September 6, 2013

Ms. Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
ATTN: CMS-1600-P  
7500 Security Blvd.  
Baltimore, MD 21244-8013


Dear Ms. Tavenner:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services (CMS or the Agency) Proposed Rule entitled Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Part B for CY 2014. 78 Fed. Reg. 43282 (July 19, 2013). The AAMC represents all 141 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians.

Calendar year (CY) 2014 will be an important year of transition for physicians and physician groups. Academic practices are busy implementing electronic health records (EHRs) and testing new care delivery and payment models. At the same time, up to six percent of a practice’s 2016 Medicare payment is at risk based on reporting and performance in 2014. It is essential that the Medicare program move ahead at a reasonable pace and with clear rules that are well understood. The AAMC’s comments will focus on areas of particular concern to academic faculty practices: the continued phase in of the Value-based Payment Modifier (Value Modifier or VM), changes to the Physician Quality Reporting System (PQRS), and continued work to promote care coordination. The AAMC’s main concerns are outlined below:

- The PQRS and Value Modifier programs are complex with many moving parts. It is premature to move to a full pay-for-performance program before CMS can ensure the accuracy and stability of the performance scoring of the cost and quality measures.
• The Medicare Spending per Beneficiary (MSPB) is a hospital-based measure that should not be included in the physician Value Modifier program.
• Measures should never be inserted directly into the VM program without first being reported through PQRS or the Quality Resource Use Reports (QRUR). Providers should have the opportunity to see their performance scores and to make improvements before their payment is modified based on performance scores.
• The proposed PQRS Group Practice Reporting Options (GPRO) are inadequate for groups that seek to make thoughtful and informed decisions regarding quality reporting. CMS needs to do the following:
  o Extend the administrative claims option for at least one more year,
  o Provide more information about the GPRO EHR option, and,
  o Simplify the PQRS choices for physicians and physician groups.
• CMS needs to further align the Medicare and Medicaid EHR Incentive Programs and PQRS. Eligible Professionals (EPs) who successfully submit clinical quality measures for the EHR Incentive Programs should be exempt from the 2016 PQRS and VM penalties.
• Care coordination for complex patients is extremely important and should be encouraged and compensated. However, the requirements for the proposed codes for complex care management codes are so administratively difficult that physicians will be unlikely to bill them. CMS should simplify the requirements for billing these new codes.
• CMS should not finalize the proposed changes related to investigational device exemptions (IDE). The Agency should work to establish a national policy on coverage for Medicare beneficiaries enrolled in clinical trials that is cohesive in its approach and designed to encourage the participation of Medicare beneficiaries.

The letter provides more details on these recommendations. The AAMC letter also comments on these proposals:
• PQRS and VM Proposals
• Physician Compare
• Medicare Shared Savings Program
• Complex Chronic Care Management Services
• Medicare Coverage of Investigational Device Exemption
• Medicare Telehealth Services
• Limiting PFS Service to Facility Rates
• Data collection for Off-Campus Provider-Based Clinics
• Medicare Economic Index
• Geographic Practice Cost Indices
• Sustainable Growth Rate
PHYSICIAN QUALITY REPORTING SYSTEM AND VALUE-BASED PAYMENT MODIFIER PROPOSALS

The value modifier and PQRS proposals are interconnected and complex. The data reported for PQRS in 2014 affects three payment calculations: the 2014 PQRS incentive, the 2016 PQRS penalty, and the 2016 VM adjustment. (See Figure 1). The AAMC believes these proposals need to be addressed in an integrated fashion; therefore, our letter will broach these topics in the following order:

- Overview of VM and PQRS Proposals
- Quality Tiering
- VM Cost Measures
- Quality Resource Use Reports
- VM Non-PQRS Outcome Measures
- PQRS/VM Quality Reporting Options
- PQRS CG-CAHPS for Groups
- Future Plans for PQRS
- Physician Compare

Figure 1: 2014 PQRS Reporting Feeds into Three Payment Calculations

- **2014 PQRS Incentive**
  - 0.5% incentive for PQRS successful reporting

- **2016 PQRS Penalty**
  - 2.0% reduction if not successfully reporting 2014 PQRS

- **2016 Value Modifier**
  - Proposed
    - Automatic 2% reduction if not reporting PQRS data; OR
    - Up to 2% at risk based on quality/cost performance for large group practices
Overview of VM and PQRS Proposals

Background

In the CY 2014 PFS proposed rule, CMS proposes the continued implementation of the Value Modifier program. Established by section 3007 of the Affordable Care Act, the VM adjusts Medicare physician payments upward or downward based on performance on cost and quality composite measures. The statute does not stipulate the size of the adjustment, but does say that it should apply to “some” physicians and physician groups in 2015 and “all” physicians and physician groups in 2017. The first year of the VM was finalized in the CY 2013 PFS final rule. This proposed rule expands the reach of the value modifier, increases the amount at risk, and significantly changes the reporting options for quality data as well as the measures and methodology for the cost composite.

In the 2013 PFS final rule, CMS finalized that the 2015 VM would apply to all group practices with at least 100 eligible professionals (EPs), with “group practice” being defined by tax identification number (TIN.) CY 2013 is the performance year for both cost and quality data. Groups must successfully report using one of the PQRS group practice reporting options (GPRO) or face a 1.0 percent reduction to their 2015 Medicare fees. This reduction is in addition to any potential PQRS penalties. Any group that successfully reports is exempt from the VM negative adjustment but has the option to elect a pay-for-performance reimbursement. Groups that elect the pay-for-performance option (called “quality tiering”) will have their payments adjusted upward or downward based on their cost and quality scores. Group practices may also qualify for an additional incentive if they perform well and care for high-risk patients. The quality composite is calculated using data submitted through the PQRS group reporting option and with outcome data derived from claims. The cost composite is a combination of total per-capita cost measures for patients attributed to the group practice.

There were three group reporting options for 2013 PQRS and 2015 VM:

- GPRO Web;
- Registry reporting; and
- Administrative claims.

A new group EHR option, which would align with the Medicare EHR Incentive Program, is available starting in 2014.

CY 2014 PFS Proposals

CMS already finalized that CY 2014 is the performance period for the cost and quality measures for the 2016 VM. In this rule, CMS proposes the following changes to PQRS and VM.
• Expanding the 2016 VM to groups of 10 or more EPs.

• Increasing the 2016 VM penalty for not reporting PQRS data from negative 1 percent to negative 2 percent. This penalty would be in addition to the negative 2 percent PQRS penalty for failure to meet the PQRS reporting criteria.

• Shifting from optional to mandatory pay-for-performance. In the 2015 VM, quality tiering is optional. CMS proposes to make it mandatory in the 2016 VM. Groups with between 10 and 99 EPs would be held harmless and would only receive a positive or neutral update. Groups of 100 or more would experience full pay-for-performance with a positive, neutral or negative update.

• Doubling the amount at risk from quality tiering, from negative 1 percent to negative 2 percent, in the 2016 VM.

• Modifying the PQRS group and individual reporting options for 2014 PQRS /2016 VM. (See Appendix A for a summary of the changes.)

• Modifying the cost composite for the 2016 VM, by adding the Medicare Spending per Beneficiary (MSPB) measure and adjusted the cost composite score methodology.

**AAMC Principles and Recommendations**

The AAMC appreciates that CMS wants to advance the PQRS and VM programs. Both programs are high-stakes programs designed to improve the value of the Medicare Program. However, to be fair and actionable, physician groups need an opportunity to understand the measurement and to improve performance. The following is a list of principles and recommendations that the AAMC believes should be applied to the PQRS and VM programs:

**Principle 1: The amount at risk in the VM should reflect that quality and cost reporting for physicians and physician practices are not stable nor mature.** The quality options for 2014 are changing dramatically (with unknown effects on reporting and performance) and most groups have not seen their cost performance data. Proposals to move from optional to mandatory pay-for-performance and to increase the amount at risk are too aggressive for the current state of physician reporting.

*Recommendation:*

*Delay full implementation of the VM pay-for-performance until the Agency can assure the accuracy and consistency of performance scoring.* CMS should keep quality tiering optional and should not increase the amount at risk within quality tiering.

  o As a corollary, CMS should not differentially target large group practices in quality tiering. All groups that have access to the same feedback data should
be at risk for both positive and negative updates. Groups with at least 25 EPs have access to the same feedback reports that large group practices have and should be subject to the same risks.

**Principle 2:** All groups and eligible professionals should have the option to strategically plan and report valid, reliable, and meaningful quality measures in a pay-for-performance program. Virtually all of the PQRS reporting options are proposed to change for 2014. Choosing the most appropriate option is a complex task, and physician groups lack the necessary information to make an informed decision. In addition, the data validity and comparability of results across the reporting mechanisms is unknown.

*Recommendation:*

*Alter the PQRS and VM quality reporting proposals to provide stable reporting options and improve alignment within PQRS and across programs.* The AAMC recommends the following changes:

- Continue the administrative claims reporting option for at least one more year;
- Provide detailed operational information about the EHR group reporting option;
- Protect EPs that attest to meaningful use from the 2016 PQRS and VM penalties;
- Allow groups to report through qualified clinical data registries; and,
- Lower the 70 percent threshold for individuals reporting within a group for the VM and recognize this as a valid group option for the 2016 PQRS payment adjustment.

**Principle 3:** Measures need to be designed and tested for the unit of measurement, and the measure should have a clear quality improvement goal. Measures that are applied to all physicians groups should be endorsed by the National Quality Forum (NQF) for physician groups. The outcome measures for the VM and the proposed MSPB measure have not been designed for physician group measurement.

*Recommendation:*

*Remove the MSPB measures and the claims-based outcome measures from the VM.*

**Principle 4:** Measures should never be introduced directly into a pay-for-performance program such as the VM. Providers should have feedback for at least one year before the performance period of a pay-for-reporting program begins. Proposals such as including MSPB measure directly into a pay-for-performance program violates this concept.

*Recommendation:*

*Report new measures for the VM through the QRUR reports prior to incorporating them into the VM program.*
Quality Tiering

CMS is proposing to move from optional quality tiering in the 2015 VM to mandatory tiering for the 2016 VM. In addition, the Agency is proposing to increase the amount at risk from negative 1 percent to negative 2 percent, though only groups with 100 or more EPs would be at risk for a negative adjustment. Groups with between 10 and 99 EPs would receive only a positive or neutral update.

The AAMC believes it is premature for CMS to make quality tiering mandatory and asks that CMS delay this change for at least one more year. Pay-for-performance should not become “mandatory” until CMS has validated that national benchmarks for cost and quality are comparable for individuals, groups, and across the various reporting mechanisms. In addition, CMS should not differentially target large group practices with a potential negative adjustment. The decision to apply full pay-for-performance should be based on the amount of feedback to which groups have access.

Other than the limited number of practices participating in GPRO Web in 2010 and 2011, no group practices have had the opportunity to review and understand their performance on cost measures. September 2013 will be the first time most groups are able to see their performance data summarized at the group level. The AAMC is pleased that the September report release will include detailed drill down files that groups can analyze to see which patients are assigned to them and understand where the costs are associated with those patients. If the purpose of the report is to help groups improve their performance, then CMS must allow enough time for groups to analyze these files, understand the methodology, and identify steps to improve performance. Releasing the reports in September 2013 and starting the 2016 VM performance period on January 1, 2014 is an unreasonable timeframe to accomplish these tasks. CMS should also seek feedback from the groups, so that the Agency can identify if additional refinements need to be made to allow more accurate comparison of efficiency measures across practices.

The AAMC also requests that CMS not increase the amount at risk for quality-tiering. If groups report data and choose to elect quality-tiering, they should not be at the same risk as groups that did not report at all. The AAMC recommends keeping the maximum quality tiering amount at risk at negative 1.0 percent.

Finally, if mandatory quality tiering is finalized, then CMS should apply the full adjustment (positive, negative or neutral) to all groups with 25 or more EPs. While groups of 25-99 EPs were not included in the 2015 VM, they have the same access to QRUR reports as large group practices and will have the same opportunity to improve performance. Groups should not be distinguished based on when they enter the VM program, but rather on when they have access to
their performance data. As the negative adjustment is one way to fund the potential VM pool, this burden should not be restricted to large group practices.

**VM Cost Measures**

_Medicare Spending per Beneficiary (MSPB)_

CMS is proposing to add MSPB to the cost composite of the 2016 VM, arguing that this measure will promote alignment because it is used in the hospital Inpatient Quality Reporting (IQR) Program and in Value-based Purchasing (VBP). To assign the hospitalizations to physician group practices, CMS proposes to change the attribution methodology for MSPB. Any group that submits a bill during the index hospitalization would be assigned the hospitalization.

The AAMC strongly opposes using MSPB in the VM for the following reasons:

- The MSPB measure is designed for hospital measurement, not for group practices. Attribution is a critical part of the measure design. CMS cannot apply this measure to physician groups and change the attribution methodology without fundamentally affecting what the measure is measuring, as well as the reliability and validity of the measure. If CMS wants to repurpose a measure from one program to another, then the Agency needs to redesign and test the measure to ensure it is appropriate for the unit of measurement. The NQF panel that is reviewing the MSPB measure echoed these comments at its recent meeting on August 27, 2013 where it confirmed the MSPB measure is being reviewed as a facility measure only.

- A cost measure should not be inserted directly into a pay-for-performance program before groups see their data results. Providers should have the opportunity to review their baseline results and improve measure performance before their payment is adjusted based on the performance.

If CMS wants to include measures that focus on hospitalization visits, then the Agency should consider adding the Medicare-specific episode-of-care measures to the QRUR feedback reports, after appropriate testing. These episode-of-care measures are in the testing phase, but their attribution algorithms are specifically designed for physician measurement.

**Refinements to the Cost Measure Composite Methodology**

CMS is proposing to modify the cost composite to adjust for the percentage of specialists in the group practice. When examining the data files, CMS noted that certain specialties tended to be in high-cost groups and others tended to be in low-cost groups. The AAMC commends CMS for proactively analyzing the data and identifying group and practice characteristics that may not be accounted for in the risk adjustment methodology. This adjustment may be an improvement, but
given subspecialty practice variation within a specialty designation, additional refinements may be necessary. Without seeing the impact of applying the specialty adjustment, and any unintended consequences of the adjustment, the AAMC is unable to support or oppose the proposal.

**Quality Resource Use Feedback Reports (QRUR)**

As mentioned above, physicians and physician groups should have the opportunity to receive feedback on their quality and cost measures prior to the implementation of a measure in the VM. This is consistent with the hospital Value-Based Purchasing Program (VBP), where measures have to be reported on Hospital Compare at least a year before being included in VBP. On the physician side, measures should be reported through the QRUR, and groups should have the opportunity to analyze the measures before the performance period for the Value Modifier begins. CMS should clearly indicate which measures will be included in the QRUR report for feedback purposes only.

**VM Non-PQRS Outcome Measures**

Last year, CMS finalized three claims-based outcome measures for the VM quality composite: 
“(1) A composite of rates of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease, and diabetes; (2) a composite rate of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia, and (3) rates of an all-cause hospitals readmissions measure.” 78 Fed. Reg. 43492. The outcome measures are applied to all physicians groups that are subject to the Value Modifier and have at least 20 patients assigned to them. The quality measures, combined with the PQRS measures, determine the group’s quality composite score.

The AAMC opposed these measures because they were not specified, nor tested, for physician groups. In April 2013, the Measures Application Partnership (MAP) clinician workgroup reviewed these measures for appropriateness for the VM and did not support the measures for the same reason. The AAMC asks that CMS remove these measures from the VM quality composite.

**PQRS/VM Quality Reporting Options**

Selecting the appropriate quality reporting option is an important strategic decision for a physician or group practice. Physicians and groups have to balance the priorities of identifying the measures relevant to the practice, the accuracy of the information submitted, and the time and staff resources needed to collect and submit the data. The selection process can be difficult given the number of reporting options available (which varies by the size of the group practice),
whether the options are recognized for group reporting in PQRS or the VM, and how the options interface with the other federal reporting programs, such as the Medicare and Medicaid EHR Incentive Programs. Further complicating the process are the significant number of changes to virtually all of the PQRS and the VM options planned for next year. (See Appendix A for a detailed summary of the PQRS changes by reporting mechanism and by group size.)

Faculty practices at academic centers come in various shapes and sizes. Many are organized as multispecialty groups with a large practice operating under one TIN. Others are a collection of smaller TINs that share common systems. Often, the faculty practice is a hybrid of the two extremes, with a large primary TIN and a few smaller TINs for niche practices. As long as PQRS and VM define group size and reporting options by TIN, academic centers have to look across their entire enterprise to determine the appropriate quality reporting strategy for the various TINs and dedicate resources to track multiple quality programs.

The AAMC is concerned about the complexity of the PQRS program, the ability of a faculty practice to strategically select a stable reporting option, and comparability of data in the different reporting options.

**Reporting Options for Large Group Practices**

The AAMC believes that large group practices may not have a sufficient number of realistic reporting options in 2014. Technically, large groups have three reporting options for 2014: GPRO Web, EHR, and Registry Reporting; yet, there are legitimate reasons to doubt that all three will really be available.

Many faculty practice groups have expressed interested in the EHR option, but CMS has not released detailed information about how the group EHR option will function. Without this information, groups do not know whether or not they will be able to meet the criteria to participate in 2014. (See the section on EHR reporting for more details.) Registry options are expensive and may be limited if enough traditional registries convert to “qualified clinical data registries.” GPRO Web is available to larger groups, but requires a significant investment in staff and resources to report the data (an investment which does not make sense for groups that ultimately desire to report through the EHR option). Also, as the GPRO Web option is proposed to be available for groups of 100 or more, it may not be an ideal option for faculty practices that have both a large and smaller practice, as the practice would have to implement a different

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1 CG-CAHPS is also an option, but must be reported in conjunction with one of the other reporting options.
2 Qualified clinical data registry is a new PQRS reporting option that is only available to individual EPs. As proposed, group practices would not be able to do a group submission through the qualified clinical data registries.
reporting option for the smaller practice. Without the administrative claims option, groups do not have a backup option if their preferred reporting option cannot be used.

This year, CMS proposes a new option for measuring group performance for the Value Modifier: if 70 percent of individual EPs report to PQRS, then the group practice will meet the reporting requirements for the VM. However, CMS acknowledges that one reason for setting the threshold at 70 percent was to deter large group practices from utilizing this option. The Agency writes:

…”only 29 percent of groups of physicians participating in the PQRS of more than 100 eligible professionals have at least 70 percent of their eligible professionals meeting the criteria for satisfactory reporting in 2011. We believe that this result is consistent with our policy to encourage group reporting by the very largest groups of physicians.

78 Fed. Reg. p. 43490 (emphasis added)

To summarize, while it appears large groups have a number of choices to report quality data, there is a risk that many of these choices will not be available in 2014. Given the unknowns, the AAMC does not believe these options provide a sufficient number of stable choices for the large group practices to report. The AAMC recommends the following improvements:

- Continue the administrative claims option for at least one more year. Quality information derived from claims data may be of limited value, but during this time of transition for quality reporting, it is important to have a low-burden reporting option for groups to fall back on.
- Provide detailed information about the EHR group reporting option.
- Expand the qualified clinical data registry option to groups.
- Expand GPRO Web to mid-size groups (with at least 50 EPs). This option would allow faculty practices to adopt GPRO Web for their large as well as their mid-size practices.
- Lower the threshold for individual reporting of PQRS measures. Groups of all sizes should have the option to report individual measures for EPs.

**EHR Incentive Program Alignment**

The AAMC has been working closely with faculty practices to help them evaluate the different available quality reporting options. A key strategic question for organizations is understanding how the PQRS reporting options align with the Medicare EHR Incentive Program. Starting in 2014, as the Stage 2 meaningful use criteria go into effect, the group practices have the option to report clinical quality measures (CQM) for Medicare EHR Incentive Program as a group. This will allow groups to submit one set of quality data and receive credit for PQRS and the Medicare EHR Incentive Program. The AAMC is supportive of this alignment but had a series of questions about how the alignment would work. In March 2013, the AAMC submitted a 5-page
memo to CMS with questions about how the EHR Incentive Programs and PQRS would align. CMS answered some questions verbally but has not released a document that clearly addresses the questions and that can be relied on by those participating in the program. The outstanding questions include:

- Does a group report on all patients, or just Medicare patients?
- Can a group use a GPRO EHR option if the group does not upgrade to a Stage 2 certified EHR until mid-year? (The PQRS reporting cycle is one year, but the EHR Incentive reporting period for 2014 is one quarter.)
- Can a group report if it has multiple EHR versions? What if some locations have upgraded and others have not?
- Does the entire group report on the same set of 9 measures/3 domains? What if the measure is not pertinent to the reason the patient is coming to the practice?
- Does it matter if individual EPs have zero denominators within the group submission?
- Does a group need to create a separate reporting structure for new physicians or for the Medicaid EHR Incentive Program?

It is critical to have the answers to these questions as soon as possible, as groups need to decide if they can use the EHR reporting strategy before the 2014 performance year begins. To facilitate alignment across PQRS and the EHR Incentive Program, the AAMC recommends that CMS make the following changes:

- For 2014 only, add a PQRS reporting period for the GPRO EHR that allows groups to report one quarter’s worth of data. This addition would align the PQRS reporting period with the EHR Incentive Program, which recognized that providers may need a shorter time period in the year when providers are transitioning to Stage 2 EHRs.
- Do not impose 2016 PQRS/VM penalties on EPs or groups who submit CQM to the Medicare and Medicaid EHR Incentive Program, even if the CQM do not meet PQRS criteria. The providers would not be eligible for the PQRS incentives, but these groups are reporting quality measures. If the data submission does not meet PQRS criteria, then it is due to lack of alignment, not lack of intent or effort. These providers should not be subject to penalties intended for EPs and groups who are not reporting any quality information.

Simplifying the PQRS/VM Quality Reporting Selection

Selecting the best quality reporting option is complex due to the staggering number of choices and rules in PQRS. The AAMC believes that PQRS needs to be flexible enough to meet the needs for the variety and types of physician practices while at the same time making available

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3 See Appendix A of the following document for a copy of the memo.  
stable reporting options that are simple to understand and evaluate. The AAMC suggests the following changes to help CMS attain that balance:

- Allow group practices to report through a qualified clinical data registry. Currently only individuals can use this mechanism.
- Allow group practices to report measures groups. Measures groups are sets of codes that individuals can report through a registry, but group practices cannot.
- Provide an option for individual EPs to submit CG-CAHPS data.
- Create a PQRS group option, similar to the VM, where groups that have a certain number of EPs reporting should be protected from the 2016 PQRS payment adjustment.

These changes would align the options available to individuals and groups for PQRS and the VM.

**Data Variability across Reporting Mechanisms**

CMS should validate the quality data results that come from different reporting mechanisms and from individual and group reporting to ensure they are comparable. A provider may be reporting the same measure, but due to differences in the reporting mechanism, may have different results. For example, a null value in a GPRO Web measure might count against a group’s performance, while a null value in EHR reporting is simply ignored. Both are reporting the same measure, but the results are different.

The AAMC is also concerned about biases that result from group reporting versus individual reporting. Groups are accountable for measures that seem unrelated to an individual visit. For example, if the group practice decides to collect diabetes measures, then all patients with an active diabetes problem list will be selected from the EHR, even if a patient is seen in the practice for something unrelated to diabetes care. If comprehensive diabetes care is not typically part of the workflow of the clinician who sees that patient, lab tests related to diabetes care will not be ordered or recorded in the system, thus penalizing the group practice. This type of incompleteness will likely diminish as groups move towards population health management. In the interim, though, the AAMC is concerned that this group level “noise” could affect comparability of results to individual EPs.

In pay-for-performance programs such as the VM, CMS has the obligation to ensure that data reported by different mechanisms are truly the same. CMS should analyze whether a systematic discrepancy exists between reporting mechanisms or between group and individual reporting that could affect the comparability of the data.
PQRS CG-CAHPS for Groups

The AAMC supports the inclusion of a formal mechanism to report patient experience data for PQRS. Patient experience data is important, yet until this year it was not possible for individual EPs or groups to select this metric for quality reporting.

One potential issue with PQRS CG-CAHPS reporting is that it does not align with the CG-CAHPS reporting requirements for other programs. For example, NCQA medical home participants have to field a different CG-CAHPS survey. The AAMC asks CMS to consider ways it can align the CG-CAHPS survey with other payers and initiatives to minimize the survey reporting burden for patients and providers.

Plans for the Future of PQRS

In addition to the 2014 proposals, CMS is seeking comments on ways to modify PQRS reporting for future years.

Alternative Definitions for GPRO Groups

The AAMC believes that groups should have more flexibility in defining themselves than just using their TIN. In the past two PFS comment letters, the AAMC outlined ways CMS can implement such a process. For example, CMS can link TINs by creating a modified version of the Medicare Shared Savings Program Accountable Care Organization (MSSP ACO) application process. To ensure that the TINs are bona fide groups, CMS can employ the concepts for “public perception and” and “shared systems.” For more information about these proposals, refer to our 2012 and 2013 physician fee schedule proposed rule comment letters.4

Removal of the Annual Self-nomination/Registration Process for GPRO

The AAMC supports removing the annual renewal registration process for group practices. Our experiences with GPRO Web indicate that once group practices register for group reporting, they continue reporting as a group. Groups should only have to go through the process if they want to make a change.

Thresholds for GPRO Web

CMS asks whether a minimum threshold should apply to participants in GPRO Web to ensure that the data reporting is comparable. The AAMC agrees with CMS that a minimum threshold may be appropriate. The Association suggests that CMS review the number of patients assigned to the 2013 group practices, analyze the variation by group size, and suggest possible thresholds. The AAMC also recommends that CMS implement an alternative definition of group before applying a threshold policy. CMS should not inadvertently exclude practices from this reporting option if consolidating their TINs into a single group would allow the group to meet the threshold minimum.

Reporting for EPs Who Practice in Hospitals

CMS presented two options to align reporting for hospital-based EPs with the hospital Inpatient Quality Reporting (IQR) Program: 1) hospital-based EPs report retooled IQR measures through a registry, or 2) hospital-based EPs inherit a hospital’s IQR performance rate.

The AAMC supports alignment across programs if the measures are appropriate for the unit of measurement and the alignment reduces reporting burden. The second option meets these criteria. IQR measures are specified for a hospital. The EP would “inherit” a hospital’s performance rate. The measures would not have to be recalculated for an individual or group. Additionally, hospitals or practices would not have to pay additional fees to report data through a registry. The AAMC suggests that CMS work with hospital-based specialty groups to design an appropriate attribution methodology to assign hospital scores to individuals who primarily work within a hospital setting.

Future Submission Timelines for Registry, EHR, GPRO Web and Qualified Clinical Data Registries

CMS is seeking comment on whether data for the Registry, EHR, GPRO Web and Qualified Clinical Data Registries should be reported quarterly versus annually. The AAMC believes that quarterly data would be valuable to providers; however, without changes to the program, GPRO Web data could not be collected efficiently on a quarterly basis.

Physician Compare

CMS has substantially rebuilt the Physician Compare website to improve the data affiliations and the underlying database. CMS will publicly report selected 2012 GPRO Web performance data in 2014 and is proposing to expand public reporting to all groups and EPs reporting those measures through any reporting mechanism. The AAMC commends CMS for improving
Physician Compare functionality, but asks CMS to be careful in displaying performance measures. This high-profile website should only display accurate information.

The AAMC is concerned about reporting all the ACO/GPRO Web measures. CMS should first validate that all measure specifications are interpreted consistently across groups and across reporting mechanisms. The UHC-AAMC Academic GPRO Network participants indicated that the interpretation of some specifications were adjusted during the reporting process. In such cases, the measures should not be reported.

In addition, the AAMC is concerned about the validity across the different reporting mechanisms. CMS should establish a plan that evaluates the accuracy of the data before reporting it on Physician Compare.

Finally, even with all the progress CMS has made on the Physician Compare Website, group practices are still finding errors about physicians and their affiliated practices. Groups need a simple way to notify CMS of physician affiliation data errors, or other errors about the group practice, so that mistakes can be readily corrected and the data displayed on Physician Compare is accurate.

MEDICARE SHARED SAVINGS PROGRAM

Quality reporting is an important element of the MSSP ACO model. ACOs must exceed quality benchmarks to share in any savings, and the shared savings rate is determined by the ACO’s relative performance on quality measures. In the PFS proposed rule, CMS discusses the data sources to establish the quality benchmarks as well as a proposal to meaningfully distinguish performance among ACOs.

Flat Rates for ACO Benchmarks

To set the quality benchmarks, CMS proposes to amend the regulations to use all possible data sources, including Medicare Advantage and Medicare fee-for-service performance data. CMS also proposes to retain the option of using “flat percentages when data are unavailable, inadequate, or unreliable.” 78 Fed. Reg. 43483. The AAMC opposes the use of flat rates with no supporting data. Given the high stakes of the ACO benchmarks, the AAMC believes these benchmarks must be set using actual, reliable performance data. If accurate or reliable data is not available, then CMS should keep the ACO measure a pay-for-reporting measure rather transitioning it to pay-for-performance.
Clustering of ACO Performance

CMS assigns “quality points” to ACO performance based on a decile distribution of quality scores. When scores are clustered, it is possible to have differences in the shared savings rate when there are no real differences in quality performance. To address this problem, CMS proposes to artificially expand the performance ranges, effectively making the lowest range lower and the highest range higher.

CMS has identified an important issue. The shared savings rate based on quality points should reflect true differences in quality performance. CMS should not artificially modify the quality point distribution to make the current scoring system work, though. Instead CMS should modify the savings scoring methodology to account for situations when quality performance is clustered and no performance difference exists. CMS also should consider when measures should be removed (because of the lack of differentiation) and consider scoring for ACO improvement over time.

COMPLEX CHRONIC CARE MANAGEMENT SERVICES

Beginning in CY 2015, CMS proposes to pay for care coordination management services for complex patients with multiple chronic conditions. The AAMC supports the expansion of care coordination payments. Academic medical centers often care for complex patients with several comorbid conditions. However, the requirements for the proposed codes for complex care management codes are too administratively difficult to implement. CMS should simplify the requirements for billing these new codes.

CMS proposes to use two new G-Codes to reimburse for non-face-to-face chronic care management services. The codes would cover services furnished to patients with two or more complex chronic conditions expected to last at least 12 months or until the patient is at risk of death. As proposed, one code (GXXX1) would cover services in the initial 90 day period and the second proposed code (GXXX2) would cover services in subsequent 90 day periods. CMS proposed several requirements and policies to bill the new complex chronic care management services:

- Before providing complex care management services the clinician must obtain beneficiary consent.
- The beneficiary must be informed a claim will be submitted for care management services and that they will be responsible for cost-sharing.
- One claim will be paid per beneficiary per 90 day-period.
- The beneficiary must have had an annual wellness visit in the preceding 12 months.
• One clinician must spend at least 60 minutes managing the patient over the 90 day period.
• Evaluation and management services can be billed if a face-to-face visit is also provided during the 90 day period.

In addition, CMS proposes the scope of complex chronic care management services to include:

• 24 hours a day, 7 days a week access to a patient’s electronic health record (EHR);
• Continuity of care with a designated care-team clinician;
• The creation of a patient-centered plan of care;
• Care coordination with home and community-based physicians;
• Management of care transitions with the practice facilitating communications of patient information through the electronic exchange of a summary of care record; and
• Opportunities for patients to communicate with clinicians through non face-to-face methods.

CMS also seeks comments on potential standards that a practice must meet, such as using a certified EHR and employing one or more advanced practice registered nurses or physicians assistants, in order to provide and bill for complex chronic care services. CMS is also considering whether being a recognized patient centered medical home (PCMH) by a national organization (Joint Commission, National Committee of Quality Assurance, etc.) may be one way for a practice to demonstrate that it has met the final standards for providing complex chronic care management services.

The AAMC supports CMS’ continued efforts to recognize care management and coordination services that occur in non-face-to-face settings and are not currently captured in the reimbursements for evaluation and management (E/M) services. In building upon the new payment for transitional care management (TCM) services proposed and finalized in CY 2013, CMS has demonstrated an increased recognition of care coordination and primary care services and the important role they play in delivering quality care to beneficiaries. While the AAMC applauds these continued efforts overall, the Association has the following concerns:

• The requirements to provide and bill for complex chronic care management services focus more on processes and less on the actual outcomes of care. Member feedback already indicated that the requirements for the TCM services finalized last year are so administratively burdensome that a large majority of AAMC members choose not to bill for them. This proposal has similar documentation difficulties. For example, CMS proposes that one clinician must spend at least 60 minutes managing the patient over a 90 day period. It would be practically impossible for a practice to monitor and track the exact amount of time a clinician manages a patient over a period of 90 days. The effort and cost involved in attempting to develop a workflow to meet this requirement would be considerable.
The AAMC does not support the proposed requirement that beneficiaries must receive a notice in advance that a bill will be submitted to CMS, along with a description of services. This proposal is not consistent with the way in which other services paid for under the fee schedule are billed. This requirement imposes yet another administrative burden and places the practice at risk for non-reimbursement if it is unable to confirm the beneficiary has received a notice.

The AAMC disagrees with CMS’ proposal to require a practice to employ one or more advanced practice registered nurses or physician assistants who, as a part of their job description, are required to provide services to beneficiaries who are receiving complex care coordination services. While the AAMC strongly supports inter-professional team-based care for beneficiaries, this requirement places an excessive burden on a practice. A practice and its clinicians should have the discretion to develop care teams that are most appropriate to meet the needs of their patients. The outcome of care should be the focus rather than the specific staff used to provide services.

The Association feels CMS should not limit the reimbursement of care management services to patients who need significant revisions to their care plan in subsequent 90-day periods. These beneficiaries are medically complex patients who require ongoing care coordination over long periods of time to prevent unnecessary visits to the emergency department or a potential hospital admission. Care coordination services for these patients are a key element to ensuring increased stability of their conditions and therefore should be reimbursed even when there are not substantial revisions to their care plan.

The AAMC supports the following:

- Allowing clinicians to bill for E/M services during the 90-day period. While some aspects of care delivery and care management can be administered through non-face-to-face methods, clinicians must be allowed to use their judgment on when it is appropriate for their patients to be seen in a face-to-face encounter.

- Recognizing that a patient centered medical home (PCMH) meets the care coordination standards. The process of being certified as a PCMH by NCQA, the Joint Commission, or other national accrediting agencies is a robust and thorough process. A practice that meets the standards set forth by these organizations should be recognized as a practice that is fully capable of delivering high quality complex chronic care management services.

- Educating beneficiaries about the advantages of having care management services provided to them by their clinical care team. We suggest that CMS develop educational materials to be made available to patients so that they may better understand these services.
MEDICARE COVERAGE OF ITEMS AND SERVICES IN FDA INVESTIGATIONAL DEVICE EXEMPTION CLINICAL STUDIES – REVISION OF MEDICARE COVERAGE

CMS has made several proposals related to coverage for investigational devices (IDEs). Devices used in clinical trials fall into one of two categories: Category A devices are new devices for which Congress amended the Social Security Act to provide that payment is limited to the routine costs of care provided that the trial meets certain criteria; Category B devices are “tweaks” on already existing devices and Medicare will pay for the routine costs of care and the cost of the device itself. CMS relies on the Food and Drug Administrative to determine if a device is Category A or B. Local contractors determine if the trial of the device merits coverage, leading to coverage inconsistencies across the country.

As is discussed below, the Agency proposes to establish a centralized review process for determining coverage of investigational devices that will replace the current process. CMS also proposes to establish 13 standards that will be used to determine if a Category A device is a device for which the Food and Drug Administration is unsure whether the device is safe and effective.

The AAMC urges CMS to not finalize the proposed changes related to Category A and B devices. As discussed below, the Agency should work to establish a national policy on coverage for Medicare beneficiaries enrolled in clinical trials that is cohesive in its approach and designed to encourage the participation of Medicare beneficiaries. It is hoped that the unsuccessful attempt to do this in 2007 provides sufficient “lessons learned” to result in a successful second attempt.

A National Process for Coverage of Category A and B Devices

The CMS proposal to establish criteria to centralize the IDE coverage process is laudable. The AAMC supports the concept of a “transparent, centralized review process” for clinical trials and the reduction in the variation of coverage that is the result of the current system’s reliance on

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5 The 13 standards are (in brief): the principal purpose of the study is to test whether the item or service meaningfully improves the health outcomes of patients who are represented by the Medicare-enrolled subjects; the rationale for the study is well supported by available scientific information or is intended to clarify or establish the health outcomes of interventions already in common use; results are not anticipated to unjustifiably duplicate existing knowledge; study design is methodologically appropriate; study is sponsored by an organization or individual capable of completing it successfully; study is in compliance with all applicable federal regulations concerning the protections of human subjects; all aspects of the study are conducted according to appropriate standards of scientific integrity set by the International Committee of Medical Journal Editors; study has written protocol that clearly demonstrates adherence to standards listed here; where appropriate, study is not designed to exclusively test toxicity or disease pathophysiology in health individuals; study is registered in ClinicalTrials.gov and/or Registry of patient Registries prior to enrollment of first study subject; study protocol specifies method and timing of public release of results on pre-specified outcomes, including negative outcomes and results must be made public within 24 months of the end of data collection; protocol explicitly discusses subpopulations affected by the item or service under investigation; and the protocol explicitly discusses how the results are or are not expected to be generalizable to subsections of the Medicare population. 78 Fed. Reg. 43343-43344.
local contractors. However, among the questions that CMS must address if it finalizes this proposal are the following:

- **Who requests the coverage?** The proposed rule says “any interested party” may request coverage. This could lead to multiple people submitting a request letter which could cause confusion. For device trials that are sponsored by the manufacturer, the onus should rest on the manufacturer to submit the request. A decision that the trial qualifies for coverage should extend to all trial sites. For device trials that are investigator-initiated, responsibility for submission of the request should rest with the Principal Investigator’s institutions, in most cases the university. Once a trial receives institutional review board (IRB) approval, the manufacturer or in the case of an investigator-initiated trial, the university, should submit the required paperwork to CMS.

- **What is the time frame for CMS’ decision?** A speedy decision followed by a quick posting on the CMS website is essential as beneficiaries are waiting for these devices. Members report that Medicare audit contractors (MACs) typically make a decision within 15 to 30 days. It is essential that the final rule establish a quick time frame; this should not be left to future guidance.

- **What happens when approved studies are extended or amended?** This issue was raised in 2007 and has not been addressed in the current proposal. For example, when approved studies are extended or amended, will they require new CMS review; will coverage continue automatically, especially for those beneficiaries already enrolled?

- **What happens to existing studies that have local contractor approval?** Will these studies be grandfathered; if grandfathered, will coverage continue for beneficiaries already enrolled; how will new potential enrollees in these studies be handled?

- **Denial of coverage.** When coverage for participation in a study is denied, how will that decision be communicated? What will be the time frame?

**Coverage Standards**

The 13 criteria proposed by CMS for Category A and B devices are nearly identical to those put forth by CMS in 2007 in a second reconsideration in the Proposed Decision Memo for Clinical Trial Policy (CAG-0071R2; hereinafter “the Decision Memo”). That proposal had the broad aim of becoming Medicare’s Clinical Research Policy. However, after an extensive public discussion, it became clear that the research community and many others considered it to be flawed, and the proposal was never finalized. At the time of the 2007 proposal, the AAMC asked that CMS use a rulemaking process to establish coverage criteria. We appreciate that the Agency is doing so now but, as discussed below, the AAMC continues to have many of the same concerns that were expressed earlier, in addition to new ones.

The AAMC is concerned that the proposal will severely limit the ability of beneficiaries to participate in clinical trials, thus making it even less likely that there will be sufficient evidence on which to base Medicare coverage determinations. The proposed criteria appear aimed more at Coverage with Evidence Development (CED) than a determination that Medicare beneficiaries
will pay for certain items and services for beneficiaries who qualify for the trial and wish to participate.

The need for CMS to adopt its own set of requirements to judge studies of Category A and B devices is unclear. There already exist well-established requirements through the National Institutes of Health, Office for Human Research Protections, and the Food and Drug Administration that protect study participants and ensure that ethical standards are met. However, if the Agency chooses to move ahead, it must ensure that the criteria are consistent with those already in existence in the National Coverage Decision (NCD), Manual Section 310.1.

The AAMC also has concerns about whether CMS has the sufficient staff expertise to evaluate clinical trial studies in a timely manner. Finally, rather than revising only the requirements for Category A and B device trials, the AAMC urges CMS to examine more broadly coverage for Medicare beneficiaries enrolled in clinical trials and to again engage stakeholders in developing a policy that will provide beneficiaries with the opportunity to participate in a clinical trial when recommended to do so by their physician or medical team. This was the stated goal of President Clinton in 2000 when he ordered Medicare to “increase the participation of seniors in clinical trials.”

The AAMC has the following specific comments on the CMS proposals:

- The 13 criteria proposed by CMS may have the effect of making many trials of Category A and B devices unavailable to Medicare beneficiaries. For example, one requirement is for a discussion of “how the results are or are not expected to be generalizable to subsets of the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.” If a protocol lacks this discussion, then a particular trial would be unavailable to any Medicare beneficiaries, even if it is the judgment of a beneficiary’s physician that he/she would benefit from participation in this trial, and the trial meets all other criteria.

- CMS should not require that the principal purpose of the study be its applicability to the Medicare population. The first proposed criteria is that: “the principal purpose of the study is to test whether the item or service meaningfully improves health outcomes of patients who are represented by the Medicare-enrolled subjects.” be changed to “one purpose of the study . . .” The AAMC suggests that this should be one purpose of the study, not necessarily the principal purpose. If CMS adopts the current proposal, the result may be to limit severely the number of studies that will be available to Medicare beneficiaries.

- All study criteria should be objective so that it is clear which studies will qualify for coverage and which will not. A number of the criteria are very subjective. For example, what are the criteria that will be used to determine that the study design is “methodologically appropriate” or that the sponsoring organization or individual is “capable of completing it successfully”? If CMS does not want to rely on other agencies
and IRBs to determine the ethical and scientific merit of studies, the Agency must propose criteria that can be consistently applied.

- CMS’ reliance on pivotal or superiority studies is unnecessarily limiting. CMS proposes automatic coverage of the costs of routine items and services in a Category A study or trial, and the costs of the investigational device and the routine items and services in a Category B study if the study is pivotal. The same is proposed if the study is a superiority study design. Most trials are not pivotal trials, nor are they superiority studies. It is unclear why CMS believes that meeting these criteria should merit automatic coverage, nor how many trials the Agency believes would fall into either category. The result of applying this requirement to Category A studies may be that virtually no such studies will meet the Medicare criteria, thereby denying Medicare patients access to them. Finally, CMS needs to explain how the approval process for pivotal or superiority studies differs from the process for other studies so that the coverage is, in fact, automatic.

- CMS should provide flexibility regarding when a study must be registered on ClinicalTrials.gov. The proposed time for registering on ClinicalTrials.gov—“prior to enrollment of first subject”—is consistent with the International Committee of Medical Journal Editors (ICJME) and other journals, but conflicts with Food and Drug Administration Amendments Act (FDAAA) requirement which is “not later than 21 days after enrollment of the first participant.” If publication of the results in a peer-reviewed journal—as distinct from the proposed CMS requirement for “public release”—is not planned, then registration only needs to be consistent with the FDAAA requirements. It should be noted that ICJME does not “define the timing of first patient enrollment, but best practice dictates registration by the time of the first patient consent.”

This proposal will provide for more limited coverage than currently is available.

CMS proposes a definition of “routine care items and services” that is much more limited than the definition of “routine care” found NCD 310.1 SSA. CMS proposes to cover only items or services generally available to Medicare beneficiaries that would be otherwise furnished even if the beneficiary were not enrolled in a clinical trial. The NCD’s more expansive coverage includes:

- Items or services required solely for the provision of the investigational item or service (e.g., administration of a noncovered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service in particular, for the diagnosis or treatment of complications.

The AAMC urges CMS to not provide less coverage for Medicare beneficiaries than now is available. To ensure a consistent terminology, the AAMC requests that CMS use the term

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6 Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals, developed by members of the ICMJE, Updated August 2013; page 11.
“routine costs” which is familiar to all who bill for clinical trials, and adopt the same definition as found in the NCD.

Finally, Congress clearly intended that participation in Category A device trials should be available to Medicare beneficiaries. The Social Security Act was amended to direct the Secretary to “not exclude . . . payment for coverage of routine costs of care (as defined by the Secretary) furnished to such individual in the trial [of a Category A device].” CMS should ensure that the final policy that it adopts is consistent with Congressional intent.

MEDICARE TELEHEALTH SERVICES

Medicare telehealth services are covered when a beneficiary is in a “qualifying originating site,” in rural health professional shortage areas. For CY 2014, CMS proposes to expand the number of originating sites by modifying the definition of “rural.” CMS will use the Office of Rural Health Policy (OFHP) Rural Urban Communicating Areas (RUCAs) to determine rural area. By changing how it defines “rural”, CMS expects it will expand access to telehealth services by beneficiaries. CMS also proposes to add transitional care management services (CPT codes 99495 and 99496) to the list of telehealth services for CY 2014.

The AAMC appreciates CMS’ efforts to expand access to telehealth services by changing the locations that can be considered originating sites. The Association also supports the addition of TCM services to those that can be reimbursed if delivered in a non-face-to-face setting. We encourage CMS to continue to expand the list of eligible telehealth services in future rulemaking.

LIMITING PFS NON-FACILITY PAYMENTS

As part of the misvalued relative value unit (RVU) initiative, CMS is proposing to limit payment for services provided in the physician office to the sum of the facility and professional fee for comparable services provided in hospital outpatient departments (HOPD) or ambulatory surgical centers (ASCs). CMS asserts that services provided in a facility setting have higher overhead costs than services provided in an office setting; therefore, if a service performed in a physician office is higher than the total fee for a service at a facility setting, the PFS fee must be incorrect. CMS early analysis identified approximately 200 misvalued codes using this methodology.

The AAMC agrees with CMS that HOPDs have higher costs than physician offices. As the proposed rule notes, hospitals have to “maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in

7 42 USC § 1395 (y)
physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals must meet Medicare conditions of participation…” 78 Fed. Reg. 43296. The costs for HOPDs are real and are documented annually through an audited cost report.

Higher HOPD costs also stem from the unique role of the hospital in the health system. An AAMC analysis of office visits confirmed that HOPDs see more complex patients and a higher proportion of dual-eligible, disabled and non-white patients compared to physician offices. HOPDs provide comprehensive and coordinated care settings for patients with chronic or complex conditions, such as pain centers or cancer clinics. Many centers of excellence are based in hospital settings and provide outstanding team-based, patient-centered care, the gold standard of care; and include wrap around services, such as translators.

Given that HOPDs have higher costs, the AAMC believes it is reasonable for CMS to identify potentially misvalued services by looking for instances where the price in the physician office is higher than the total price in an HOPD setting. Rather than automatically assuming the PFS amount is incorrect, however, CMS should analyze the identified codes to determine whether the service is truly mispriced. The decision to revise a price should be based on accurate and valid data analysis, including considering whether the service is truly comparable across setting. If further analysis supports the conclusion that these codes are misvalued, then CMS should make changes to these codes rather than adopt a broad policy that blindly links the services without considering the unique characteristics of the service of each setting.

COLLECTING DATA ON SERVICES PROVIDED IN OFF-CAMPUS PROVIDER-BASED FACILITIES

CMS is interested in better understanding hospital acquisition of physician practices and the integration of those practices as departments of the hospital, particularly given the co-payment implications for Medicare beneficiaries and the cost to the Medicare program of paying hospital facility fees. To collect data on the frequency, type, and payment for services furnished in off-campus provider-based departments, CMS suggests the possibility of collecting data through a claims-based approach (adding a HCPCS modifier for hospital services furnished in these provider-based departments) or a cost-report based approach (breaking out costs and charges for provider-based departments as outpatient service cost centers on the hospital cost report). CMS also suggests the option of adding a site of service code or the HCPCS modifier to physician claims forms.
The Association recognizes the importance of beginning to collect this type of data, given how little is currently known in the aggregate about provider-based facilities and how important having accurate information is to the broader conversation around the site in which healthcare services are delivered. There is currently no consensus within the academic community, however, as to which of CMS’ options would be preferable. Some teaching hospitals already collect this information on a claim level and believe it would not add considerable additional burden, while others find that adding a place of service code or HCPCS modifier would be difficult and burdensome because of the manual nature of this task. Some teaching hospitals already report sites separately on the cost report, while others who have multiple on-campus and off-campus based clinics in a single accounting unit would find a cost report approach extremely difficult.

Given the differing opinions and the complexities surrounding this data collection, the AAMC encourages CMS to convene a group of CMS staff and hospital stakeholders to identify the most accurate and least burdensome way of collecting meaningful data. In discussing CMS’ proposed options, AAMC members raised granular issues that are best identified by providers themselves. For example, CMS should consider how to address cases in which a patient is treated on the same day in both on-campus and off-campus provider-based settings. Additionally, given the inaccuracies that often persist in codes on claims that are not tied to payment, CMS should work with a stakeholder group to determine the best way of collecting the most accurate data.

The AAMC also urges CMS to work with stakeholders to review results of the survey the Department of Health and Human Services Office of Inspector General (OIG) is conducting on some of these issues. CMS and the provider community should have the advantage of understanding what the OIG has learned from this effort and should target future data collection at questions that remain unanswered.

Finally, the AAMC strongly encourages CMS to engage the hospital and physician stakeholder community in putting any data the Agency collects on off-campus provider-based departments into context. CMS says the Agency wants to better understand trends around hospital acquisition of physician offices, but the type of data CMS proposes to collect will not answer the questions the Agency is asking. This data will provide only a snapshot in time and will not immediately identify shifts in hospital ownership of physician practices or the types of patients who are treated in these off-campus provider-based locations. Beginning to collect data on these locations may be an important first step, but it should only be an introduction to a much broader dialog with providers about the what services are being provided and the characteristics of patients who are treated in provider-based facilities.
REVISING THE MEDICARE ECONOMIC INDEX (MEI)

The AAMC commends CMS for convening a technical panel on the Medicare Economic Index (MEI) and for implementing most of its recommendations. In the 2011 AAMC physician fee schedule proposed rule comment letter, the AAMC had urged CMS to convene such a technical panel before revising and rebasing the MEI.

GEOGRAPHIC PRACTICE COST INDICES (GPCI)

To get accurate office rent data for the practice expense GPCI, CMS is considering using a proprietary data source. The AAMC believes it is important for the public to have an opportunity to comment on proposed changes, and they need access to information to provide meaningful comments. Therefore, the AAMC believes CMS should use the most accurate publicly available datasets to set the GPCI adjustments.

SUSTAINABLE GROWTH RATE

Unless there is Congressional action, physician fees will decrease 24.4 percent on January 1, 2014. The AAMC remains concerned with the projected negative update and supports a full repeal of the SGR. We encourage CMS to work with Congress to revise the physician payment formula so that physicians will no longer face an annual negative update. We also encourage CMS to find ways of funding this repeal that does not harm other providers.

If you have any questions concerning these comments, please feel free to contact Mary Wheatley, Director, Quality and Physician Payment Policies, at mwheatley@aamc.org or 202-862-6297.

Sincerely,

Joanne Conroy, M.D.
Chief Health Care Officer

cc: Mary Patton Wheatley, AAMC
    Ivy Baer, AAMC
    Evan Collins, AAMC
APPENDIX A
Quality Reporting Changes from 2013 to 2014

Table 1: Changes by PQRS Reporting Mechanism

<table>
<thead>
<tr>
<th>Reporting Mechanism</th>
<th>Group</th>
<th>Individual</th>
<th>Potential for EHR Alignment</th>
<th>Reporting Requirements</th>
<th>Changes from 2013 to 2014 (as proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPRO Web + (CG-CAHPS)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>18 predetermined measures for a sample of patients assigned by CMS.</td>
<td>Restricted to groups with 100 or more EPs.</td>
</tr>
<tr>
<td>Registry</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>9 measures/3 domains for 50% of applicable patients.</td>
<td>Increased the number of measures from 3 to 9. Decreased the reporting threshold to 50%. Added requirement for 3 domains.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>For individuals, there is a choice for a 6 month reporting period and to report “measures groups”</td>
<td></td>
</tr>
<tr>
<td>EHR</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>9 measures/3 domains EHR must be certified for measures.</td>
<td>EHR group reporting is new for 2014.</td>
</tr>
<tr>
<td>EHR/Registry + CG-CAHPS</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>CG-CAHPS required measures AND 6 measures/2 domains from EHR/Registry Groups must use a certified survey vendor.</td>
<td>CG-CAHPS new option available to groups with 25 or more EPs starting in 2014.</td>
</tr>
<tr>
<td>Claims</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>9 measures/3 domains (unless fewer than 9 measures apply) for 50% of Medicare Part B Pts.</td>
<td>Increased the number of measures from 3 to 9. Only option for EPs reporting with fewer than 9 measures.</td>
</tr>
<tr>
<td>Qualified Clinical Data</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>9 measures/3 domains for 50% of applicable patients</td>
<td>New reporting option for individuals only.</td>
</tr>
<tr>
<td>Registry</td>
<td></td>
<td></td>
<td></td>
<td>CMS calculates measures from the administrative claims information submitted by practices.</td>
<td>Available for 2013; not available for 2014.</td>
</tr>
<tr>
<td>Administrative Claims</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Table 2: Changes by Group Size

<table>
<thead>
<tr>
<th>Group Definition</th>
<th>2014 PQRS Group</th>
<th>2016 VM Group</th>
<th>Reporting Options</th>
<th>Changes from 2013 to 2014 (as proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 EP per TIN</td>
<td>No</td>
<td>No</td>
<td>Not considered a group in either VM or PQRS. See individual reporting options in Table 1.</td>
<td>See changes to the individual reporting options listed in Table 1.</td>
</tr>
<tr>
<td>2-9 EPs per TIN</td>
<td>Yes</td>
<td>No</td>
<td>Registries, EHR</td>
<td>Administrative claims option removed in 2014.</td>
</tr>
<tr>
<td>10-24 EPs per TIN</td>
<td>Yes</td>
<td>Yes</td>
<td>Registries, EHR</td>
<td>Group size subject to 2016 VM. Administrative claims option removed in 2014.</td>
</tr>
<tr>
<td>70% Individuals for groups with 10+ EPs</td>
<td>No</td>
<td>Yes</td>
<td>See individual reporting options in Table 1.</td>
<td>New option for “group reporting” for Value Modifier in 2014. Not an option for PQRS group reporting.</td>
</tr>
</tbody>
</table>