



Sound Policy. Quality Care.

August 24, 2010

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011
CMS-1503-P

Dear Dr. Berwick:

The Alliance of Specialty Medicine (Alliance) and its member organizations are pleased to provide comments on the proposed changes to the Medicare Physician Fee Schedule for CY 2011. The Alliance is a coalition of 10 national medical specialty societies representing more than 200,000 physicians and surgeons. We are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. The Alliance has a number of significant concerns with the proposed rule. We fear that some of the provisions will substantially decrease payment for certain physician services, particularly imaging, in ways unrelated to the actual cost of delivering care. These changes could adversely affect beneficiary access to high quality care.

The Alliance must take this opportunity to protest the continued role of the sustainable growth rate formula in setting the conversion factor for the Physician Fee Schedule. We fully recognize that Congress, not CMS, is responsible for the SGR and only Congress can change it. However, we must point out the difficult practice conditions physicians have been operating under due to the four legislative fixes and two sets of technical corrections to the conversion factor thus far in CY 2010. The disruption and cash-flow issues generated have been troubling. As you know, the crisis has only been postponed until November 30, 2010. Carrying forward past and proposed SGR cuts will result in a 30 percent reduction to physician payment in 2011. Our members cannot survive cuts of this magnitude. Should the SGR cut be implemented in the coming year, many physicians may be forced to reduce access to Medicare patients. Physician payment reform should recognize reasonable cost increases due to inflation and changes in technology so that reimbursement covers the true costs of providing services to Medicare beneficiaries.

Specialist Perspectives on CY 2010 Coding and Payment Methodologies

American Association of Neurological Surgeons • American Association of Orthopaedic Surgeons
American Gastroenterological Association • American Society of Cataract & Refractive Surgery • American Urological Association
Coalition of State Rheumatology Organizations • Congress of Neurological Surgeons
Heart Rhythm Society • National Association of Spine Specialists • Society for Cardiovascular Angiography and Interventions

The Alliance is pleased to respond to CMS' request for public comment on physician perspectives on CY 2010 coding and payment methodologies. Prior to 2010 CMS' decision to eliminate the reporting of all CPT consultation codes, these services were most frequently performed and reported by specialty physicians after a patient referral from a primary care physician. A recent survey, conducted by the American Medical Association (AMA), in concert with several medical specialty societies, regarding the impact on clinical care of elimination of reporting of consultation codes, clearly finds that this policy is having a negative impact on physician efforts to improve access and coordination of care for Medicare beneficiaries.

Results of the survey indicate that the approximately 5500 physicians who completed the survey have been forced to take a number of cost-cutting steps to offset revenue losses associated with the elimination of these codes. For example:

Three out of every ten (30%) have already reduced their services to Medicare patients or are contemplating cost-cutting steps that will impact care.

One-fifth (20%) have already eliminated or reduced appointments for new Medicare patients.

Nearly two-fifths (39%) will defer the purchase of new equipment and/or information technology.

More than one-third (34%) are eliminating staff, including physicians in some cases.

Following CMS's suggestions that consultants no longer need to provide primary care physicians with a written report, about 6 percent of responding physicians have stopped providing these reports, while nearly another 19 percent plan to stop providing them.

In the 2010 MPFS proposed rule, CMS asserted the elimination of recognition of consultation codes was intended to be "budget neutral" and crosswalks were crafted by CMS with the utilization of office consultation codes translated into office visits and utilization of hospital and facility consultation codes translated into initial hospital and facility visits. Based on data obtained from the AMA/medical specialty society survey, it does not appear that CMS was successful in maintaining budget neutrality in implementing this change in policy.

The Alliance respectfully requests that CMS closely examine the negative impact the elimination of the reporting of all CPT consultation codes is having on the coordination of care for Medicare beneficiaries and provide confirmation that this change was conducted in a budget neutral manner, as initially proposed.

Potentially Misvalued Services Under the Physician Fee Schedule and Validation

The ACA requires the Secretary to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of those services so identified. CMS has always had this responsibility and makes appropriate adjustments to RVUs by taking into account the recommendations provided by the AMA RUC and MedPAC. However, the new statutory language highlights the importance of this function to Congress. The AMA RUC established a process to objectively identify potentially misvalued services in 2006 using the categories now specified in the ACA. As part of this process, the national medical specialty societies and their members are asked to fund the collection of physician time and other data. Medical specialties have spent substantial resources and staff time to collect new data for this purpose which may lead to reduced payment for services performed by their membership. CMS recognizes the important role of the AMA RUC in the proposed rule and notes that the existing AMA RUC process has identified over 700 potentially

misvalued codes in the seven categories. The RUC review process relies on clinical expertise and objective data.

The ACA permits the Secretary to use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services. In addition, the Secretary may conduct surveys and other data collection activities, studies, or other analyses, as the Secretary determines to be appropriate, to facilitate the review and appropriate adjustment of potentially misvalued codes. While the AMA RUC would welcome the opportunity to review other data sources, it is critical to recognize that other data sources must measure time in a consistent manner for all physician services in order to be usable. The RBRVS is a “relative” payment system. It would be inappropriate to use data sources that isolate specific physician services and measure the time for those codes in an inconsistent manner.

The ACA also specifies that the Secretary shall establish a formal process to validate relative value units under the Physician Fee Schedule. The validation process may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service, and may include validation of the pre-post-, and intra-service components of work. CMS states its intention to establish a more extensive validation process of RVUs in the future beyond its current assessment of the AMA RUC-recommended work RVUs. CMS is soliciting public comments regarding approaches, including the use of time and motion studies, to validate estimates of physician time and intensity that are factored into the work RVUs for services with rapid growth in Medicare expenditures.

Any alternative methods for validating physician time and intensity must preserve the relativity of physician services, which is key for the Resource-Based Relative Value Scale (RBRVS). The Alliance continues to support the AMA RUC process which has improved continuously since its inception in 1992. The AMA RUC and its 120 component medical specialties and healthcare professional societies have exhibited a strong commitment to continually refining the RUC process to insure the process produces the most accurate, granular, and equitable values possible. We believe that a process involving practicing procedural and cognitive physicians, as well as other health care professionals, is optimal for determining the value of physician services. To reiterate, the RBRVS is a relative value system. Application of a validation process only for certain physician services would destroy the relativity of values in the system. It is not likely that CMS is planning to conduct time and motion studies on all physician services given the cost of such studies. The Alliance would oppose use of time-motion studies for validation of physician time and intensity for a subset of physician services.

Codes on the Multispecialty Points of Comparison List

The AMA has established clear criteria for including codes in the Multispecialty Points of Comparison (MPC) List. The list is used to help judge relativity of procedures across specialties. The Alliance does not agree with CMS that there is compelling evidence that the codes on the MPC are potentially misvalued. In the absence of compelling evidence, we question the value of a wholesale reassessment of the codes on the list. We are concerned that this process could be burdensome for specialties and duplicative of the process already established by the AMA RUC. This is particularly true of services valued by the RUC and accepted by CMS.

Codes with Site of Service Anomalies

The Alliance strongly objects to the CMS proposed “reverse building block” methodology to value services identified as having a site of service change. We stand by the comments that we provided in our 2010 MPFS letter and join the American College of Surgeons (ACS) and the American Medical Association (AMA) in objecting to the methodology that CMS has proposed to evaluate the codes identified as potentially misvalued due to site of service anomalies. The service times and post-operative visit data historically assigned to these codes is assumed by CMS to be correct. The “Pre-AMA RUC Evaluated” reviewed time and post-operative visit data for these codes is either from a RUC survey conducted over 10 years ago or from the original Harvard studies. The RUC survey instrument did not survey respondents for the number or level of post-operative visits when it was initially established. This data was estimated when the RUC began its refinement of the original CPEP data. Further, pre-service time has been a contentious issue in the last few years at the RUC and one for which continued review is still needed.

For the codes whose original times came from the Harvard studies, the RUC and virtually all the specialties have always expressed concern about the accuracy of Harvard data. The Harvard studies relied upon several necessary methodological assumptions and compromises. For example, the Harvard group surveyed too few cases to cover the range of clinical practices in a specialty and used an extrapolation methodology to assign final values for total work to non-surveyed physician services which produced RVUs that seemed incongruous or paradoxical.

For some interventional procedures that have transitioned from inpatient to outpatient settings, we have found that times have decreased (from the original estimations), but intensity has increased significantly. Typically, providers must convey the same amount of information to the patient in the outpatient setting, but in a compressed amount of time. Clearly this makes the service more "intense". Physician work does not decline just because a procedure has moved to an outpatient setting. The same care activities that were conducted in the hospital must be carried out in the physician's office. One example of this process is found in **CPT 53445, Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff. When the procedure is performed on an outpatient basis**, much of the complex post-operative care of these patients is transferred to the office. This increases the number of office visits, increases demand on office staff in monitoring phone calls, dealing with questions about pain, edema and voiding problems. The additional office visits and increased use of supplies do not change the high level visits for patient teaching, typically two 30-minute visits equivalent to a level 4 established patient.

Professional Liability Insurance Relative Value Units

The Alliance commends CMS for using the risk data of the dominant specialty in the development of malpractice RVUs for procedures with a Medicare frequency of fewer than 100 times a year as part of the FY 2010 MPFS. Although the PLI component may represent a small portion of Medicare payment overall, for many medical special specialties, the proportion of cost related to PLI premiums is exorbitant. Our specialties have worked with the AMA RUC to try to ensure that the PLI component of the MPFS is resource-based and in rank order. We were very disappointed with the errors in the PLI values for high-risk services that occurred in the FY 2010 MPFS. Although these errors were detected and corrected for claims going forward, many specialties that were underpaid based on the erroneous values have gone up to eight months without receiving the balance of payment owed to them. Vigorous oversight by CMS staff of the values published by the contractor responsible for developing PLI values is essential.

We were disappointed to learn from the RUC that CMS has not uniformly implemented RUC recommendations for appropriate cross-walks to use to establish PLI values for new codes. The PLI RVUs for new codes have in some cases borne no relationship to the RUC recommendations and CMS has provided no explanation for these deviations. We understand that CMS plans to publish a list of the PLI values for new and revised codes in November in the CY 2011 Final Rule along with the cross-walk codes used. We hope this will make the PLI valuation more clear, and we appreciate the willingness of CMS to consider comments regarding appropriate PLI values.

Multiple Procedure Payment Reduction

CMS is proposing changes to the Multiple Procedure Payment Reduction (MPPR) that meet and exceed the requirements of the ACA. The ACA requires CMS to increase the MPPR, which cuts the technical component of certain imaging services provided on contiguous body of the patient in the same session, to 50 percent from its current level of 25 percent. CMS is going beyond the provisions of the ACA to apply the MPPR to CT, CTA, MRI, MRA, and ultrasound procedures furnished to the same patient in the same session on consecutive body parts across modality. CMS estimates that this change will reduce payment for 20 percent more procedures than the current policy. This policy would cut payment for physician-based imaging which has already been severely reduced by prior policies, such as the Deficit Reduction Act cuts and the increase in the equipment use rate for high cost equipment.

CMS justifies this expansion of the MPPR to contiguous body parts and multiple modalities by explaining that duplicate resources would be saved for activities such as greeting the patient, obtaining consent, retrieving records, and cleaning procedure rooms. These activities may not be repeated in imaging contiguous body parts during one session with one modality. However their time and expense components are minute and would not equate to a 50 percent reduction in the TC for the second or subsequent procedure. These minor "savings" would not be realized at all when a physician provides an image through a second modality. CMS states that it would be highly unlikely for a single practitioner to furnish more than one imaging procedure involving 2 different modalities to one patient in a single session. This is not correct. Certainly urologists may provide ultrasound followed by a CT scan when a patient undergoes an ultrasound for renal colic that reveals the presence of a mass. The two imaging procedures would be performed in different rooms with different technicians and supplies. Only the greeting, the gown, and the record retrieval would be shared across the imaging procedures. The Alliance is alarmed by the suggestion that CMS may seek to apply the MPPR approach to the Professional Component of these and other diagnostic services. We are not able to identify potential reductions in physician time or intensity when multiple images with or without multiple modalities are performed. We suspect that intensity and physician stress may actually increase in these multiple procedures.

We are concerned that CMS continues to target imaging for payment reductions. The result of these cuts may be to reduce access of Medicare beneficiaries to physician-based imaging. Driving imaging back to the hospital setting will have very real cost consequences for Medicare and Medicare patients who will face higher cost-sharing. Medicare should reimburse appropriate imaging services at a payment level that covers legitimate costs.

High-Cost Supplies and Updating Equipment and Supply Costs

The Alliance commends CMS for seeking to create a “regular and more transparent process for considering public requests for changes to PE database price inputs for supplies and equipment used in existing codes”. As proposed, CMS would accept requests for supply and equipment input price updates throughout the year with all requests received by year-end, December 31st, to be considered in the proposed rule making process for the following calendar year. The possible proposed outcomes for such requests including possible referral to the RUC-PERC process are clearly detailed by CMS and the transparency of this proposed process is appreciated and supported by the Alliance.

While we support CMS’ proposed process for updating the pricing for equipment and supplies, the Alliance does not support CMS’ proposal to use the GSA medical supply schedule as the only source in setting the pricing for “high-cost” or other supplies. It is believed that CMS is correct in concluding that “discounts may vary depending on suppliers and the volume of supplies purchased”. However, the assertion by CMS that the GSA medical supply schedule does not reflect any “discounting” is believed to be completely inaccurate. The federal government, by its’ very nature, is believed to inherently have unique purchasing power not afforded to the average, every day physician’s office. Per CMS’ own finding, the GSA “establishes long-term government-wide contracts with commercial firms”. Small businesses, such as physicians’ offices, simply do not have this same clout in negotiating supply pricing as the federal government and the VA.

We believe that the 23 percent lower pricing for high-cost supplies that the CMS’ contractor found in comparing the GSA medical supply schedule to existing CPEP pricing reflects the unique purchasing power of the federal government and the inherent typical discounting this purchasing power is granted. Instead of using the GSA schedule as the “individual item ceiling price for a single item purchase”, the Alliance believes the GSA schedule pricing should be used as the absolute floor with an adjustment to increase the pricing found in the GSA schedule by the average discounting afforded the federal government (currently believed to be 23 percent, based on the CMS’ contractor findings). We urge CMS to continue to seek independent third party sources for identifying the cost of high-cost supplies.

Refinement Panels

We are pleased that CMS has proposed to make the Medicare Refinement Process more transparent. However, we urge CMS to use a methodology that would allow the RUC-passed value to prevail when appropriately supported by the pertinent specialty societies when the evidence is strongly supported by the rank order and resources of the procedure. The MPFS final rule is the first opportunity for the public to see the RVUs for the coming fiscal year and a full and fair review process is warranted prior to their publication, particularly in those cases where CMS has changed the RUC recommended value.

Physician Feedback Program

The Alliance is very concerned about implementation of the separate, budget neutral payment modifier imposed by the ACA to govern differential payment to physicians based on their relative cost and quality of care provided to Medicare patients. We welcome the commitment CMS expresses in the NPRM to engage in a large-scale effort to obtain stakeholder involvement. We look forward to active engagement in this process. We also support the development of a public Medicare-specific episode grouper. We feel the mandated completion dates for both the episode grouper and the payment modifier are highly unrealistic. We must object to the use of GEM quality measures to link to

per-capita cost data for designated conditions. A number of the identified conditions, such as prostate cancer and COPD, have no appropriate GEM measures. If CMS is unable to apply PQRI measures with some relationship to designated conditions, CMS should consider omitting per-capita resource use analysis for those conditions.

Statistical Issues:

Attribution

The Alliance requests additional clarification on the attribution methodologies. In Phase I, two methods of attribution were used, the “multiple-proportional” and the “plurality-minimum.” We oppose the use of the “plurality-minimum” in Phase II. Physicians should not be held accountable for costs and resource use that they do not influence, nor should they be held accountable for treatment choices made by patients or other specialists, perhaps in opposition to their own clinical recommendations. The plurality-minimum method is appropriately implemented for only those instances when a single physician provides most of the beneficiary’s care. However, the proposed method of attributing all cost and resources to the physician who performed 30 percent of E&M services appears to be arbitrary rather than based on clear statistical differences or critical aspects of clinical care. The plurality-minimum approach does not provide physicians accurate feedback about their resource use. Given the choice between multiple-proportional and plurality-minimum, specialty physicians find the multiple-proportional attribution approach to be more fair and credible. As suggested by CMS, we agree that for some aspects of care, such as a surgical episode, it may be desirable to attribute the entire cost to the performing surgeon.

In the Phase I reports, hospital costs were attributed to physicians. Physicians are concerned by the prospect of being held accountable for the costs of high-cost institutions, and several suggested that CMS disseminate hospital cost data so that physicians can make informed decisions when choosing institutional affiliations.

Benchmarking and Peer Groups

Specialty physicians wish to be compared to their peers with respect to case mix and type of services rendered. Some specialists may perform procedures infrequently at different points in their careers or through a focus on post-procedure management. Interventional physician specialists with active practices differ substantially from fellow specialists who provide medical management. Comparisons of interventional specialists with more cognitive subspecialists within the same specialty are not helpful for learning and quality improvement. This type of differentiation within specialties can be identified through review of claims history. In addition, medical and specialty organizations have data that could permit CMS to assign subspecialty designations for some physicians.

With regard to the appropriate minimum case sizes and minimum peer group sizes, we suggest that a power analysis be conducted based on the number of comparisons. Determination of sample size for comparisons is more complex and may differ by clinical condition. We recommend that CMS work with physician specialties on some key clinical conditions to test different sample sizes. A minimum sample size of 30 may be considered appropriate for some types of studies, but this number may not be appropriate for all types of clinical conditions.

Composite Cost and Quality Measures

The Alliance appreciates CMS' recognition that composite measures are methodologically and operationally complex, thus, we urge CMS to carefully test and evaluate the different composite methodologies. Since the first step to create a composite measure is to identify the individual components (i.e., individual measures) that should comprise the composite, a reliable Medicare-specific episode grouper is essential to this initial process. Once an episode of care is identified, the highly complex issue of selecting the scoring method needs to be considered. The most common scoring methodologies include: equal weighting, opportunity scoring, compensatory, variable weighting determined by latent variable analysis, and all-or-none. Equal weighting is the simplest scoring, which involves summing across all measures using equal weights or applying predetermined weights to the raw item scores. The disadvantage to equal weighting is that it assumes a linear relationship between all items. Additionally, equal weighting permits high performance on some measures while masking poor performance on other measures that may be critical to quality. Weighting the items by importance may help mitigate the issue of masking poor performance on some measures, however, it is difficult to obtain an appropriate assignment of the weights. There is no gold standard for how weights should be assigned and expert consensus is relied upon. Unfortunately, studies have shown that expert consensus in determining the weights are difficult to achieve. Opportunity scoring, which CMS has used before, involves summing the numerators for each indicator, summing their denominators and dividing the former by the latter. As with equal weighting, opportunity scoring may also mask poor performance on some measures. Compensatory scoring involves "or" rules for which a provider could achieve any of the specified targets for the quality measures to achieve a successful score. In variable weighting, empirically derived weighting schemes multiply scores for each item or measure by the relative variation explained by that measure compared with all other measures to be considered in the composite. The weights are determined by latent variable analyses (e.g., factor analysis, structural equation modeling) and averaging the weighted measures then creates the composite. In all-or-none scoring, the provider needs to achieve all of the specified values for the quality measures to be combined in order to count as a success. The major disadvantage to the all-or-none approach is that it is only appropriate if all the measures are equally important to the clinical condition.

The National Quality Forum (NQF) and the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI) have developed guidance on creating composite measures. These organizations favor the simplest approach to scoring. That is, the NQF argues that equal weighting should be applied unless differential weighting is justified. The AMA-PCPI favors the use of the "all or none" scoring methodology for cases where there are a set of process measures in which each measure is considered equally important. In cases where the composite measure combines process and outcome measures, AMA-PCPI generally recommends equal weighting. However, the AMA-PCPI warns that mixing different measure types (e.g., process, structure, outcomes) into one composite poses methodological challenges due to risk adjustment and attribution issues. Furthermore, process, structure, and outcome measures do not share the same scale. For example, medication adherence rates might be widely dispersed over a wide range while survival rates might be tightly clustered in a narrow range. In order to combine a mix of measures into one composite, each measure score needs to be standardized. There are various options of standardization, for example, some groups recommend rescaling each measure score by the reciprocal of its standard deviation or its range and then weighting the rescaled estimates equally (see O'Brien, et al., 2007. Quality measurement in adult cardiac surgery: Part 2—Statistical considerations in composite measure scoring

and provider rating. *The Annals of Thoracic Surgery*, 83, 13-26). The AMA-PCPI at present considers mix measures composites to be highly complex and does not offer guidance on this matter. Moreover, the actual development of any type of composite measure is still in the beginning stages and no single organization has perfected the method. The Alliance believes that more than one composite measure is clinically valid and that CMS should clarify this matter in the final rule.

We believe that more empirical work on creating composite measures needs to be done before CMS can create an adequate quality and cost index to append as a modifier for physician payment. We suggest that, as a starting point, CMS must first determine the relevant cost and quality measures that will go under a composite for each of the five identified chronic conditions and then conduct statistical analyses using different scoring methodologies to determine the best approach for each clinical condition, as the most appropriate approach might differ depending on the condition. As the NQF, AMA-PCPI, and medical specialties gain experience in developing composite measures, they may have useful insights to provide. CMS should continue to seek stakeholder comment throughout the composite measure development process. At this early stage in the RUR program, given the substantial statistical and methodological hurdles to creating cost and quality composites and a single cost and quality index, it is premature to expect that an accurate payment modifier based on resource use will be ready by 2015.

Disclosure of Self-Referral Imaging

The Alliance welcomes many of the provisions CMS proposes to implement the ACA disclosure requirement for the in-office ancillary services exception to the prohibition on physician self-referral. We are extremely pleased that CMS chose to apply the ACA distance requirement to alternative suppliers to the distance from the referring physician's office rather than the distance from the patient's residence. To do otherwise would impose a significant burden on referring physicians.

We fully agree with the decision to make the requirements applicable to services furnished on or after the effective date of the final regulation- January 1, 2011. We urge CMS to limit the disclosure requirement to MRI, CT, and PET as is proposed in the NPRM. We feel the impact of this new disclosure process should be limited to high-cost imaging that is not ordered with high frequency. The disclosure process will undoubtedly be confusing to patients and burdensome to physicians. Its scope should be limited and its impact closely monitored.

The Alliance recognizes that the purpose of the disclosure requirement is to inform patient decision-making regarding where to obtain imaging services. The list of alternate suppliers is intended to be an informational resource to patients. To improve the impact of this information for Medicare beneficiaries and to minimize burden on referring physicians, the Alliance recommends that the number of required alternate suppliers be set at 5 rather than 10. We believe patients will be confused and concerned about the list of suppliers and will find the information more useful if it is more concise. We agree that referring physicians should be permitted flexibility in drafting the supplier lists. Physicians may choose to omit suppliers who are known to have quality or access problems. We must object to the CMS expression of concern in the NPRM that "physicians located in large metropolitan areas will draft a list that includes suppliers located mostly at the edges of the 25-mile radius, thereby increasing the chances that the patient will choose to receive imaging services from the referring physician's practice." Our members will strive to create lists that include the highest

quality, most accessible suppliers in their areas. For this reason, we also ask that referring physicians be given the option to include hospitals on the list of alternate suppliers.

Because the notification of alternate suppliers is not a clinical document, we do not feel it belongs in a patient's medical record. Such paper notices will also become obsolete when physician offices transition to electronic health records. We propose instead that physicians maintain a dated notification log at the front desk that patients will sign once they have received and reviewed their disclosure lists. These logs will then be retained and filed by the office for potential review by regulators or accreditors.

PQRI

To increase physician participation in Physician Quality Reporting Initiative (PQRI), the Alliance recommends that CMS carefully consider the availability of measures in the PQRI program for sub-specialty medicine. Sub-specialists, such as electrophysiologists, should not be denied an incentive payment (or in 2015, receive a penalty) if the available PQRI measures are not applicable to their specialty. Furthermore, the availability of sub-specialty specific measures will be imperative when CMS begins publicly reporting physician performance as part of Physician Compare. Without relevant measures, Physician Compare will not accurately reflect the quality of physician care for those specialists who do not have access to salient measures.

For consideration for future reporting years, we recommend that CMS incorporate additional nationally recognized measures for inclusion in PQRI, such as NQF-endorsed "Monthly International Normalization Ratio Measurement". Inclusion of such measures will improve successful participation among sub-specialists. To maximize the availability of NQF-endorsed measures for use in PQRI, we also recommend increased support for consensus development projects that focus on high impact, high cost diseases such as atrial fibrillation.

The Alliance applauds the expansion of the Group Practice Reporting options, especially the addition of GPRO-II. GPRO-II allows a group practice of 2-199 Medicare participating physicians an opportunity to integrate and participate in PQRI. The Alliance opposes the arbitrary cap on the first 500 groups that apply given that this reporting option has the advantage of mid-year interim feedback reports to assist participating groups in determining whether their PQRI data is being captured appropriately by the Agency. The Alliance recommends that all self-nominations postmarked in the month of January, 2011 be accepted for this reporting option. If CMS opts to implement the cap, the Alliance would strongly encourage CMS to designate a percentage of the slots for multispecialty and single-specialty group practices. The Alliance recommends that CMS not restrict the selection of PQRI measures for this reporting option given that multispecialty groups with primary care, multi-specialty groups without primary care, and single-specialty groups will be participating. Restrictions to selected PQRI measures may limit the diversity of practices that elect to report through this option.

Interim Feedback Reports

Since the inception of the PQRI, the Alliance has stated that interim feedback reports and an appeals process should be implemented as part of the program. We are therefore pleased that the ACA included a provision that requires CMS to provide timely feedback to physicians on whether they have satisfactorily submitted data on quality measures. The Alliance appreciates efforts to date by CMS to provide physician participants with feedback on PQRI reporting and performance rates and to improve

the quality and timeliness of these reports. We support CMS's pledge to continue to issue feedback reports on or about the time of issuance of the PQRI incentive payment. However, we remain concerned about CMS' proposal to limit more frequent interim reports to only those physicians reporting 2011 measure groups through the claims-based reporting mechanism. We understand the logic behind starting with those who are required to report a set number of cases (i.e., 30 Medicare beneficiaries). Interim reports would inform these participants how many more cases he or she needs to report to meet the reporting criteria. Nevertheless, we feel strongly that interim feedback reports are a valuable tool for all PQRI participants—even those who have to report a percentage of applicable cases. Interim feedback reports provide physicians with information related not only to progress, but to errors in quality data submission which are common when relying on a claims-based reporting system. The Alliance urges CMS to make interim feedback reports available to any and all PQRI participants using a claims-based reporting option. CMS should provide this feedback while the reporting period is ongoing (e.g., based on first quarter claims data), but especially prior to the start of the 6-month reporting period so that physicians can adjust reporting practices accordingly. If limited resources are a barrier to CMS providing interim feedback to all PQRI participants, the Alliance recommends that CMS at least give participants the opportunity to receive interim feedback reports upon request.

Appeals Process

The Alliance also appreciates that the ACA requires CMS to create an informal appeals process through which physicians who do not qualify for the PQRI incentive can request a review of a determination that quality measure data was not reported satisfactorily. Beginning January 1, 2011, physicians will have 90 days to electronically file an "informal appeal." We do not feel 90-days is an adequate time period for physicians to file an appeal and instead request that physicians be given through the end of the reporting year. Some physicians in large practices may not even see their PQRI report for a month or two after CMS sends it. . We also support electronic submission of these requests, which will help to ensure a timely, streamlined process. As CMS gets more experience with this process, we hope it will aim to minimize its response time to these request to less than 60 days so that it does not delay the flow of reporting and so that physicians can promptly apply any lessons learned to current reporting efforts. As CMS becomes more familiar with reviewing appeal requests, we hope that it will work with Congress to implement a more formal appeals process that includes standardized and transparent rules for submitting and reviewing evidence, especially as penalties apply to satisfactory PQRI reporting in 2015. A formal appeals process should balance consistency in decision-making with timely resolution of cases. It should also include multiple levels of appeal beyond what in 2011 will be an initial and *final* determination. Formalizing the appeal process and expanding opportunities to challenge a determination will be especially critical as the PQRI transitions from positive incentives to payment penalties.

Incentives for Electronic Prescribing (e-prescribing) – The Electronic Prescribing Incentive Program

The Alliance recognizes the value of e-prescribing and appreciates the continuation of the e-prescribing incentive program into 2011. We also support CMS' proposal to modify the requirements for 2011 so that physicians need only report on twenty-five services involving e-prescribing. However, we have serious concerns about CMS' proposal to impose financial penalties in 2012 and 2013 based on a physician's e-prescribing activity during the first six months of 2011. Most physicians will be unaware that the 2012 and 2013 penalties are based on the 2011 reporting year, which begins January 1, 2011, and may fail to successfully e-prescribe and be subject to the penalty. We encourage CMS to ensure

consistency with its other reporting programs and use a look-back period of no more than one year to assess penalties in 2012 and 2013. Furthermore, we strongly recommend that CMS add more exemption categories to account for physicians facing hardships. Finally, we request that CMS provide regular feedback reports on physician participation in the e-prescribing program (also see PQRI section) and create a standardized appeals process for physicians that want to appeal determinations related to eligibility and incentive qualification

Productivity Adjustment regarding the Ambulatory Surgical Center Fee Schedule

In applying the multifactor productivity (MFP) adjustment to the ambulatory surgical center (ASC) annual payment update, we are pleased that CMS proposes to hold the consumer price index for urban consumers (CPI-U) update factor to zero in the instance where the percentage change in the CPI-U for a year is negative. While our societies believe it is unfair to use CPI-U as the update factor for ASCs, we believe that CMS is correct in its interpretation that the “percentage increase” in the CPI-U, which must be determined before applying the MFP adjustment, cannot be a negative number.

As required by statute, the productivity adjustment must be equal to the 10-year moving average of changes in annual economy-wide, private, non-farm business MFP, as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period. As specified in the proposed rule, the end of the 10-year moving average of changes in the MFP would coincide with the end of the CPI-U timeframe (beginning with July 1 of the previous year and ending with June 30 of the current year). We believe that the proposed 10-year moving average window could result in an MFP adjustment for ASCs that is different from the MFP adjustment for providers paid on a fiscal year basis (hospitals). We believe that this difference could become yet another factor that causes further divergence in ASC and hospital outpatient department (HOPD) payment rates. The Alliance requests that CMS develop one MFP adjustment for providers for which the 10-year moving average window would not vary by calendar or fiscal year.

Thank you for your attention to our concerns and to the unique needs and contributions of specialty medicine. We would be happy to discuss the issues raised in further detail, as needed. We are also pleased to congratulate you on your appointment as Administrator. We look forward to working with you to meet the needs of Medicare and Medicaid patients. Please contact: Inger Saphire-Bernstein (410.689.3745) isaphirebernstein@auanet.org or Joel Harder ((202) 552-0910), JHarder@scai.org if you have any questions on this letter

Sincerely,

American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
Heart Rhythm Society
National Association of Spine Specialties
Society for Cardiovascular Angiography and Interventions

