic conditions, and for 2015, has assigned a $41.92 payment to the code, in addition to adding the use of a certified electronic health record (EHR) to the requirements to bill for this code. Several additional requirements must be met to bill for the code, and the EHR must house electronic care plans that are accessible to all providers within the practice, as well as exchanged with providers outside of the practice.

AMGA applauds the implementation of this code. 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 largely done so without compensation, because it is the right thing to do. We believe that shifting resources into complex chronic care management services is necessary and will help preserve Medicare expenditures over time by keeping patients with chronic conditions who are at-risk of being hospitalized healthier, and out of the hospital or emergency department, and helping them to live better lives.

Several AMGA members have expressed concern about the additional beneficiary co-payment for these services, however, and feel that the chronic care management code should be considered a preventive service. AMGA member medical groups have previously provided non-face-to-face care management services to their patients with no additional financial liability to them, and our groups have concerns about their patients being willing to accept additional co-pays. In addition, the feedback we have received from our medical group members is that the payment may not be adequate for the scope of services provided, because providing non-face-to-face care management services requires the ongoing involvement of a care team. In general, 20 minutes per month, per patient, may not adequately represent the care management services being provided between office visits for the eligible patient population. While implementation and valuation of this code is a positive step in the right direction, we suggest that early on CMS monitor adequacy of the payment to ensure that the intended goals are being met.

Concerning the documentation requirements, in general, AMGA believes the standards are reasonable, but urges CMS to streamline certain provisions to limit operational burden. For example, patients should be permitted to give their consent for opt-in verbally, which could then be notated in the EHR, rather than through the use of yet another form for patients to sign. This would help eliminate the unnecessary administrative burden of obtaining patient consent to receive these important services.

AMGA supports the proposal to modify the supervision requirements for services furnished to patients "incident to" from Direct Supervision to General Supervision, given the requirement that beneficiaries have access to care management services 24/7, and that these services are provided in a team-based and collaborative manner.

Elimination of Global Surgical Codes

CMS proposes to eliminate all 10 and 90-day global surgery codes during the 2017-2018 timeframe, and to pay separately for post-operative visits, citing Health and Human Services Office of the Inspector General reports that have identified numerous surgical procedures that include more post-surgical visits in the global period than are being furnished. AMGA recommends that, rather than doing away with the global surgical payment concept altogether, that CMS reevaluate the codes in question and revalue them. The global surgical codes resemble payment bundles, which are being evaluated as a mechanism that could help shift health care financing toward one that recognizes value over volume, and are currently being tested by the Center for Medicare and Medicaid Innovation in order to gain experience with the concept.

Further, unbundling of these codes could have unintended consequences with respect to hospital readmissions. For example, Medicare patients who are financially liable for co-payments for the surgical procedure itself may not wish to incur further financial liability for outpatient post-surgical visits. The additional financial liability could lead to patients delaying post-operative visits, or skipping them altogether, thus affecting the overall quality of their care, or resulting in a hospital admission (or

readmission) for something that could have been prevented, had they been seen in the immediate post-surgical timeframe.

AMGA suggests that it would more beneficial to rebase the pricing of the questionable global surgical codes in question rather than eliminating them altogether, since payment bundles may expand in the future as an alternative payment model, and keeping the global surgical codes in place can contribute to better post-surgical outcomes.

Medicare Telehealth Services

Our member groups recognize the promise that the emerging technology of telehealth has in potentially transforming healthcare by improving access to care, patient engagement, and patient satisfaction and we are encouraged by the expansion of covered services for Medicare telehealth in the proposed rule. However, as CMS continues to move forward in its support of this evolving method of delivering health care, there are some issues that we hope will be considered in the process.

As the use of telehealth services expands, it is important that the program requirements in quality reporting keep up with this expansion. Some quality measures require face-to-face interaction with patients, yet could be modified to be inclusive of telehealth interactions. We would suggest that the elements of clinical visits that are measured for PQRS, but conducted via telehealth visits, count toward compliance with the applicable measures.

We also ask that CMS consider the expansion of existing telehealth pilot programs taking place at the Center for Medicare and Medicaid Innovation, to include pilots on payment parity within urban communities and a more liberal definition of originating sites. The continued exploration and testing of telehealth services should be a priority, since these services improve access, and have the potential to reduce hospital readmissions through efficient care coordination, and are provided in a cost-effective manner. An additional step that we ask CMS to consider in continuing to develop telehealth services is to examine how to integrate the use of telehealth services into new payment models. If telehealth services are to become a viable method of healthcare delivery, expanding their use into multiple payment models will be integral in that effort.

Minimum Reporting Requirements for Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) Interface

AMGA was pleased to see the proposal to reduce the reporting requirements for the PQRS GPRO web interface from 411 to 248 consecutively ranked and assigned patients. This will ease the reporting burden significantly for many medical groups, since much of the data to complete the GPRO web interface must be manually extracted from patient records. However, we have heard from some of our larger member medical groups that 248 patients may not provide an accurate sample size, since several of our medical groups are also participating in the Medicare Shared Savings Program, which also employs this reporting tool, and have well in excess of 5,000 patients attributed to their Accountable Care Organization, in some cases several times that number. We would therefore recommend that participants in the GPRO have the flexibility to choose either 248 or 411 as their sample size, whichever they believe would be the most accurate representation of their particular attributed patient population.

Medicare Shared Savings Program (MSSP)

For 2015, CMS is proposing to make modifications to the measure set used in the MSSP by adding 12 measures, and dropping eight, for a total of 37 quality measures in the program, in addition to rewarding Accountable Care Organizations (ACOs) for improvement, as well as success in attaining shared savings. The improvement score proposal would allow ACOs to earn two extra points for each quality measure domain, not to exceed the current maximum for each domain. CMS has also proposed changes that will better align the MSSP and the Medicare EHR Incentive Program clinical quality measure (CQM) requirements.

Incentives for Improvement in MSSP

AMGA is pleased to see that CMS has proposed a methodology that will reward for improvement in the MSSP, as this will be helpful as medical groups develop strategies to succeed in this nascent program. AMGA would recommend, however, as we did last year, that the improvement provision includes scoring based upon either an "attainment score" or an "improvement score" and determine success in the program on whichever is higher. We would recommend that the approach mirror the methodology CMS has developed for its Hospital Value Based Purchasing program[1], and adopted for use in California's Pay for Performance Program. [2] We believe that providing a maximum of two points in each quality measure domain to reflect improvement may not go far enough to award improvement. The approach we propose would do more to encourage ACOs to continue their participation in the program.

Continued Alignment of Quality Reporting Requirements

We also appreciate CMS' efforts to continue aligning MSSP reporting requirements with those of other federal quality reporting programs. Collectively, the reporting requirements and timeframes of the MSSP, the Physician Quality Reporting System, the Electronic Health Record Incentive Program, and the Value Modifier create significant complexity for health care providers to navigate, and any efforts to mitigate them and move toward a "report once" environment is helpful.

Proposed Modifications to the Quality Measures Used to Establish Quality Performance Standards that ACOs Must Meet to be Eligible for Shared Savings

CAHPS Stewardship of Patient Resources: Medical groups have told us that this measure will be operationally difficult to implement, but believe it is reasonable to include it for pay for reporting only. Since this is a relatively new measure, CMS should engage in a conversation with the medical community about benchmark building for this measure.

Skilled Nursing Facility (SNF) 30-Day All-Cause Readmission Measure: We support the inclusion of this measure for feedback and performance measurement only. We note that behavioral health claims are broadly unavailable, and ACOs should not be held accountable for measures for which they are

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

[2] Integrated Healthcare Association, *The California Pay for Performance Program, The Second Chapter Measurement Years 2006-2009*. June 2009.

not able to collect adequate data and monitor over a performance period. We would therefore recommend that psychiatric admissions should be excluded.

All-Cause Unplanned Admissions for Patients with Diabetes Mellitus (DM), Heart Failure (HF) and Multiple Chronic Conditions: As with the proposed SNF readmission measure, ACOs have built-in incentives to provide medical management and care coordination to help keep their patients out of the hospital. We therefore support inclusion of this measure, however we recommend that the measure be pay for reporting for three years while stakeholders work to understand the measure, develop a data set, and analyze the overlap with existing HF and Chronic Obstructive Pulmonary Disease admissions measures.

Depression Remission at Twelve Months: Although we recognize the potential impact of depression on a patient's ability to adhere to treatment plans for other conditions, we recommend against adding this measure. The multi-year look-back increases anomalies and therefore decreases reliability. In addition, behavioral health claims are broadly suppressed, and therefore often unavailable, making it difficult for ACOs to have actionable data on this condition. We recommend testing this measure through pay-for-reporting only, in order to contribute to the evidence base.

Diabetes Measures for Foot Exam and Eye Exam: AMGA supports the Diabetic Eye Exam measure, given the prevalence of diabetic retinopathy. This process measure effectively tracks a high-prevalence condition while providing results that have immediate benefits to clinical decision making. We do not support the Diabetic Foot Exam measure, while we agree with it in principle. Our members tell us that this is a weak process measure that does not have immediate clinical decision-making implications. In addition, diabetic foot exams are ideally documented asynchronously from a clinical encounter with clinicians only addressing the minority of results that fail the screen, and this measure would not allow for that process.

Coronary Artery Disease Symptom Management: We do not support inclusion of these measures given the primary care focus of ACOs, some of which will not have access to outside specialist cardiology medical records to support reporting of this measure. Documentation from outside cardiologists may not contain the required elements or level of specificity of the cardiologist's own chart. ACOs without internal cardiology services may perform poorly simply because of reporting limitations, even when symptoms are being managed appropriately.

Documentation of Current Medications in the Medical Record: We do not support use of National Quality Forum (NQF) #0097 for medication reconciliation, and recommend use of NQF #0554 instead. NQF #0554 has been well-tested and has stood the test of time, having been in use for five years. Several elements of the measure make it preferable. The measure does not require an outpatient visit, so it captures every discharge. For example, home health nurses are often the first to complete a medication review, and their reconciliation promotes a more patient-centered, efficient and timely workflow. The measure also includes medical reconciliation conducted by a prescribing practitioner, clinical pharmacist, or a registered nurse, which promotes system-based care and improvement. And lastly, this measure is clearly not a "topped out" measure, with NQF data suggesting that there is room for improvement.

Fall Risk Assessment: AMGA supports this measure for patients who are 65 and older, as a screening measure only. With respect to outcomes, an evidence base of recommended interventions has yet to be developed, but several AMGA member medical groups have indicated that they would be eager to help develop the evidence base.

Proposals to Update the Benchmarking Process

Quality measurement programs can only succeed with a rigorous benchmarking process. New measures, updating, or clarifying measures with new information that modifies the data reported, require new benchmarks. For any new measure, we strongly recommend one year for data collection, one year for interpretation enforcement through uniform audits, and pay for performance only in the third year. Adjusting benchmarks upward for well-audited measures where the measure itself remains unchanged requires lead time of at least one year for an ACO to measure its performance against the new benchmark and develop a plan to close any gap.

Adjustments to "topped out" measures, or making a downward adjustment to the benchmark without a change to the measure itself, requires no lead time. However, the sooner such measures are made available to ACOs and put into action, the better.

Local Coverage Determination Process for Clinical Diagnostic Laboratory Tests

CMS is proposing several revisions to the Local Coverage Determination (LCD) process for all new draft clinical diagnostic laboratory test LCDs published on or after January 1, 2015. The revisions include reducing the public comment period from 45 days to 30 days and making optional a Carrier Advisory Committee (CAC) meeting, in other words there would be no requirement to hold an open stakeholder meeting prior to Medicare Administrative Contractors (MACs) making coverage decisions. Under the new proposals, final LCDs would become effective on the date of publication, which would eliminate the notice period of 45 calendar days.

AMGA does not support the proposed changes to the LCD process for clinical diagnostic laboratory tests. Clinician input is essential to determining new payment policies, and we believe the proposal to make optional the CAC meeting unnecessarily restricts the process.

We also strongly advocate for leaving the 45-day notice period in place. Clinicians need time to consider new payment policies of any kind, and we do not support the removal of the notice period.

We appreciate the opportunity to comment on these proposals. If you have questions, please do not hesitate to contact Karen Ferguson of my staff at kferguson@amga.org.

Sincerely,

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