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August 31, 2012

Ms. Marilyn B. Tavenner

Acting Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1590-P

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, DME Face to Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013

Dear Ms. Tavenner:

On behalf of the more than 78,000 members of the American College of Surgeons (ACS), we appreciate the opportunity to submit comments to the proposed rule: *Medicare Program; Payment Policies under the Physician Fee Schedule, DME Face to Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013* (Proposed Rule) that was published in the *Federal Register* on July 30, 2012. The ACS is a scientific and educational association of surgeons, founded in 1913, to improve the quality of care for the surgical patient by setting high standards for surgical education and practice.

PROVISIONS OF THE PROPOSED RULE

Resource-Based Practice Expense Relative Value Units

Specialty Mix for Low Volume Services

The Centers for Medicare & Medicaid Services (CMS) proposed to calculate the specialty mix for low volume services (fewer than 100 billed services in the previous year) using the same methodology that is used for non-low volume services instead of the current methodology, which uses the dominant specialty. CMS states that the dominant specialty tends to change from year to year, resulting in fluctuations in practice expense (PE) relative value units (RVUs).



While we agree that the proposed methodology might expedite this step of the PE RVU calculation, we believe that errors in reporting might still result in continued variation from year to year. In the past, the American Medical Association/Specialty Society Relative Value Scale Update Committee (AMA RUC) has sent CMS specialty assignment information for all codes reported less than 100 times per year based on a deliberative discussion. The intent was for CMS to use this information as a hard stop entry for purposes of calculating practice expense RVUs. This would have eliminated year to year fluctuations for low volume codes, many of which are surgical procedures that are rarely performed or not typically performed in the Medicare population, such as pediatric surgery. As such, CMS chose to use the *dominant* specialty for each of the low volume services; however, the agency now proposes to use *all* specialties with claims for a code. We disagree with CMS's proposal, which we believe will result in erroneous data and will disadvantage specialties that perform rare procedures and services. Instead, we urge CMS to work with the AMA RUC to update the specialty assignment list for low volume codes and to use that data in the PE RVU formula.

Equipment Cost per Minute

CMS proposes to replace the interest rate used in calculating equipment-related PE RVUs (finalized in calendar year (CY) 1998) with a "sliding scale" approach based on the current Small Business Administration (SBA) maximum interest rates for different categories of loan size (price of the equipment) and maturity (useful life of the equipment). We agree with this approach and also with CMS's adoption of the prime rate as the base rate for the calculation, rather than the London Interbank Offered Rate (LIBOR), or an optional peg rate, both of which are options in the SBA maximum interest rate formula.¹

Potentially Misvalued Codes under the Physician Fee Schedule

Improving the Valuation of the Global Surgical Package

CMS seeks comments on methods for obtaining accurate and current data on evaluation and management (E/M) services furnished as part of the global surgical package. In the proposed rule, CMS reviews the results of several studies by the Office of Inspector General (OIG) that have called into question

¹ The optional peg rate is a weighted average of rates the Federal government pays for loans with maturities similar to the average SBA loan. It is calculated quarterly and published in the Federal Register.

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whether E/M services in various global surgical packages are actually furnished to Medicare beneficiaries. Specifically, the studies indicated that in the limited number of records reviewed, the E/M services do not match the current CMS time and visit database.

Global surgical payments are based on typical work, but allow for variations in the actual post-operative services that may result in more or less work than the typical. According to the surgical package definition in the surgery guidelines of Current Procedural Terminology (CPT[®]), “the services provided by the physician, as part of the global surgical package, to any patient by their very nature are variable.”² We have serious concerns that the OIG review lacks credibility due to the fact that it is based on limited data. The OIG report is based on a review of 300 claims for almost 300 procedure codes, which results in a small subset of claims reviewed per procedure. Furthermore, many of the codes identified by the OIG have since been reviewed by the AMA RUC as potentially misvalued services with reductions in relative value work units and reductions in visits. Therefore, it is not surprising that the OIG’s random selection of a few patient files per code from 2007 shows variation from what has been determined to be typical.

We also acknowledge that documentation problems could make it difficult to determine which services were actually furnished, since these services are not typically billed separately under a global surgical policy. It is important to note that documentation guidelines have never been designed nor proposed for application in global period. In other words, failure to find documentation of each and every E/M service furnished during the global surgical period is not definitive evidence that the services were not furnished. The proposed rule acknowledges as much.

The AMA RUC collects data on the level of E/M visit, while the OIG report did not. The OIG review should not be considered to be more reliable than the information obtained from the national medical specialty societies and peer reviewed by the AMA RUC. The ACS continues to support the AMA RUC’s thoughtful and deliberative process for evaluating codes, which utilizes standard physician work estimation surveys to set the global surgical payment. As a peer review group, all specialties participate and judge the data as presented. Isolated cases and anecdotal information are not accepted as typical. If further study of this issue is to be done, we urge CMS to continue to work with the

² American Medical Association. CPT 2012 Professional Edition. American Medical Association Press. ISBN 978-1-60359-568-1. P54.

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AMA RUC and specialty societies to complete a rigorous and thorough review of a large representative sample of AMA RUC-reviewed procedure codes.

Expanding the Multiple Procedure Payment Reduction Policy

CMS proposes to apply a 25 percent multiple procedure payment reduction (MPPR) to the technical component of certain diagnostic cardiovascular services and certain diagnostic ophthalmology services. As the rationale for this proposal, the agency uses a CMS analysis of the most frequently furnished code combinations for all diagnostic services using CY 2011 claims data. Of the several areas of diagnostic tests that CMS examined, the agency found that billing patterns and PE inputs indicated that cardiovascular and ophthalmology diagnostic procedures, respectively, are frequently furnished together and that there is some duplication in PE inputs when this occurs. The CMS analysis eliminated the lower number of minutes for each duplicated clinical activity in a code pair and used this as support for proposed payment reductions in the form of the MPPR. CMS states that the cardiovascular and ophthalmology services proposed represent codes frequently billed together and that various clinical labor activities would not be duplicated for subsequent procedures.

The ACS has generally supported the MPPR policy in the past because we agree that under certain circumstances there could be potential efficiencies during imaging procedures involving contiguous body areas, within a family of codes, and provided to the same patient at the same session. However, we have concerns with this proposal and, in particular, the findings of its analysis that there is duplication in PE inputs when these codes are furnished together on the same date of service. CMS' methodology of eliminating the smaller number of minutes assigned to one code in the frequently performed together code pairs for clinical staff and equipment is not appropriate for pairs of services that are performed in different types of rooms and that are also performed by different types of clinical staff. For example, CMS states that "greeting and gowning" the patient would not be duplicated for the subsequent diagnostic services furnished on the same day. However, if the patient has the second service performed in a different type of room, time is going to be spent during the subsequent test to greet and re-gown the patient. The same argument is true for time being spent under both service codes for the equipment and supplies of both rooms and the cleaning of both rooms. Thus, we recommend that prior to implementing this policy, CMS conduct its study again with a new methodology that takes into account the frequency of different types of rooms and different types of clinical staff involved in the services that are performed together on the same day.

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Primary Care and Care Coordination

Post-Discharge Care Management

The ACS generally believes that transitional care management services are important for those beneficiaries who require care above and beyond what is currently captured in discharge management and post-op office visits; however, we have reservations about this code and how CMS proposes to define patient eligibility. We also have concerns about the current utilization estimate.

Utilization Estimate

For budget neutrality calculations, CMS estimates that physicians or qualified non-physician practitioners would provide post-discharge transitional care management services for 10 million discharges in CY 2013. CMS states that this number “roughly considers the total number of hospital inpatient and SNF discharges, hospital outpatient observation services and partial hospitalization patients that may require moderate to high complexity decision-making.”³

Our review of 2010 Medicare data shows approximately 29 million claims for facility procedures with a global period of 000, 010, or 090 and approximately 10 million claims for all discharge management codes. CMS’s estimate of 10 million claims for the new G-code implies that CMS believes that 25 to 35 percent of both medical and surgical Medicare patients discharged from a facility or SNF will require moderate to high complexity decision-making. We believe this is a significant overestimation of utilization as not every discharge will require this level of care coordination, resulting in an inappropriate application of budget neutrality calculations. This overestimation also exaggerates the actual benefit that primary care and others able to utilize this code will receive.

Another concern with respect to the CMS estimate for utilization is the lack of auditable guidance regarding what constitutes a moderate or high complexity patient (e.g., four or more co-morbidities) requiring transitional care. We do not

³ “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face to Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013; Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Quality Improvement Organization Regulations; Proposed Rules,” 77 Federal Register 146 (30 July 2012) 44779.



believe that it is appropriate to “crosswalk” from the current CPT medical decision making matrix. The ACS believes that the definition of moderate to severe complexity needs additional clarification on what exactly constitutes complexity. We believe that without a clear definition of what constitutes complexity, essentially every Medicare beneficiary will qualify, which is not the intention of this code.

We urge CMS to utilize the expertise of the CPT Editorial Panel and AMA RUC Workgroups that have been studying this issue to determine a more realistic estimated Medicare utilization for a new transitional care code, along with guidelines for appropriate reporting.

Transitional Care Reporting in the Event of a Readmission Within a 30-day Period

CMS proposes to pay only one claim for the post-discharge transitional care G-code billed per beneficiary at the conclusion of the 30-day post-discharge period. Post-discharge transitional care management relating to any subsequent discharges for a beneficiary in the same 30-day period would be included in the single payment.

CMS has stated that care management involving the transition of a beneficiary from care furnished by a treating physician during a hospital, SNF, or Community Mental Health Center (CMHC) stay to the beneficiary’s primary physician in the community can avoid adverse events such as readmissions or subsequent illnesses, improve beneficiary outcomes, and avoid a financial burden on the healthcare system. In addition, CMS notes that the Patient Protection and Affordable Care Act (ACA) requires CMS to reduce hospital readmissions. CMS has also indicated that hospitals may be penalized for readmissions for certain conditions.

Given this information, we recommend that CMS develop a mechanism to monitor readmissions for patients receiving transitional care to determine if this effort positively impacts beneficiary outcomes and decreases the burden on the healthcare system. To do this, physicians would need to report transitional care at the *beginning* and end of the care period. CMS would not be able to determine readmission rates for transitional care patients if physicians chose not to report the new G-code because of readmission. This may require a “start” and a “stop” modifier to the new G-code, where GXXX1-start is reported on the day of discharge and GXXX2-stop is reported 30 days later for payment. These “tracking” modifiers are similar to CMS’s modifier AI (physician of record) that

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is appended to 99221 to designate the admitting physician. Not only will this provide CMS with the information necessary to correctly pay claims according to the payment rules CMS has articulated in this proposal, but it will also provide valuable information over time identifying whether the care that is supposed to be delivered in association with this code is achieving the intended results.

Transitional Care Reporting by Physicians Who Report a Discharge Day Management Code

In defining post-discharge transitional care management, CMS indicates that the agency believes the discharge management codes accurately describe the work related to discharging a patient from a facility. The CPT[®] guide states that hospital discharge services (99238 and 99239) include, as appropriate, final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.⁴ With respect to the current E/M office or other outpatient visit CPT codes, CMS indicates that these codes do not appropriately describe comparable care management work for the beneficiary post-discharge.

We believe that 99238 and 99239 sum up the hospital stay and lay out a plan for further care and that the office visit codes will assess patient status at some time post-discharge. We further believe the post-discharge transitional care code is meant to pay for work during the gap between a patient's discharge and when the patient comes to a physician's office for a face-to-face assessment.

We urge CMS to recognize the work of transitional care management as distinct from 99238 and 99239 (Hospital discharge day management) and allow reporting, as appropriate, by physicians who also report discharge day management codes.

Transitional Care Reporting by Physicians Who Report a 010- or 090-Global Surgical Service

As discussed above, transitional care management is distinct from discharge day management and episodic or acute office visit work. Facility discharge day management and follow-up office visits related to the surgical procedure are

⁴ American Medical Association. CPT 2012 Professional Edition. American Medical Association Press. ISBN 978-1-60359-568-1. P17.



inherent to the work of 010- and 090-day global surgical services. The discharge day management is consistent with the CPT description for codes 99238 and 99239 (i.e., includes, as appropriate, final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms).⁵ The follow-up office visits within the global period are those required and related only to the surgical event. For example, CPT code 44140 Colectomy, partial; with anastomosis, the post-service office work describes:

“Examine and talk with patient. Monitor healing of incision with appropriate physical examination, including answering questions from patient and family. Remove sutures and staples, when appropriate. Monitor diet caloric intake by weight. Arrange for dietary consultation as needed. Review pathology report in response to family/patient questions. Answer patient/family questions. Write medication prescriptions. Post discharge labs/films are ordered and reviewed, as necessary. Begin routine surveillance for recurrent tumor. Discuss schedule of tumor marker and imaging surveillance. Discuss the need for postoperative chemotherapy with patient. Offer referral to cancer support groups. Discuss progress with referring physician(s) (verbal and written). Discuss case with oncologist and prepare documents for transmission to that office. Dictate progress notes for medical record.”⁶

However, for some surgical patients, especially those cared for by general surgeons, the surgeon is responsible for transitional care management that relates to the complex patient needs, in addition to post-surgical needs.

For this reason, we believe that physicians reporting a 010- or 090-day global code should also be allowed to report the new transitional care management code, if all required work is performed and documented, as these transitional

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⁵ American Medical Association. CPT 2012 Professional Edition. American Medical Association Press. ISBN 978-1-60359-568-1. P17.

⁶ CodeManager® 2012 with Netter's Atlas of Human Anatomy for CPT® Coding Quarter 2



care management services are distinct from discharge day management work, and therefore, are distinct from the services in the 010- and 090-day globals.

Transitional Care Management G-code Payment

In developing payment for this new G-code, CMS recognizes the significant non-face-to-face work performed by qualified healthcare providers for patients within 30 days after discharge and in addition to typical services related to an office visit. The services described by CMS that are part of the proposed new code are, for the most part, not inherent to either discharge management or office visit codes.

In the proposed rule CMS specifically states “we have explicitly constructed this proposal as a payment for non-face-to-face post-discharge transitional care management services separate from payment for E/M or other medical visits.”⁷ As such, the ACS disagrees with the amount of physician time that CMS has assigned the new G-code (i.e., 38 minutes). Given all the discussion surrounding transitional care and complex care management over the past few years and based on the AMA RUC work to develop payment for the medical home, we believe the new G-code should have minimal physician time and possibly different and more clinical staff time than proposed by CMS. We believe that much of the physician time is captured in E/M codes that would be utilized during the occurrence of face-to-face visits. Therefore, we urge CMS to consider coordinating establishment of payment for this new code with the ongoing CPT and AMA RUC efforts related to transitional and chronic care management.

OTHER PROVISIONS OF THE PROPOSED REGULATION

Durable Medical Equipment Face-to-Face Encounters and Written Orders Prior to Delivery

CMS proposes to add an additional condition of payment for certain covered items of durable medical equipment (DME) in order to reduce the risk of fraud, waste, and abuse. For these items, a physician must have documented and communicated to the DME supplier that the physician or a physician assistant, a nurse practitioner, or a clinical nurse specialist has had a face-to-face encounter with the beneficiary no more than 90 days before the order is written or within 30 days after the order is written. CMS states that requiring a face-to-face

⁷ *Supra* fn 3 at 44778.



encounter that supports the need for the covered item of DME would reduce the risk of fraud, waste, and abuse since these visits would help ensure that a beneficiary's condition warrants the covered item of DME. CMS estimates the overall economic impact of this proposal on the health care sector to be a cost of \$49.95 million in the first year and \$285.2 million over five years. The total beneficiary impact is estimated at \$29.75 million in the first year and \$161 million over five years.

We support CMS' efforts to strengthen the integrity of the Medicare program and to protect the program from fraud, waste, and abuse. We also support steps CMS has taken to enable beneficiaries to receive more appropriate DME and benefit from higher quality care. We believe that this specific DME proposal, however, is too broad. We encourage CMS to focus on the top five or ten items of DME that truly present the highest risk of fraud, waste, and abuse, rather than the entire specified list of 175 items of DME. According to the Medicare Fee-for-Service 2011 Improper Payments Report of the Comprehensive Error Rate Testing (CERT) programs, oxygen supplies, glucose monitoring supplies, and nebulizers with related drugs had the highest incidence of improper payments within the realm of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS), accounting for 4.1 percent, 3.3 percent, and 1.4 percent of the total Medicare FFS projected improper payments, respectively. These three DMEPOS groups accounted for approximately 45 percent of the DMEPOS improper payments in the 2011 reporting period.⁸ Power mobility devices and positive airway pressure devices also ranked high, according to the report.⁹ A more narrow and concentrated focus of this proposal would also reduce the beneficiary impact of this proposal. In addition, starting in a more focused way would allow CMS to evaluate the impact of the new policy before deciding whether it should be expanded to other items.

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⁸ Centers for Medicare & Medicaid Services, *Medicare Fee-for-Service 2011 Improper Payments Report*, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf>.

⁹ *Id.*



The Electronic Prescribing Incentive Program

The 2014 Payment Adjustment: Proposed Criterion for Being a Successful Electronic Prescriber for Groups Comprised of 2-24 Eligible Professionals Selected to Participate Under the eRx GPRO

For the 2013 incentive, groups participating via an electronic prescribing (eRx) Group Practice Reporting Option (GPRO) comprised of two to 24 eligible professionals (EPs) would need to report the eRx measure's numerator code during a denominator-eligible encounter at least 225 times during the 12-month 2013 incentive reporting period (January 1, 2013-December 31, 2013). For the 2014 payment adjustment, CMS proposes to still require reporting at least 225 times, but now only in a six month reporting period (January 1, 2013-June 30, 2013).

We believe that groups consisting of two versus 24 EPs are significantly different. Particularly for the smaller groups, applying the 225 prescription requirement to groups with considerable variation in size does not seem reasonable. We recommend that instead of requiring an actual number of prescriptions, CMS use percentages and thresholds similar to the eRx requirement in the Electronic Health Record (EHR) Incentive Program. We believe that will better align both of the programs. In the event that CMS is not willing to move to a percentage threshold, we ask that CMS reduce the 225 prescription requirement in the 2014 six-month performance period (January 1, 2013-June 30, 2013) by half since the 2013 proposal also requires 225 prescriptions but to be achieved within a full 12-month period.

Proposed Significant Hardship Exemptions:

CMS proposes to add two related additional significant hardship exemptions for the 2013 and 2014 eRx payment adjustments in addition to the four that were finalized in the 2012 MPFS:

- Eligible Professionals or Group Practices Who Achieve Meaningful Use During Certain 2013 and 2014 eRx Payment Adjustment Reporting Periods; and
- Eligible Professionals or Group Practices Who Demonstrate Intent to Participate in the EHR Incentive Program and Adoption of Certified EHR Technology.

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The ACS appreciates and supports CMS' inclusion of these additional exemptions; however, we strongly recommend that should CMS require EPs to apply for these EHR-related significant hardship exemptions, the application process should allow EPs to submit limited information since CMS has access to the EHR data needed to make the exception determinations. We urge CMS to clarify how the agency will proceed with implementation of these hardship exemptions.

Proposed Deadlines and Procedures for Requesting Significant Hardship Exemptions for the 2013 and 2014 eRx Payment Adjustment

CMS proposes that in order to request an exemption for the 2013 eRx payment adjustment, CMS would analyze the information provided in the Registration and Attestation System for the EHR Incentive Program to determine whether the eligible professional or group practice has either: (1) achieved meaningful use under the EHR Incentive Program during the applicable reporting periods; or (2) registered to participate in the EHR Incentive Program via the Registration and Attestation System for the EHR Incentive Program and adopted certified EHR technology (CEHRT), or both, if applicable.

For the newly proposed exemption regarding "intent to participate," the EP must provide its CEHRT product number when registering for the EHR Incentive Program. If it is not operationally feasible to accept this information via the Registration and Attestation system for the EHR Incentive Program, CMS proposes the agency would access requests for significant hardship exemptions via a mailed letter to the Office of Clinical Standards and Quality. CMS is only proposing submission of requests for these proposed exemptions at an individual EP level. CMS proposes that EPs within an eRx GPRO may, as individuals, request a significant hardship exemption.

While we appreciate the addition of the newly proposed exemption categories, we believe that it will be overly burdensome for each individual EP who is part of a GPRO to apply for the proposed exemptions as individuals. We urge CMS to find a more streamlined alternative for these individuals to receive an exemption for the 2013 payment adjustment.

For 2014, CMS proposes that requests for a significant hardship exemption for the 2014 eRx payment adjustment be submitted by the Communications Support Page by June 30, 2013. CMS is also considering accepting requests by the proposed submission process for the 2013 payment adjustment, receiving EPs' information through the Registration and Attestation System for the EHR

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Incentive Program and via a mailed letter to the Office of Clinical Standards and Quality. We would appreciate if CMS allows for as many options as possible. Thus, we would be supportive of all of the proposed options.

Physician Quality Reporting System (PQRS)

Group Reporting

CMS proposes to change the number of EPs comprising a PQRS group practice from 25 or more to two or more. For 2013 and beyond, CMS also proposes that group practices interested in participating in GPRO must submit their self-nomination and include which single reporting mechanism the group intends to use (claims, registry, EHR, or the administrative claims option). Once a group is approved for GPRO participation by CMS, the group would not be allowed to change this reporting mechanism. While we are generally supportive of this proposal, we believe that groups should be allowed to change their reporting mechanism during the calendar year should they feel the need to report through another option. For example, if a group is reporting through claims, and an applicable registry becomes available later in the year, the groups should be allowed to switch.

Reporting Period

CMS says it intends to move to using only 12-month reporting periods for the 2017 payment adjustment; the sole reporting period would be January 1, 2015 through December 31, 2015. We would urge CMS to tie the payment adjustment year closer to the reporting period for the payment adjustment so that there is less lag time between the two. This two year look-back policy unfairly accelerates the date by which EPs must meet PQRS requirements to avoid penalties. In order to support improvements in quality, financial incentives (positive or negative) need to be linked to clearly identifiable actions or behavior. The proposed two-year lag creates a disconnect between the performance of participating EPs and the financial incentives, thus undermining the opportunities for improvement. We advocate CMS decrease the lag time for *all* of the CMS quality reporting programs.

Registry-Based Reporting

For the 2015 payment adjustment, CMS previously adopted CY 2013 (January 1, 2013-December 31, 2013) as the reporting period. For the 2015 payment adjustment, CMS now proposes to add a six-month reporting period (July 1,

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2013-December 31, 2013) for the reporting of measures groups via registry. Similarly, for the 2016 payment adjustment, CMS proposes the same 12-month and six-month reporting periods but for the year 2014. We are supportive of the addition of a six-month reporting period for reporting measure groups via registry. However, we strongly urge CMS to tie the payment adjustment year closer to the performance year.

For the registry-based reporting method for 2013, CMS proposes to reduce the threshold from 30 to 20 Medicare Part B FFS patients. For reporting measures groups via registry, CMS proposes to change the criteria to require reporting for “at least 20 patients, a majority of which must be Medicare Part B FFS patients” for both the 12-month and six-month reporting option. The ACS supports lowering the threshold from 30 to 20 patients for registry-based reporting. The ACS also supports the inclusion of some non-Medicare patients as it will allow for more reliable data collection. Also, while our understanding of the word “majority” is “50 percent plus one” or more of patients, we seek clarification on what CMS specifically means by “majority,” especially since the proposed rule acknowledges that a patient’s personal identification information may be stripped when data is collected via a qualified registry and that it may be difficult to distinguish Medicare and non-Medicare patients. In fact, the proposed rule explicitly says that “the reporting of some non-Medicare patients could serve as a proxy for the reporting of Medicare patients whose data is not easily distinguishable as data on Medicare patients under [the registry] reporting mechanism.”

CMS proposes to audit qualified registries and any registry found to have submitted “grossly inaccurate data” (for example, inaccurate tax identification numbers or National Provider Identifier numbers on five percent or more of the registry’s submission) would be disqualified from the subsequent year under the PQRS program; the decision to disqualify would be final. The ACS believes that for the first year a newly qualified registry is approved, that the registry should be given a higher threshold (greater than five percent inaccuracy). If inaccuracies do exist, we believe that many registries in the first year of operation are able to address issues once they are identified. For this reason, we would recommend that CMS should not apply this low threshold until the second year of participation in PQRS. We believe that this is appropriate for newly qualified registries, but not those that already have a record of participation in PQRS.

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EHR- Based Reporting

CMS does not intend to require qualification of EHR products beyond 2013 or post a list of qualified EHR vendors and their products. As a result, EPs “would need to work with their respective EHR vendor to determine whether their specific EHR product has undergone any testing with the PQRS and/or whether their EHR product can produce and transmit the data in the CMS-specified format and manner.”¹⁰ The ACS does not support this. Providers should have a guarantee from CMS that their EHR meets the necessary qualifications for participation in PQRS rather than pure reliance on their vendor. In addition, we believe that, due to the confusion between the various reporting programs, providers may assume that their certified electronic health record system may be automatically qualified for PQRS reporting. CMS should continue to provide a list of EHR products qualified to participate in the PQRS program.

For 2014, CMS proposes to align the PQRS EHR reporting option with the proposed EHR Incentive Program reporting options depending on which Stage 2 proposal is finalized.¹¹ We had commented in the EHR Stage 2 proposed rule that we appreciate CMS’ efforts to align the two programs, but we strongly urged CMS to further expand the list of clinical quality measures (CQMs) to include more measures in PQRS, and to not require physicians to report on core measures or measures within a specific domain if those measures do not apply to their practice. Many of the measures that were proposed were weighted toward primary care and preventive medicine and difficult for specialists to meet.

However, CMS has recently released the EHR Stage 2 final rule, in which the agency finalized a hybrid Option 1: it has reduced the number of CQMs that must be reported on (from 12 to nine); decreases the total number of domains required to be covered by the selected CQMs (from six to three); and recommends, but does not require, reporting from a core set of CQMs. CMS also finalized the option to report quality measures through the PQRS EHR

¹⁰ *Supra* fn 3 at 44811.

¹¹ The EHR Incentive Program Stage 2 proposed rule outlined two options for restructuring the reporting of Clinical Quality Measures: Option 1a: select and submit 12 clinical quality measures available for EHR-based reporting including at least 1 measure from each of the following domains: —(1) patient and family engagement, (2) patient safety, (3) care coordination, (4) population and public health, (5) efficient use of healthcare resources, and (6) clinical process/effectiveness; or Option 1b: submit 12 clinical quality measures composed of all 11 of the proposed Medicare EHR Incentive Program core clinical quality measures as specified and plus one1 menu clinical quality measure as specified.



Reporting Option rather than having to choose from the EHR Meaningful Use CQMs. We are appreciative of this change.

CMS also notes that an EP meeting the CQM component of meaningful use during the PQRS 2015 and 2016 payment adjustment reporting periods (during CY 2013 and CY 2014, respectively) using a direct EHR product or EHR data submission vendor that is certified EHR technology would be able to meet the requirements for satisfactory reporting for the 2015 and 2016 PQRS payment adjustments by submitting a single set of data. The ACS supports this proposal.

GPRO Web-Interface

In addition to the 18 measures proposed for the GPRO Web-interface, CMS also proposes to add a patient experience survey-based measure, such as, but not limited to, the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for group practices participating in the PQRS GPRO and for Accountable Care Organizations (ACOs). In terms of including a CAHPS survey as one of the measures required to be reported on for the Web-interface GPRO, we believe that this measure should be made voluntary as it is expensive to administer, especially if groups are required to administer this for years beyond 2013. If it is not feasible for CMS to separate this measure out from the GPRO Web-interface, we ask that CMS make this measure elective. In addition, using the CG-CAHPS is not equally meaningful to all members of a multi-specialty group such as the surgeon members, for example. Therefore, we urge CMS to also consider adding the CAHPS Surgical Care Survey (S-CAHPS) as a measure (NQF # 1741) since it would be more meaningful for surgeons who are part of a multi-specialty group (or a large single specialty surgical group) to use instead of the CG-CAHPS. In regard to publicly reporting the CAHPS survey data on Physician Compare, please see our comments in the Physician Compare section, below, of this letter.

In terms of the GPRO Web-Interface reporting mechanism, CMS believes it is necessary to limit its use to group practices of 25 or more EPs because the 18 measures used for this reporting option reflect a wide variety of disease modules and make it ideal for large group practices that are more likely to be multi-specialty practices. We ask CMS to clarify the requirements of this reporting option and the information that will be posted on Physician Compare. If a provider reports a zero on any of the 18 measures, what will be published on Physician Compare? Secondly, the ACS is not supportive of the fact that groups of 100 or more EPs would only be allowed to report via the GPRO Web-

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Interface or the Administrative Claims Option (discussed in more detail below). We believe that the GPRO Web-Interface Option and the Administrative Claims Options are limiting in that they only allow groups to report on a limited set of measures. We also believe that the GPRO Web-Interface option would be overly burdensome for single-specialty group practices, especially since it forces them to report on the CG-CAHPS measure. We have provided more comments on this issue in the Physician Compare section, below, of this letter. We also believe that CMS should provide groups of 100 or more EPs with the same level of flexibility offered to smaller groups so that groups of 100 or more can select measures that are more appropriate for the patients the practice treats.

Administrative Claims Option

For purposes of reporting for the 2015 and 2016 PQRS payment adjustments, CMS proposes a new reporting mechanism, the administrative claims option. Under this, CMS would analyze every EP's or group practice's Medicare claims to determine whether the EP or group has performed any of the clinical quality actions indicated in a specific set of measures. While we appreciate CMS offering an additional reporting mechanism, we seek clarification on this reporting option. Would the information reported through the administrative claims option eventually be posted on Physician Compare? Furthermore, despite the discussion of attribution of quality under this reporting mechanism in the value-based payment modifier section of the proposed rule, it is unclear how CMS will attribute patients to a physician under this option. We discuss areas for clarification regarding attribution in the value-based payment modifier section, below, of this letter. We urge CMS to adopt the same attribution methodology for the administrative claims option for the purposes of avoiding the PQRS payment adjustment in 2015 and 2016 *and* for the administrative claims option for the purposes of the value-based payment modifier.

For EPs and group practices using the administrative claims option, the proposed satisfactory reporting criteria for purposes of the 2015 and 2016 payment adjustments would be the inclusion of all measures in Table 63 of the proposed rule for 100 percent of the cases to which the measures apply. CMS also says that it considered the option of defaulting to the administrative claims option for those EPs who report using a different PQRS reporting mechanism but fail to meet the criteria for satisfactory reporting. Once again, we are not prepared to provide comment on defaulting physicians to this option without more details on the mechanism for implementation.

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We also urge CMS to exclude the proposed All Cause Readmission measure from the list of measures in the Administrative Claims Option. First, we request that CMS provide clear measure specifications for this measure. The proposed rule references the ACO All Condition Readmission Measure, but other factors could come into play, especially if applied to the value-based payment modifier as discussed below. For example, shortcomings in the risk adjustment as applied to an ACO covering 5,000 or more beneficiaries would only be exacerbated when applied to individuals or smaller groups.

The rationale to exclude the All Cause Readmission measure is based on findings that conclude current risk adjustment models perform poorly. A recent systematic review of risk adjustment models in the *Journal of the American Medical Association* found that “models of patient-level factors such as medical comorbidities, basic demographic data, and clinical variables are much better able to predict mortality than readmission risk. Broader social, environmental, and medical factors such as access to care, social support, substance abuse, and functional status contribute to readmission risk in some models, but the utility of such factors has not been widely studied.”¹² The article then explains that “the success of some models in certain populations and the lack of success of others suggest that the patient-level factors associated with readmission risk may differ according to the population studied.”¹³ Furthermore, the following quote argues against the use of risk models to compare hospitals, but we believe this rationale applies to groups of physicians as well:

[T]he poor discriminative ability of most of the administrative models we examined raises concerns about the ability to standardize risk across hospitals to fairly compare hospital performance. Until risk prediction and risk adjustment become more accurate, it seems inappropriate to compare hospitals in this way and reimburse (or penalize) them on the basis of risk-standardized readmission rates. Others have reached similar conclusions, and also have expressed concern that such financial penalties could exacerbate health disparities by penalizing hospitals with fewer resources. Still others have argued that readmission rate is an incomplete accountability measure that fails to consider “the real outcomes of interest—health, quality of life, and value.” Use of readmission rates as a quality metric

¹² Kansagara D, Englander H, Salanitro A, et al. Risk Prediction Models for Hospital Readmission: A Systematic Review. *JAMA*. 2011;306(15):1695.

¹³ *Id.* at 1696.



assumes that readmissions are related to poor quality care and are potentially preventable. However, the preventability of readmissions remains unclear and understudied.¹⁴

Outcomes can vary widely, resulting in potentially unfairly penalizing hospitals and physicians for readmissions that are not under their control. Lastly, if readmission measures are included, they should exclude readmissions for conditions that are unrelated to the original admission, such as “readmission” due to traumatic injury.

Alternative Reporting Option

For the 2015 and 2016 payment adjustments only, CMS proposes an additional alternative reporting method in which EPs and group practices would (only) have to “report 1 measure or measures group using the claims, registry, or EHR-based reporting mechanism.”¹⁵ The ACS is supportive of CMS’ flexibility in adding this alternative reporting method within the PQRS program while we continue to make additional improvements in the program that can provide for more meaningful participation in PQRS. However, in the final rule, we urge CMS to more explicitly acknowledge that this option does not involve any minimum threshold of data or patients, which is what CMS staff has stated during Open Door Forums.

PQRS Quality Measures for 2013 and 2014

The ACS is concerned with the classification of PQRS Measure 19: Communication with the Physician Managing Ongoing Diabetes Care. In table 30 of the proposed rule, CMS has classified this measure as a Clinical Process/Effectiveness measure; however, we believe it would be more appropriately classified as a Care Coordination measure. As the measure domains begin to play a bigger role in Medicare quality programs, it will be particularly important that this measure is appropriately classified.

Physician Compare Web site

The ACS generally believes that Physician Compare, generally speaking, requires additional consultation and development, possibly via townhall meetings and other mechanisms, which will allow specialty societies to work in

¹⁴ *Id.*

¹⁵ *Supra* fn 3 at 44824.



collaboration with CMS. For example, we would like to serve as a resource for CMS to help determine what type of information beneficiaries need regarding surgical care. There are many problems with the current version of Physician Compare that range from incorrect addresses to inaccurate identification of specialty. CMS should carefully review these issues first to ensure that the agency develops an accurate and precise method of collecting, displaying, and updating information on the Web site. Furthermore, CMS should work with specialty societies to make a better determination of what physician information is helpful for a patient in order to help them make an informed decision rather than overwhelming them with an abundance of unnecessary information. Rather than trying to align elements of PQRS and the value-based payment modifier with the Physician Compare Web Site, we strongly urge CMS to distinguish Physician Compare as a public reporting Web site for patients that focuses on communicating validated, meaningful information to patients using statistically significant sample sizes. Our comments are made in an effort to assist in that task.

Reporting Thresholds

CMS previously established a minimum threshold of 25 patients for reporting measure performance on the Physician Compare Web site. CMS now proposes to lower this threshold to 20 patients, beginning with data collected for services furnished in 2013. This would align with the proposed minimum patient reporting thresholds for the PQRS measures group reporting for the 2013 and 2014 incentives, and the proposed reliability thresholds for the physician value-based payment modifier. While we understand the need for CMS to collect information on 20 patients for the PQRS program, we believe that for the purpose of collecting information for public reporting, this sample size is insufficient to apply across all measures. We also strongly believe that CMS should distinguish between what is statistically valid for public reporting versus collecting information for PQRS tracking. CMS should focus on publicly reporting information that is both statistically significant and meaningful for patients. We believe that CMS is confusing data collection and quality improvement activities with public reporting for patients. In short, we urge CMS not to change the minimum threshold for reporting data on Physician Compare.

Basic Practice Information

CMS intends to add whether a physician/other health care professional is accepting new Medicare patients, board certification information, and intends to

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improve the foreign language and hospital affiliation data. CMS also intends to include the names of those EPs who participated in the Medicare EHR Program and the names of those EPs who satisfactorily participated under the PQRS GPRO according to the most recent data available. We request more information regarding the steps CMS will take to ensure the accuracy and reliability of the data the agency hopes to collect. Furthermore, while we understand that some of this information will be obtained through the enrollment information provided by physicians, we question how CMS will collect the rest of the information. We believe that this information is going to require constant updating. If CMS is unable to update physician information in a timely manner, then the information will not be accurate or reliable. Again, we urge CMS to only consider posting information that is truly meaningful to a patient, rather than overwhelming them with too much unnecessary and confusing information.

Reporting Group Performance on Composite Quality Measures

CMS proposes to publicly report composite measures that reflect group performance across several related measures. To this end, Table 35 of the proposed rule includes composite measures for diabetes and coronary artery disease into the PQRS starting in 2013, and CMS says it will consider future development of other composite measures. We ask that CMS clarify whether all members of a multi-specialty GPRO must report on the exact same measures. If so, we urge CMS to clarify how the agency plans on reporting information on Physician Compare in situations where physicians in a multi-specialty group report a zero for a measure they are unable to report. In addition, since CMS intends to include only group-level information on the Physician Compare Web site, the agency should also have a clear disclaimer indicating why individual physician information is not posted so that a patient does not construe lack of information for an individual physician (non-group physicians) in a negative way.

Patient Experience of Care Information

CMS states in the proposed rule that “we propose, no earlier than 2014, to publicly report 2013 patient experience data for all group practices participating in the 2013 Physician Quality Reporting System GPRO, not limited to those groups participating via the GPRO Web-interface, on Physician Compare.” CMS intends to administer and collect patient experience survey data on a sample of the group practices’ beneficiaries. CMS also states that it intends to administer and collect the data for these surveys, at least for 2013, therefore it

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does not anticipate any notable burden on the groups. We have several concerns with this proposal. The ACS is concerned that administering and collecting data on the patient experience survey will not be feasible for CMS or every group practice given the significant cost to administer these surveys in a statistically reliable fashion. We urge CMS to take this factor into serious consideration. In order to obtain meaningful, valid survey results, it is necessary to meet the required sample size for group reporting. These sample sizes have been determined by the Agency for Healthcare Research and Quality's CAHPS Consortium. For example the Clinician & Group CAHPS Survey and the CAHPS Surgical Care Survey recommended sample size for groups of 20 or more is 300 completed surveys. To achieve the recommended 40 percent response rate of 300 completed surveys, CMS would need to administer 750 surveys per group.¹⁶ Furthermore, if CMS adds the S-CAHPS survey as a reporting option on Physician Compare, we would like to highlight that the S-CAHPS measure was validated based on the entire S-CAHPS survey as single instrument and therefore all questions that make up the survey would need to be reported on Physician Compare. Selecting only certain questions compromises the validity of the measure.

In addition, CMS is also proposing an alternate option of providing confidential feedback reports to group practices using 2013 patient experience data before they publicly report future years' data on Physician Compare. This would allow groups to make improvements for patient experience scores if necessary. Under this option, the program year 2014 patient experience data would be the first to be reported on Physician Compare and therefore, this information would be publicly reported no earlier than 2015. The ACS has several questions regarding the alternative option. First, would CMS be incurring the cost of administering the survey only for the first year and then leaving it to the groups to incur the cost of administering the survey for the second non-baseline year? If CMS is incurring the cost of administering the survey and providing groups confidential feedback reports in 2013, and if a group decides not to administer the survey in 2014, what information will CMS post on Physician Compare? Furthermore, in its Regulatory Impact Analysis, CMS should include the cost of administering CAHPS surveys in subsequent years if it intends for groups to administer the surveys themselves. While we are extremely supportive of collecting patient experience of care information and were instrumental in the

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¹⁶ CAHPS® Clinician & Group Surveys and Instructions: Fielding the CAHPS® Clinician & Group Surveys. Rockville, MD: Agency for Healthcare Research and Quality; September 2011. Document No. 1033. Available at https://cahps.ahrq.gov/clinician_group/cgsurvey/fieldingcahps-cgsurveys.pdf.



creation of S-CAHPS and in obtaining National Quality Forum (NQF) endorsement for the survey, we believe it is important for CMS to consider the significant financial obligation of administering a CAHPS survey and recognize that it is likely that many groups, especially smaller ones, will not be able to afford to administer the survey.

Also, in addition to CMS collecting the CG-CAHPS information through the PQRS program, we believe that CMS needs to create an additional method that would allow groups to voluntarily participate. In this case, CMS will need to clearly indicate that the absence of information on the Physician Compare Web site does not imply anything negative about a group.

PQRS-MOC Bonus Participation

CMS further proposes posting the names of those physicians who earned a PQRS Maintenance of Certification (MOC) Program incentive as data becomes available, but no sooner than 2014. The ACS believes that posting the names of physicians who earned the PQRS MOC program incentive payments is not entirely meaningful to a patient. It is not always a physician's choice as to whether to participate in the PQRS MOC bonus. If the physician's medical specialty board decides not to participate in the PQRS MOC program, then the physician is not even eligible to receive the incentive. In addition, we fear that the absence of this information may imply that a physician is not participating in MOC at all, when in reality the PQRS MOC incentive criteria require providers to participate "more frequently" than otherwise required. As such, we believe that the names of physicians who earned the PQRS MOC program incentive should not be posted as it is not meaningful information to patients.

Specialty Society Selected Measures

CMS is also considering allowing measures that have been developed and collected by approved and vetted specialty societies to be reported on Physician Compare as deemed appropriate, and as they are found to be scientifically sound and statistically valid. We are appreciative of CMS' willingness to accept measures from approved and vetted specialty societies. However, we seek clarification on what exactly this would look like, what types of measures CMS is conceptualizing, and whether these specialty-developed measures would replace measures that CMS is considering, or if they would be in addition to what the agency is considering. Should CMS allow measures that have been developed and collected by approved and vetted societies, we ask that CMS consider evaluation criteria used by the leading national quality organizations

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such as the NQF: importance to measure, scientific acceptability, usability, and feasibility.¹⁷

Quality Measure Performance

CMS also proposes to include additional claims-based process, outcome and resource use measures on Physician Compare. As an initial step, CMS proposes to include group level ambulatory care sensitive condition admission measures of potentially preventable hospitalizations, no earlier than 2015, for those group practices comprised of two to 99 EPs participating in the 2014 PQRS GPRO (as well as for ACOs). CMS states that the agency is considering allowing measures that have been developed and collected by approved and vetted specialty societies to be reported on Physician Compare, as deemed appropriate, and as they are found to be scientifically sound and statistically valid. However, according to the ambulatory care sensitive condition admission measures of potentially preventable hospitalizations specifications provided by CMS, this measure has not been tested, and it is unclear which specialty societies approved and vetted this measure. Furthermore, this proposed measure does not have a statement of acceptable minimum sample size within its specifications. We ask CMS for further clarification on the approval of this measure, and do not recommend including this measure on Physician Compare if the measure has not been tested and/or does not have a vetted minimal statistically valid sample size.

The next proposed step by CMS would involve publicly reporting performance rates on quality measures included in the 2015 PQRS and value-based payment modifier for individual EPs. We appreciate this staged process, but between now and 2015, we believe that CMS needs to carefully consider the statistical reliability of this information because sample size needs to be made on a measure by measure basis. A recent analysis showed that 30 observations produced acceptable reliability for only four of 14 widely-used primary care measures, and for some measures acceptable reliability exceeded 200.¹⁸ Also, we believe that publicly reporting on quality measures included in the 2015 PQRS and value-based payment modifier for individual EPs is another example of information that is unnecessary and overwhelming for a patient. To date,

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¹⁷ Romano PS, Hussey P, Ritley D. Selecting Quality and Resource Use Measures: A Decision Guide for Community Quality Collaboratives. Rockville, MD: Agency for Healthcare Research and Quality; May 2010. AHRQ Publication No. 09(10)-0073.

¹⁸ Friedberg MW, Damberg CL. A five-point checklist to help performance reports incentivize improvement and effectively guide patients. *Health Aff (Millwood)*. 2012 Mar;31(3):612-8.



public reports on health care quality information have been difficult for patients to understand and, therefore, have had little impact on patient choice.¹⁹ Therefore, measures reported on Physician Compare should be chosen based on their ability to resonate with patients so that patients are empowered to assess quality information and use it to make health care decisions.

Standards of Care

For all measures publicly reported on Physician Compare, CMS proposes to post a standard of care, such as those endorsed by the NQF. CMS says that such information will serve as a standard for consumers to measure individual provider and group level data. We seek clarification on what CMS means by “standard of care” and if CMS is referring to a formal clinical evidence-based guideline or perhaps evidence that had previously been supplied to support the endorsement or approval of a measure, as well as how this relates to NQF. The NQF creates standards for measurement science but that does not necessarily translate into the standard of care. Furthermore, many consumers and physicians may interpret the “standard of care” as a legal term. We believe that posting this information on the Physician Compare Web site will be overly burdensome and is likely not meaningful to patients. If the standard of care is posted on Physician Compare, we encourage CMS to test the information with patient focus groups to be sure the information is understandable to patients.

Physician Value-Based Payment Modifier and Physician Feedback Reporting Program

Beginning January 1, 2015, the Secretary is required to apply a value-based payment modifier to specific physicians and groups of physicians the Secretary determines are appropriate. The Secretary is then required to apply the payment modifier to all physicians and groups of physicians by 2017.

Group Size

CMS proposes to initially include all groups of physicians with 25 or more EPs in the value-based payment modifier for 2015. To establish group size, CMS

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¹⁹Totten AM, Wagner J, Tiwari A, O’Haire C, Griffin J, Walker M. Public Reporting as a Quality Improvement Strategy. Closing the Quality Gap: Revisiting the State of the Science. Evidence Report No. 208. (Prepared by the Oregon Evidence-based Practice Center under Contract No. 290-2007-10057-I.) AHRQ Publication No. 12-E011-EF. Rockville, MD. Agency for Healthcare Research and Quality. July 2012.



defines EPs as any of the following: (1) a physician; (2) a practitioner (such as a nurse practitioner or physician assistant); (3) a physical or occupational therapist or a qualified speech-language pathologist; or (4) a qualified audiologist. Regardless of CMS' decision with respect to the size of PQRS groups, we urge CMS to increase the number of EPs to establish group size for the value-based modifier from 25 to 200. The CMS GRPO I program required groups to have at least 200 EPs to participate. A group size of 200 was also the starting point for the initial phase of the Physician Feedback Reports. As such, we believe the group size of 200 or more EPs is ideal for the initial implementation of the value-based payment modifier as well. Due to their limited scope, the quality and cost measures currently included in the value-based payment modifier present significant challenges for single-specialty groups; however, groups of 200 or more EPs are more likely to include multiple specialties, which would increase the reliability of the reporting. Multi-specialty groups would also be more likely to report more data on the existing measures. If more data is reported, there is a greater chance the data will be useful and actionable.

In our discussion of the GPRO Web-interface reporting mechanism, above, we express concern that groups of 100 or more EPs are forced to use either the GPRO Web-interface or the administrative claims reporting option for PQRS, both of which restrict the groups to a preselected list of measures. As described above in the PQRS section, we urge CMS to provide groups of 100 or more EPs the same flexibility and access to the variety of measures that is allowed to smaller groups who are also able to use claims, registry, or EHR reporting. If CMS finalizes its proposal to require groups of 100 or more EPs to use only GPRO Web-interface or administrative claims reporting for avoiding the PQRS payment adjustment, it will be even more critical for the value-based modifier to be initially limited to large groups to allow for an "apples-to-apples" comparison of the groups' performance.

Both the set of 18 GPRO Web-interface measures and the set of 15 administrative claims measures are focused on preventive care for chronic disease. However, not all groups of 100 EPs or more are multi-specialty, which means a single specialty group of 100 or more EPs would be forced into a reporting option where they have very few, if any, measures to report. It is one thing for groups to be required to use a limited reporting option for PQRS, but it is a different matter for the application of the value-based payment modifier. Comparing the performance of groups of 100 or more EPs who were restricted to a limited set of measures to the performance of smaller groups who had access to measures that were more applicable to their practice would be

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inequitable for purposes of the value-based modifier. In addition, given the difficulties associated with dissemination of the Physician Feedback reports, limiting the group size to 200 or more EPs would also allow CMS more time to educate physicians on the availability of the reports. As such, we strongly urge CMS to limit the group size for the value-based payment modifier to 200 or more EPs. At the very least, we urge CMS to allow all five reporting options to any size group under the value-based payment modifier.

Additionally, CMS proposes to set the value-based payment modifier at -1.0 percent for those groups of 25 or more EPs that have not met the PQRS satisfactory reporting criteria on PQRS GPRO quality measures for the 2013 and 2014 incentive or the proposed criteria for the satisfactory reporting using the administrative claims-based reporting mechanism. As proposed, physicians who are in groups of 25 or more EPs and who are successfully reporting PQRS as *individuals*, rather than as part of their group, would receive this -1.0 percent adjustment. We urge CMS to not apply the -1.0 percent adjustment to these individuals who are, in fact, satisfactory PQRS reporters. Rather, we believe it is more fitting to consider these physicians satisfactory PQRS reporters for the purposes of the value-based payment modifier and allow them to receive a 0.0 percent update. These physicians would not be eligible for quality tiering, but because they are meeting the individual PQRS requirements it would be unfair to subject them to the -1.0 percent value-based payment modifier. We understand that this recommendation could have implementation difficulties. As such, an alternative would be to allow a hardship exemption for individuals who are in groups but who are successful individual PQRS reporters. A second alternative is to only apply the value-based payment modifier to those groups that are already reporting PQRS as groups under GPRO. Given that this policy will be finalized in November of 2012, there is insufficient time for the physicians in groups of 25 or more who are reporting as individuals to educate themselves and change their policies and procedures to switch from individual to group PQRS reporting.

Application of Value-Based Modifier to Individuals

In the proposed rule, CMS solicits feedback on whether to apply the value-based payment modifier to individuals in addition to groups starting in 2015. We recognize that the ACA requires that the value-based payment modifier apply to all physicians and groups of physicians by 2017; however, we urge CMS not to apply the value-based payment modifier to individuals in 2015. One of CMS' specific principles intended to govern the implementation of the value-based payment modifier is a focus on gradual implementation. We agree

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that this is an important principle and that beginning with groups is one way to progress gradually. We also believe that focusing first on groups would be less of a strain on CMS resources. In addition, existing concerns with the risk adjustment of the measures would be exacerbated if the value-based payment modifier were implemented too broadly in the beginning stages. Also, at this point there is still lack of clarity regarding the best attribution methodology to utilize and there is a lack of data regarding the impact of the various attribution methodologies on individuals. For these reasons, we encourage CMS to not apply the value-based payment modifier to individual physicians in 2015.

Proposed Quality Measures

Administrative Claims Option Under PQRS

CMS proposes to include the proposed PQRS administrative claims reporting option as a reporting option for groups for purposes of the value-based payment modifier. We commend CMS' efforts to promote an additional reporting option for physicians to avoid the 2015 and 2016 PQRS payment adjustment. We are also very appreciative that CMS has included this reporting option in the implementation of the value-based payment modifier. We agree with CMS' interpretation of this provision that groups who participate via the administrative claims reporting option would be considered successful PQRS group reporters for the purposes of the value-based payment. We understand that reporting under this mechanism could be temporary, and we recognize the importance of continuing to work to develop specialty specific measures for inclusion in PQRS that will eventually lead to more actionable performance data.

Outcome Measures for Groups of Physicians

In addition to selecting one of the five PQRS GPRO reporting methods and satisfactorily reporting the required number of measures for the required number of beneficiaries associated with the selected method, CMS proposes to include an additional four outcome measures. We provide comments on two of these measures: the All Cause Readmission measure and the 30-Day Post-Discharge Visit measure.

As we discussed above in the section related to the PQRS administrative claims proposal, we urge CMS to exclude the proposed All Cause Readmission measure from the evaluation of the value-based payment modifier. First, we request that CMS provide clear measure specifications for this measure as it

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would apply in the case of the value-based payment modifier. The proposed rule references the ACO All Condition Readmission Measure, but other factors could come into play with respect to the value-based payment modifier. For example, shortcomings in the risk adjustment as applied to an ACO covering 5,000 or more beneficiaries would only be exacerbated when applied to individuals or smaller groups.

The rationale to exclude the All Cause Readmission measures is based on findings that conclude that current risk adjustment models perform poorly. A recent systematic review of risk adjustment models in the *Journal of the American Medical Association* found that “models of patient-level factors such as medical comorbidities, basic demographic data, and clinical variables are much better able to predict mortality than readmission risk. Broader social, environmental, and medical factors such as access to care, social support, substance abuse, and functional status contribute to readmission risk in some models, but the utility of such factors has not been widely studied.”²⁰ The article then explains that “the success of some models in certain populations and the lack of success of others suggest that the patient-level factors associated with readmission risk may differ according to the population studied.”²¹ Furthermore, the following quote argues against the use of risk models to compare hospitals, but we believe this rationale applies to groups of physicians as well: “the poor discriminative ability of most of the administrative models we examined raises concerns about the ability to standardize risk across hospitals to fairly compare hospital performance.

Until risk prediction and risk adjustment become more accurate, it seems inappropriate to compare hospitals in this way and reimburse (or penalize) them on the basis of risk-standardized readmission rates. Others have reached similar conclusions, and also have expressed concern that such financial penalties could exacerbate health disparities by penalizing hospitals with fewer resources. Still others have argued that readmission rate is an incomplete accountability measure that fails to consider “the real outcomes of interest—health, quality of life, and value.” Use of readmission rates as a quality metric assumes that readmissions are related to poor quality care and are potentially preventable. However, the preventability of readmissions remains unclear and understudied.”²² Outcomes can vary widely, resulting in potentially unfairly

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²⁰ Kansagara D, Englander H, Salanitro A, et al. Risk Prediction Models for Hospital Readmission: A Systematic Review. *JAMA*. 2011;306(15):1695.

²¹ *Id.* at 1696.

²² *Id.*



penalizing hospitals and physicians for readmissions that are not under their control. Lastly, if readmission measures are included, they should exclude readmissions for conditions that are unrelated to the original admission, such as “readmission” due to traumatic injury.

The 30-Day Post-Discharge Visit measure tracks the rate of provider visits within 30 days of discharge from an acute care hospital. The proposed rule states that the 30-day post-discharge visit measure helps incentivize physicians to engage in more effective care coordination, so presumably a visit in the 30-day post-discharge period is a positive occurrence as opposed to the readmissions measure, above. However, because surgeons often provide care that is included in a 010- or 090-day global period, surgeons typically do not bill care in the 30-day post-discharge period. It would not even be feasible for a G-code to be established in this case because surgeons would have no billable code to which to attach it. While we understand that some surgeons use code 99024 to track visits in the global period, if this occurs, this information is maintained in practice management systems and is not communicated to CMS. As such, we have concerns with the implementation of this 30-Day Post Discharge measure as a way to measure performance for the value-based payment modifier.

Proposed Cost Measures

For the evaluation of the cost composite score, CMS plans to use the total per capita cost measure for all beneficiaries and per capita cost measures for beneficiaries with four specific chronic conditions: chronic obstructive pulmonary disease (COPD), heart failure, coronary artery disease (CAD), and diabetes. Regardless of the attribution method used, the per capita cost measures will most likely not attribute costs to the majority of specialists that do not treat the four specific conditions of COPD, heart failure, CAD, or diabetes. That leaves the remaining total per capita cost measure as the only way to calculate the cost composite score for many specialists. As discussed in more detail below regarding the attribution methodology, it is possible that little to no costs would be attributed to specialists, depending on the methodology selected. The costs that are in fact attributed could have an attenuated connection to the behavior that the costs are intended to measure. Under these circumstances, it would be inequitable to set a value-based payment modifier amount based on a measure of cost where there is a weak connection with the actual services provided; moreover, measuring costs in this manner would not create an incentive to change the behavior purportedly behind the cost measure.

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Attribution of Quality and Cost Measures

Calculation of the administrative claims-based quality measure and the cost measure performance rates requires CMS to attribute Medicare beneficiaries to groups of physicians. CMS used two different attribution methodologies in the 2010 Physician Feedback reports: the “plurality of care” and the “degree of involvement” methods. We provide comments on each of these methods below. Regardless of which method is chosen, we urge CMS to use the same method for attribution of claims under the administrative claims-based option both for PQRS and for the calculation of the value-based payment modifier.

“Plurality of Care”

Under the “plurality of care” method, CMS plans to attribute Medicare fee-for-service (FFS) beneficiaries to the group practice that billed a larger share of office or other outpatient E/M services (based on dollars) than any other group. Under this method, each patient would be attributed to only one group. The benefits of this method are that it is simple and comprehensible. It also emphasizes the important role of the ongoing treatment of chronic conditions. Although this approach might be appropriate for the Medicare program, it should not be generalized to the non-Medicare population. The disadvantage of this method, as CMS points out, is that the reliance on E/M services restricts the applicability of this method relative to some specialists. For example, other than in the rare circumstance where one group of surgeons provides the entire care for a beneficiary in a year, most patients will likely not be attributed to groups of surgeons because surgeons bill using E/Ms less frequently than many other physicians. Under this scenario, it will not be possible to calculate the cost composite score for such physicians and, in turn, not possible to calculate a value-based payment modifier amount under the quality tiering approach.

“Degree of Involvement”

Under the “degree of involvement” method, CMS plans to attribute beneficiaries for cost purposes by classifying patients for which a physician submitted at least one claim into three categories based on the amount of involvement with the patient:

- For directed patients, the physician billed for 35 percent or more of the patient’s office or other E/M visits.

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- For influenced patients, the physician billed for fewer than 35 percent of the patient's outpatient E/M visits but for 20 percent or more of the patient's total professional costs.
- For contributed patients, the physician billed for fewer than 35 percent of the patient's outpatient E/M visits and for less than 20 percent of the patient's total professional costs.

This method could lead to a more granular analysis of the true costs; however, we request more clarity on this approach. It is unclear how the classification of patients based on the three categories (directed, influenced, or contributed) would translate into actual costs attributed to the physicians. For example, if a patient were classified as "directed," it is unclear what percentage of the costs associated with that patient would be attributed to the physician or group. In addition, because the overwhelming majority of physicians did not receive a Physician Quality and Resource Use Report in 2010, it is difficult to provide cogent comments without more data on the applicability of this method to specific groups and the types of beneficiaries they treat.

Benchmarks

CMS proposes that the benchmark for each quality measure be the national mean of each measure's performance rate during the performance period. For the cost measures, CMS proposes that the peer group include all other groups of physicians for which CMS uses the same attribution methodology. In the 2010 Individual Physician Quality and Resources Use Reports, CMS benchmarks quality against all physicians, but benchmarks cost within specialty peer groups. Because costs vary substantially from specialty to specialty, comparing physician costs to others within their specialty could provide a more accurate picture of the costs, along with more actionable data.

Quality Tiering Model

CMS proposes the quality tiering model for the value-based payment modifier for comparing the quality of care furnished to cost. Under this model, CMS proposes to classify the quality of care composite scores into high, average, and low quality of care categories based on whether they are statistically above, not different from, or below the mean quality composite score. CMS proposes to classify groups of physicians under a similar methodology for cost. CMS then proposes to compare the quality of care composite classification with the cost composite classification to determine the value-based payment modifier

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adjustment according to Table 70 in the proposed rule (reproduced below). CMS proposes to establish the upward payment adjustment factor (“x”) after the performance period has ended based on the aggregate amount of downward payment adjustments.

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

Under this approach, groups of physicians who provide care in the high quality/low cost, average quality/low cost, or high quality/average cost tiers will be eligible for an additional +1.0x if the groups’ attributed to the patient population has an average risk score in the top 25 percent of all risk scores. We strongly urge CMS to allow *all* groups of physicians who elect quality tiering to be eligible for the additional +1.0x across all quality/cost categories if the groups’ attributed patient population has an average beneficiary risk score in the top 25 percent of all risk scores. We believe that no physician group that takes on the risk of furnishing care to high risk Medicare beneficiaries should be penalized compared to other groups. In addition, uncertainty as to whether a group will receive the payment for taking on high risk patients could dissuade groups from electing quality tiering or even from providing care to such patients.

We also question the rationale behind making the downward adjustment for groups of physicians who have not met the PQRS satisfactory reporting criteria (-1.0 percent) equivalent to the maximum downward adjustment for those groups who have met the PQRS satisfactory reporting criteria, but elected quality tiering and were high cost/low quality (also -1.0 percent). We believe that those groups who have met the PQRS satisfactory reporting criteria, but elected quality tiering and were high cost/low quality should not be penalized as harshly as those who were not successful PQRS reporters at all, and we urge CMS to change the maximum downward adjustment for those groups who have met the PQRS satisfactory reporting criteria, but elected quality tiering and were high cost/low quality to -0.5 percent. This would also create an incentive for groups to meet the PQRS criteria and elect the quality tiering option.

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Physician Feedback Reports

In September 2011, CMS disseminated feedback reports to physicians that participated in the PQRS GPRO, and in March 2011 CMS produced and disseminated reports to physicians practicing in Iowa, Kansas, Missouri, and Nebraska. CMS acknowledged in the proposed rule that often physicians did not access their reports because they did not know the reports were available.

Although a successful physician feedback report program is an essential component of the value-based payment modifier, it is not clear that this information will be provided in time to inform physicians about their 2015 utilization, which is the basis for the 2017 payment period. CMS should work with societies to ensure that physicians understand these reports. It is also important for CMS to make these reports available to all physicians in 2014. We also encourage CMS to include patient-specific information in the drill down of the reports since this level of detail is needed to verify and take action on the report.

We appreciate the opportunity to comment on this proposed rule. The ACS looks forward to continuing dialogue with CMS on these important issues. If you have any questions about our comments, please contact Bob Jasak, Deputy Director for Regulatory and Quality Affairs in our Division of Advocacy and Health Policy. He may be reached at bjasak@facs.org or at (202) 672-1508.

Sincerely,

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