Ms. Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
ATTN: CMS-1612-P  
7500 Security Boulevard  
Baltimore, MD  21244-8013  

Re: CY 2015 Physician Fee Schedule (PFS) Proposed Rule, File Code CMS-1612-P

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, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models and Other Revisions to Part B for CY 2015. 79 Fed. Reg. 40318 (July 11, 2014). 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, 83,000 medical students, and 110,000 resident physicians.

This letter begins with a high-level review of the priority issues for academic medicine regarding physician payments, quality reporting, pay-for-performance, data collections for alternative payment models, and adjustments to the new Open Payments Sunshine Act Program, as proposed in the rule.

PQRS and Value Modifier

The AAMC is concerned that if all proposals are finalized, up to nine percent of a practice’s Medicare payments will be at risk for satisfactory reporting of Physician Quality Reporting System (PQRS), successful attestation of the Medicare/Medicaid Electronic Health Record (EHR) Incentive Program, and performance in the Value-based Payment Modifier (Value Modifier or VM). This increase in the of amount at risk is simultaneous with other major changes: upgrading to Stage 2 of the EHR Incentive Program, the shift to ICD-10 coding diagnostic system in 2015 (which affects measure specifications), substantial changes to measures and reporting requirements for PQRS, and delayed, incomplete or non-existent information on performance for the VM. The payment adjustments are also applied to a payment system that has no predictable update, leaving physician group practices with the continual uncertainty
about whether Congress will overturn the projected steep cuts with a positive, neutral, or even a potentially negative update. The constant changes imposed by CMS are expensive to implement and confusing to providers and the lack of information makes it difficult to provide meaningful comments on proposals. The AAMC, with our partners at University HealthSystem Consortium (UHC) through the UHC-AAMC Faculty Practice Solutions Center (FPSC), has been working closely with almost fifty academic centers to understand and improve their performance in these programs. The AAMC provides detailed recommendations from this work later in the letter. At a high-level, the AAMC recommends that CMS:

- **Not increase the amount at risk for the VM**
  This acceleration is premature. Numerous VM and PQRS changes each year mean that CMS, providers, and the general public are in the dark regarding the impacts on providers. Early data indicates that providers caring for the sickest patients will be much more likely to receive a negative adjustment.

- **Provide feedback to providers before performance period begins**
  Nine months into the 2016 VM performance period, providers still do not know their performance based on modifications finalized in the 2014 PFS final rule.

- **Not finalize proposed changes to the total per capita cost measures**
  The suggested modifications mistakenly assign some patients to specialty care practices and increase the cost measures for those providers who care for dying patients.

- **Stabilize PQRS reporting and provide a transition period to implement necessary changes**
  CMS should appreciate the costs, in both time and financial resources, to integrate new quality measures into practice. Instability in measures and reporting requirements makes it impossible for practices to wisely invest in performance improvement.

**“Open Payments Sunshine Act” Program**

With respect to the proposed changes to the regulations implementing the “Open Payments Sunshine Act” program, the AAMC is very concerned about the proposal to delete §403.904(g)(1), an exclusion for certain payments made in connection with accredited continuing medical education (CME). This provision was appropriately included in the final rule and made explicit CMS’ understanding that when a physician is compensated for speaking at an accredited CME program and is not chosen or directly compensated by an applicable manufacturer, there is no financial relationship between the physician and the manufacturer, and, therefore, industry support of the event should not be reported as an indirect payment to that physician speaker. In response to the proposed change to the continuing education exclusion, the AAMC urges the following:

- CMS should not finalize its proposal to remove the CME exclusion and rely solely on an interpretation of another provision of the rule because this will result in misreporting and inconsistent implementation of when an applicable manufacturer is considered “unaware” of the recipient of commercial support for accredited CME.
- CMS should retain a specific exclusion for reporting compensation to speakers for accredited CME programs when the speaker selection, compensation, and presentations are all independent of direct relationships with applicable manufacturers.
- CMS should consider making no changes to the rule until after the Open Payments database has been made public and stakeholders have had an opportunity to understand how the relevant provisions were interpreted and implemented during the first reporting period.

Other Issues of Interest

Other priority recommendations from the AAMC include:

- For program evaluation needs, the Centers for Medicare and Medicaid Innovation (CMMI) should consider the necessary data elements needed for program evaluation on a program-by-program basis rather than establishing a blanket approval for all elements which can be secondarily collected through claims or EHR uploads.
- AAMC urges caution, more clarity and a postponed effective date in the collection of information on off-campus provider-based facilities.
- CMS should not adopt interim G-codes for new and revised CPT codes.
- CMS makes several improvements to the new Chronic Care Management code, however, billing for the code is still too administratively complex.
- CMS should not finalize proposals to transition to zero-day global payments, but should engage stakeholders about their concerns and identify all the ramifications of unbundling the payments.

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SECTION I: QUALITY AND EFFICIENCY PROPOSALS

Because PQRS, the Value Modifier, EHR Incentive Program, Physician Compare and Medicare Shared Savings Program (MSSP) are closely connected, the AAMC has submitted a coordinated response that considers the impact across the programs. In addition, because faculty in academic centers almost always work in a group practice (often a large multispecialty group practice), AAMC comments represent the perspective of groups rather than solo practitioners.

General Comments and Recommendations on VM and PQRS Proposals

The VM and PQRS proposals are interconnected and complex. PQRS is a pay-for-reporting program in which groups or individuals have to “satisfactorily report” quality measures to CMS in 2015, or they will face a two percent reduction in their Medicare payments in 2017. Because of the variety of practice types, PQRS has numerous options for eligible professionals (EPs) or groups to submit quality information. The VM, in contrast, is a pay-for-performance program in which groups (or solo practitioners) are measured on cost and quality and have their 2017 Medicare Part B payments adjusted based on their 2015 performance. Generally, CMS uses the PQRS data plus additional cost and quality measures calculated from Medicare claims data as input into a “quality-tiering” methodology to determine whether a practice will receive a positive, negative, or neutral adjustment. Because PQRS data is integral to the VM methodology, the VM program places an additional automatic penalty for not reporting PQRS data. Additionally, because the VM is measured at the group level, group practices such as faculty practice plans at academic centers, have to assess which PQRS options satisfy the requirements for both PQRS and the Value Modifier. The programs are also connected to the Medicare/Medicaid EHR Incentive Program, because some PQRS options provide credit for the EHR Incentive Program clinical quality reporting requirements.

The AAMC understands CMS faces a daunting challenge in implementing overlapping programs, but the Association has significant concerns with the pace and scope of the proposed changes. In total, if the proposals are finalized, 9 percent of a practice’s 2017 Medicare payments are at risk for successful reporting of PQRS (2 percent at risk), successful attestation of the EHR Incentive program (up to 3 percent at risk), and performance in the value modifier program (4 percent at risk). While the adjustments for the PQRS and Medicare EHR Incentive Program are set by statute, the Association is extremely concerned with CMS’ proposal to double the amount at risk for the VM program from 2 percent to 4 percent, larger than any other hospital or physician quality performance program. The increase in the amount at risk is occurring simultaneous with significant changes to PQRS and other changes such as the transition to ICD-10 codes (which affects virtually all quality measure specifications) and the continued transition to Stage 2 of Meaningful Use. In addition, because of the time lag to receive feedback reports, group practices have incomplete or non-existent information on cost performance. Such an environment makes it impossible for providers and groups to understand how they are being measured, how they currently fare, and how they can improve performance.
CMS’ ability to accurately measure quality and cost performance in the VM is currently limited. The AAMC is concerned that the cost measures cannot distinguish between true outliers in costly care and physicians who care for complex patient populations. The quality data comes from multiple sources and reporting mechanisms which makes comparisons challenging. Finally, the current VM program does not have a comprehensive way to evaluate care for complex patients by the variety of providers who coordinate and manage care.

Physician reporting in general, and the Value Modifier in particular, needs a period of stability in which the quality measures, the cost measures, and the methodology do not experience radical change. This is necessary to determine who is a “good” performer and who is a “poor” performer, along with ensuring that there are no unintended consequences before the amount at risk is increased. The AAMC is very concerned that CMS and providers will not discover flaws in the methodology before unintended consequences occur. For example, the 2012 Quality Resource Use Report (QRUR) Experience Report, the most recent available data, indicates that groups with the highest risk patients are very rarely classified as “low-cost” or “high-quality” (2 percent and 5 percent respectively) and are much more likely to be classified as “high-cost” and “low quality” (31 percent and 23 percent respectively), and therefore are likely to be subjected to a penalty. Even with risk adjustment, groups caring for these high risk patients are four times more likely to be labeled “high cost.” We discuss this issue in more detail later in our comments. In recent years, CMS has implemented several cost methodology adjustments that may improve the performance distribution in the Value Modifier, but unfortunately, the group practices and stakeholders have yet to see this information. Similarly, the requirements for quality reporting have changed dramatically each year, leaving providers less than two months from the publication of the final rule in November to implement the necessary changes before the performance period begins. With so many constantly moving parts, providers and group practices are unable to strategically invest and focus on quality improvement programs. Quality measurement and reporting should be tools for meaningful performance improvement in addition to transparency. Without measure stability and sufficient performance notice to providers these policies’ potential is significantly diminished.

In addition to stability, CMS should provide a period of time to test new measures and methodology changes before implementing them in a pay-for-performance program. In the hospital pay-for-performance program, Hospital Value-Based Purchasing (VBP), Congress established a statutory requirement that quality measures be reported for at least one year prior to the start of the pay-for-performance period. Unfortunately, academic group practices do not have the same benefit. At the time this comment letter is submitted, most academic practices will not be able to estimate their performance for the 2016 VM, which was finalized in last year’s PFS final rule. They will first have access to that information when they download their 2013 QRUR report in September, nine months into the twelve-month performance period for the 2016 VM. That is too late to affect performance for that year and too late to provide feedback to CMS through this comment period. Similarly, the impact of the new proposed changes to quality and cost measures would not be known to providers until late in the 2015 reporting cycle, again too late to act upon.
The lack of stability and delayed feedback creates chaos at physician practices, which is compounded when a practice looks at the number of cumulative changes required for PQRS, the VM, and the EHR Incentive Programs. Academic centers have to coordinate activities for hundreds, sometimes thousands of clinicians. In impact analyses, CMS significantly underestimates the effort to properly implement a quality initiative, which is not just collecting the data. Faculty practices dedicate resources to set up systems of care to monitor quality improvement initiatives, educate providers, and adjust workflows. When the measures and the rules are constantly changing, providers have no target, their investments are wasted, and provider morale and care improvement efforts suffer. Though last minute measure changes are necessary sometimes, CMS should provide groups more time to transition to new measures.

The AAMC, with our partners at UHC, through the UHC-AAMC Faculty Practice Solutions Center (FPSC), has been in the forefront of understanding the implications of the Value Modifier methodology and the PQRS group reporting for academic practices and helping them improve performance. Our work started in 2010 when group reporting was first introduced and has now grown into a much broader network. In the past year, almost 50 practices participated in the FPSC Quality and Efficiency (Q&E) Module and shared their data results from the QRURs. To our knowledge, this is the largest network of its kind analyzing the data in the QRUR feedback reports. Through the FPSC Q&E Module, groups also have the opportunity to network with each other and discuss their challenges and best practices. The AAMC and UHC have openly shared key data findings and feedback with CMS, providing detailed feedback and recommendations to improve the feedback reports and improve communication with providers. The data and detailed experiences from this work have informed our recommendations:

**Summary of VM and PQRS Recommendations:**

- **Scale back the amount at risk for performance for the value modifier.**
  CMS should not increase the amount at risk in quality tiering without providing an opportunity for both providers and CMS to understand the implications of the current proposals. CMS needs to understand why the methodology disproportionately affects providers caring for high-risk patients and make those corrections; otherwise, CMS may be penalizing the wrong providers. One of CMS’ stated principles for implementing the VM is to do a gradual implementation. The AAMC believes the current proposal to double the amount at risk is not consistent with that principle. The AAMC also recommends that CMS provide only a neutral or positive adjustment for quality tiering for the 2016 and 2017 VM, as providers would not have information on how they perform until late in the performance year. The positive adjustment could be funded by providers who do not report PQRS.

- **Decouple the amount at risk for not reporting PQRS and the amount at risk for poor performance in quality tiering.**
  In the proposed rule, Agency proposes to increase the VM penalty for not reporting PQRS because previous PQRS incentives of 1 to 2 percent were not enough to incentivize widespread participation in PQRS. (79 Fed. Reg. at 40505.) If PQRS reporting is the policy concern, then CMS should have separate adjustments for groups who are not reporting PQRS data from the quality tiering methodology. Before setting that adjustment amount, however, CMS should
analyze and address the reasons providers have not been reporting PQRS. For example, many providers have been focusing on EHR implementation, which requires providers to report on quality measures, but that data submission does not always count towards PQRS reporting. In addition, PQRS has had so many changes in previous years that providers are not sure which reporting option works best for them.

- **Create a stable reporting environment, by minimizing quality measure changes and allowing time for changes to be implemented.**
Changes to the GPRO Web Interface, which is the reporting mechanism for several large groups and for the MSSP and Pioneer accountable care organizations (ACOs), are of significant interest to academic medicine. The AAMC supports modifications that are due to changes in the evidence base. However, the Association remains concerned about the operational and resource needs that are necessary to implement these measure additions and recommend that measure changes be considered for a later reporting cycle after a specified transition period.

Because groups must report ALL measures in the GPRO Web measure set to get credit for reporting, CMS must be very deliberate about which measures to add to the set. The measures must add value and be operationally feasible. In addition, measures for this set should be reviewed by the Measure Applications Partnership (MAP) for appropriateness and feasibility. The proposed measures have not gone through this type of MAP review.

- **Test new measures before immediately implementing them into the value modifier.**
CMS has been improving its QRUR feedback reports, but the Agency is not using these reports effectively to provide actionable information to the community before the performance period begins. For example, in the 2014 PFS final rule, CMS finalized inclusion of the Medicare Spending per Beneficiary (MSPB) measure; however, groups will not receive information on their performance on this measure until after the comments for this proposed rule are due.¹

- **Do not finalize the attribution methodology revisions for total per capita cost measures and GPRO web reporting.**
CMS should not finalize the attribution methodology to move certain non-physician practitioners (nurse practitioners (NP), physician assistants (PA), and certified nurse specialists (CNS)) to step 1 of the attribution methodology. This modification incorrectly assumes that all or most of these professionals provide primary care. Based on FPSC data, over 60 percent of these clinicians’ services support a specialty care practice. Adding them to step 1 could inaccurately assign some patients to the specialty team instead of their primary care team.

Similarly, CMS should not finalize the proposal to include partial-year enrollees, particularly those patients who died during the year. The AAMC understands the importance of measuring

¹ CMS estimates that 41 percent of eligible professionals are in a TIN that has an MSPB score, and for approximately 7 percent of the EPs, the MSPB is the only cost score, yet these groups have no idea how they will perform on these measures. 79 Fed. Reg. 40494.
cost at the end-of-life, but adding these patients could modify the cost scores by as much as 10 percent and would disproportionately impact groups that care for these patients. Another unintended consequence is that some end-of-life patients may be inappropriately assigned to GPRO Web measure reporting. For example, a terminal patient should not be measured for mammogram screenings. Making this change, without providing detailed information on the impact to providers, would be irresponsible.

- **Allow new measures to be reported for one year before they are included in a pay-for-performance program.**
  The MSSP ACO program provides an opportunity for new ACOs to phase in new measures. The VM should adopt this policy for new GPRO Web measures.

- **Allow groups new to GPRO Web, MSSP, or Pioneer ACOs, or any group reporting option at least one year of reporting before their data are included in value modifier quality tiering.**
  Data from the FPSC work indicates that provider performance improves the longer a group participates in GPRO Web. The first year, substantial time is dedicated to building the infrastructure and processes, that groups do not have the capacity to immediately maximize performance. The MSSP ACO program recognizes the need to establish this infrastructure and allows ACOs one year of reporting before performance is considered. The same policy should apply to groups starting GPRO Web reporting.

  CMS should also consider a phase-in for groups that choose to do other group reporting options such as registry reporting and EHR reporting. Again, shifting the reporting process from individual to an entire group requires a shift in infrastructure processes. CMS should provide an exemption from quality tiering for the first year a group signs up for any PQRS group reporting option.

- **Provide more flexibility in how groups define themselves.**
  Currently, PQRS and VM only define group practices by TIN number. While TIN is one way to define a group, it should not be the only way. The AAMC requests that CMS consider implementing the “parent-child” relationship of ACOs to establish a mechanism for related groups to nominate themselves as a single entity.

- **Claims quality measures used in the VM need to be aligned with ACOs, tested for physician groups, and risk adjusted for clinical and socioeconomic factors.**
  CMS calculates claims measures as part of the VM quality composite. These measures look at admission rates and readmission rates of the attributed patient population, but they are not adjusted for any clinical risk factors. The AAMC does not support these measures in the VM, because they were not specified for group level measurement and were not supported by the MAP; however, if CMS chooses to keep these measures, then they should be adjusted for clinical risk and socioeconomic factors.
Incorporate a socioeconomic adjustment into the MSPB measure

The AAMC does not support the use of MSPB in the VM because the measure has not been designed or tested for physician group practices. The AAMC also notes that the Affordable Care Act (ACA) requires that cost measures “take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals…” (emphasis added) for the VM. The MSPB as currently implemented does not adjust for socioeconomic status. If the Agency insists on using this untested measure, it should at least meet the VM statutory requirement and adjust for socioeconomic factors. Ideally, these adjustments would be tested in advance of the MSPB’s being used for actual payment adjustments.

Detailed Value Modifier Comments

The following is the AAMC’s response to specific proposals in the Value Modifier.

Do Not Finalize Proposal to Increase Amount at Risk for VM

CMS does not propose to modify the basic framework of the VM but does propose to double the amount at risk. Specifically, CMS proposes to increase the amount at risk for not reporting PQRS from negative 2 to negative 4 percent. Groups that meet the PQRS reporting options then automatically go into “quality tiering.” Groups with 10 or more EPs would be subject to a negative, neutral, or upward adjustment. Groups with fewer than 10 EPs and solo practitioners would only be subject to a neutral or upward adjustment.

As noted earlier in the letter, the AAMC strongly opposes the proposal to double the amount at risk in the VM from negative 2 percent to negative 4 percent, particularly for quality tiering. First, four percent is an excessive amount, more than any other performance program for either hospitals or physicians. Second, no group has had experience with the VM, as CY 2015 is the first year it will be implemented. CMS and stakeholders need time to understand the measures (which is difficult to do because the measures keep changing) and the methodology. Third, preliminary data from the 2012 QRUR Experience Report indicates that the value modifier may disproportionately affect providers who care for the sickest patients: “…[P]atients attributed to high quality and low cost groups had fewer risk factors, on average, than those attributed to groups with average and low quality and cost scores.”² (See Table 1.) In fact, groups with the most clinically complex patients are more than four times likely to be classified as “high” cost compared to all large groups (31 percent to 7 percent respectively), even after risk adjustment.

Table 1: Group Characteristics for 2015 Quality Tiering (Based on 2012 Data)

<table>
<thead>
<tr>
<th>Group Characteristic</th>
<th>Quality</th>
<th></th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>Avg</td>
<td>High</td>
</tr>
<tr>
<td>All groups with 100+ EPs</td>
<td>9%</td>
<td>84%</td>
<td>5%</td>
</tr>
<tr>
<td>Groups with the most clinically complex patients (HCC Risk Score in the top quartile)</td>
<td>23%</td>
<td>67%</td>
<td>5%</td>
</tr>
<tr>
<td>Average HCC Risk Score (Higher scores = riskier patient population)</td>
<td>1.59</td>
<td>1.07</td>
<td>0.96</td>
</tr>
</tbody>
</table>

Source: PY2012 QRUR Experience Report, Table V.5

AAMC understands that the 2012 data must be viewed cautiously, because CMS made numerous changes to the quality reporting options along with the cost measures and methodology; but as CMS has not published the results of those changes, there is no more recent information available for review. This type of data is necessary before CMS increases the amount at risk.

The delay in feedback reports is another reason to be cautious about increasing the amount at risk in the VM. Of the academic medical centers in the FPSC cohort, only one would have experienced a negative adjustment based on the 2012 QRUR, but these practices have absolutely no idea how they will perform when the new specialty adjustment is applied for the 2016 VM and when the MSPB measure is incorporated into their cost score. That information will not be available until they get their 2013 QRUR report (expected in September), which is nine months into the performance year for the 2016 VM.

For all of these reasons, CMS should not finalize the proposal to increase the amount at risk for quality tiering. If CMS is concerned about PQRS reporting, then the Agency can separate the amount at risk for not reporting from the amount at risk in quality tiering.

In addition, CMS should reconsider the quality tiering policy for the 2016 VM and the 2017 VM, and state that all group practices (regardless of size) will only have a neutral or upward adjustment in 2016. The upward adjustment could be funded by groups that do not report PQRS data. That policy change would encourage PQRS reporting and would not inadvertently penalize providers caring for sick patients.

**Support Expansion of the VM Payment Adjustment to All PQRS Eligible Professionals**

The AAMC supports the CMS proposal to expand the 2017 VM payment adjustment to all PQRS eligible professionals. Currently, PQRS is an input into the VM, and the number of PQRS eligible professionals is considered when determining the size of the group practice for the VM. Prior to the 2017 VM, however, only physician payments were adjusted. Expanding the payment adjustment to include all PQRS EPs aligns the eligibility criteria for both PQRS and the VM. CMS may need to ensure that group practices consisting of only non-physician clinicians have received feedback reports before they are
eligible for a negative payment adjustment through quality tiering. As with other groups, sufficient and timely feedback is needed to understand VM performance.

**Exempt ACOs and Participants in Other Alternative Payment Models from the VM**

The AAMC urges CMS to explore its authority to create an exemption for MSSP and Pioneer ACOs and other participants in alternative payment models from the VM program. The Association understands that section 3007 of the ACA requires that CMS apply the VM to all physicians and groups of physicians no later than January 1, 2017. However, as CMS noted, these programs have their own rules and incentives to ensure providers deliver high quality and efficient care. The AAMC believes that the general waiver authority granted to MSSP by Congress under the ACA and the provision authorizing CMMI would allow CMS to continue to exempt EPs participating in the MSSP, Pioneer ACO, and other CMMI programs from the VM. If organizations participating in ACOs want to be included in the VM, however, they should have the option to do so.

If CMS includes the alternative payment models in the VM, then the AAMC supports the proposal to classify groups within the ACO as “average cost,” at least for the 2017 VM. The AAMC agrees that because cost measures are calculated so differently, comparison of the two would be confusing.

**Slight Modifications Needed to Proposals for Applying the VM to TINs Entering or Leaving an ACO or Other Alternative Payment Models**

In the proposed rule, CMS outlines numerous scenarios of how the Agency will handle TINs that enter or leave an MSSP ACO, Pioneer ACO, and other CMMI models between the performance year and the payment adjustment year. The AAMC appreciates that CMS is providing this detail, because regardless of whether ACO participants are subject to the VM, there will be groups that transition in and out of payment models. While the tables can get confusing, this level of detail is necessary for providers to understand the implications of joining or leaving an ACO.

In general, the AAMC supports CMS’ position that the VM does not “track” or “carry” an individual’s performance from one TIN to another. The AAMC believes that most of the scenarios listed in Tables 56 and 57 are consistent with this policy; however the AAMC does have concerns about a few of the scenarios in the rule, which are described in the table below.
### Scenario

<table>
<thead>
<tr>
<th>Table 56, Scenario D – Dropping out of an ACO. In this case a TIN was in an ACO during the performance period and was not in the ACO before the payment adjustment period. CMS would assume the TIN has “average quality” and would calculate the cost data from the TINs history.</th>
<th>The AAMC recommends that CMS change this option so that the group is deemed “average cost” for the payment adjustment. During the performance period, the group was working to achieve ACO cost benchmarks. Calculating a different cost calculation after the performance period is over changes the rules for measurement. To be consistent, CMS should label the TIN as average quality and average cost.</th>
</tr>
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<tbody>
<tr>
<td>Table 57, Scenarios a1-a3: Dropping out of Pioneer or Comprehensive Primary Care (CPC) Initiative. In this case, some or all of the EPs within a TIN are in either the Pioneer or CPC Initiative during the performance period and were not in an MSSP or similar CMMI model during the payment adjustment period. CMS proposes to calculate the cost metrics based off the historical payments for these groups.</td>
<td>Similar to the situation above, the AAMC believes these groups should be classified as “average cost” because at least a portion of the group was being measured on different cost metrics during the performance period.</td>
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In addition to these modifications, the AAMC notes that some groups may enter and leave these programs in the middle of the year. CMS needs to provide guidance as to what happens when a TIN leaves in the middle of these time periods.

**VM Quality and Cost Measures**

**In Limited Circumstances, CMS Should Exempt Some PQRS Measures from the VM Quality Tiering**

CMS proposes to use each measure reported via PQRS for the VM quality tiering, assuming the measure has been in PQRS for at least a year and CMS can calculate a benchmark for that measure.

The AAMC believes, however, that in the following limited circumstances, measures submitted to PQRS should not be considered for performance.

- **Measures that are new to GPRO Web/ACO reporting should not be included for performance in the first year of reporting.**
  This policy is consistent with the MSSP ACO policy, which allows ACOs to report measures one year before being measured on performance.
- **Groups that are new to GPRO Web Interface reporting should have at least one year to report measures before they are measured for performance.**
  GPRO Web participants typically spend the first year setting up the infrastructure to do reporting, and need time to adapt to the new processes. Significant performance improvement occurs in later years. The AAMC’s proposal is also consistent with the MSSP ACO policy that allows groups to receive full credit if they are able to report for the full year. The latest GPRO data from the FPSC Q&E module shows that participants who reported via the GPRO Web Interface for two years improved on virtually all the measures.

- **Finally, groups that are new to group reporting (via registry or EHR) should have at least one year to report before their measures are used for performance.**
  CMS should also consider a phase-in for groups that choose to do a group reporting option, such as registry reporting and EHR reporting, for the first time. Again, shifting the reporting process from the individual to the entire group, especially large multispecialty group practices, requires a shift in infrastructure processes. CMS should provide an exemption from quality tiering for the first year a group signs up for a PQRS group reporting option.

**Claims Quality Measures Need to Align with ACOs, Be Tested for Physicians Groups and Be Risk Adjusted for Clinical and Sociodemographic Factors.**

Previously, 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. at 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.

This year, CMS proposes some adjustments to this methodology. First, CMS proposes to increase the sample size for the readmission rate measure from 20 to 200 to ensure reliability. Second, CMS proposes to continue using these three measures in the quality composite if the TIN is not part of an ACO. If the TIN is an ACO, then CMS will use the ACO-specific readmission measure but will not use the other admission composites, because the ACOs are not being measured by those metrics.

The AAMC believes that providing readmission rates to provider groups can be valuable in helping groups identify opportunities for improvement; however the AAMC continues to be concerned about the inappropriate usage of admission composite measures in the Value Modifier quality tiering methodology. In April 2013, the MAP clinician workgroup reviewed these measures for appropriateness for the VM and did not support the measures, because they are
community measures and have not been tested for physician groups. In addition, these measures are not risk adjusted for clinical or sociodemographic factors, which will negative impact providers who care for sicker and disadvantaged patients.

Among the academic practices that were included in our QRUR benchmark analysis, every practice had risk profiles that were higher than the national average. The risk percentiles ranged from the 63rd percentile to the 81st percentile, and the median was the 74th percentile. Even with the “primary care” attribution methodology assignment, academic medical centers were taking care of the sicker, more complex patients. However, in part because the scores are not risk adjusted, academic medical centers did worse on these measures, with several centers being tagged as “outliers” for admissions compared to providers who cared for healthier patients. Not adjusting for clinical factors is unacceptable. In addition, the AAMC has long stated that admissions and readmissions measures should also be adjusted for sociodemographic factors to ensure a fair comparison. The Association believes these measures require that adjustment as well.

While the AAMC supports the need for reliable measures, the requirement to change the sample size for the readmission measure, from 20 to 200, reinforces concerns that this measure may not be appropriate for physician accountability. As the costs of readmissions are already included in the total per capita costs, the AAMC does not believe this measure adds value to the VM.

Finally, the AAMC encourages CMS to align the claims measures for the ACO program and the VM. As both programs use a similar 2-step methodology for attributing patients, claims measures should be similar.

In summary, the AAMC does not support these measures in the VM quality tiering, because they were not specified for group level measurement and were not supported by the MAP. The Association requests that these measures be removed from VM quality tiering. If CMS chooses to keep these measures, then they should be adjusted for clinical risk factors and for sociodemographic factors. Finally, the claims measures for the ACO program and VM should be aligned as the attribution methodology to assign patients are similar in both programs.

All VM Cost Measures, Including MSPB, Should Have a Socioeconomic Adjustment

As noted above, the AAMC opposes the use of the MSPB measure in the Value Modifier. If this measure is included, then the measure must account for socioeconomic factors, which is consistent with section 3007 of the ACA. If the Agency insists on using this untested measure, it should at least meet the VM statutory intent and adjust for socioeconomic factors.

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CMS Should Not Finalize Proposed Changes to the Total Per Capita Cost Measures

CMS applies a two-step methodology to assign beneficiaries to group practices for the total per capita cost measures. The first step is to identify the group that furnished the plurality of primary care services by primary care physicians. Any patient not assigned in the first step goes to the second step and is assigned based on the plurality of primary care services provided by all clinicians including nurse practitioners (NP), physician assistants (PA), and certified nurse specialists (CNS). The measure also excludes any beneficiaries with partial year enrollment, such as new Medicare enrollees and patients who died, as these patients would not have a full year of cost data.

When the total per capita cost measure went through the NQF endorsement process, the technical review panel expressed concerns that the measure did not include NPs, PAs, and CNSs in the first step because these clinical personnel often deliver primary care. The panel was also concerned that the measures did not capture costs for end of life care.

Based on feedback from the NQF, CMS proposes to make two modifications to the attribution process for the total per capita cost measure in the VM. First, it would move all NPs, PAs, or CNSs to step 1 of the attribution methodology. Essentially, these non-physician professionals would now be included in the list of “primary care” providers. In addition, CMS would include patients who newly enroll in Medicare and those who pass away during the year in the measure.

CMS provides no analysis to stakeholders about the implications of the methodology changes in the proposed rule; however, the appendix of the NQF report for this measure contained some relevant information. While these changes seem minor, the AAMC estimates they could have a disproportionate and unintended impact on faculty practices and believes these changes should not be finalized.

First, moving all NPs, PAs, or CNSs to step 1 of the attribution methodology incorrectly assumes that all or most of these professionals provide primary care. However, FPSC data shows that at academic medical centers, on average, 63 percent of the services provided by these non-physician clinicians are for specialty care. Adding them to step 1 could inaccurately assign some patients to the specialty team and away from their primary care team. Rather than finalize the proposal, CMS should consider creating new specialty codes to distinguish which non-physician practitioners practice primary care and which practice specialty care.

Similarly, CMS should not finalize the proposal to include partial-year enrollees, particularly those patients who died during the year, for multiple reasons. Based on the sample of data in the NQF report, adding these patients who died could modify the cost scores by as much as 10 percent and would disproportionately impact groups that care for these patients. Although CMS noted the correlation between the cost measure with and without partial-year enrollees was high, the Agency also has a chart that indicates approximately 10 percent of providers in the high-cost
quintile could change quintiles based on this adjustment. With mandatory quality tiering, and proposals to increase the amount at risk to 4 percent, that is a large amount of uncertainty for providers. In addition, CMS does not describe how it will adjust the costs for partial year data. Finally, the attribution could affect GPRO Web reporting as well as cost performance. Certain GPRO Web measures, such as mammogram screening, are not appropriate for patients receiving end-of-life care.

In short, the AAMC has major concerns that these proposed changes could have unintended consequences and that implementing the changes could significantly affect provider performance in the quality tiering methodology. CMS has not done its due diligence to analyze the impact of these changes and share the analysis with the providers and the broader stakeholder community. Consequently, CMS should not finalize these proposals.

Additional Time Needed for Informal Appeal for VM

CMS proposes that starting 2016, groups will have 30 days after the release of the QRUR reports to request an informal review of the VM adjustment. The AAMC believes 30 days is too short. A 90-day period is needed for groups to download reports, analyze the results, and determine whether to file an informal appeal.

CMS Should Have an Option for Hospitalists That Aligns With Hospital Value-Based Purchasing

CMS is seeking feedback on how to align hospital-based physicians with the inpatient VBP program. The AAMC supports a voluntary option that aligns across programs, is appropriate for the physician practice, and reduces reporting burden. The AAMC supports a nomination process whereby groups can elect this option and identify the corresponding partner hospitals. CMS should not attempt to use the EHR Incentive criteria to determine hospital-based physicians, because eligibility would not be stable (as providers can change hospital-based status each year).

Quality Resource Use Reports (QRUR)

The annual QRUR report is a critical tool used to provide feedback to physicians. The AAMC applauds CMS for working with various stakeholders to make improvements year after year in these reports. The Association looks forward to seeing the new enhancements for the 2013 performance year QRUR which is expected to be widely released in early September 2014.

Through the FPSC Q&E Module, the AAMC and UHC have been working with practices to analyze the data in the QRURs and look for trends. While we commend CMS for the Agency’s work to improve the QRUR, several challenges still remain. This data is the only source of feedback to providers, yet they do not receive reports until September, nine months into the reporting period for a future VM.

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The AAMC believes that CMS has the opportunity to use the QRURs more effectively to test possible options or methodology changes for the VM. For example, CMS finalized a policy to include the MSPB in the 2016 VM. Approximately 41 percent of the EPs were assigned a cost score based on this measure, but they have no idea how they will perform. Approximately 7 percent of the EPs are in a group where the only cost measure will be the MSPB. The AAMC encourages CMS to use the QRUR reports to test methodology changes to the value modifier before finalizing the proposals in a pay-for-performance program.

The AAMC also encourages CMS to further improve QRUR experience reports by enhancing the tables that describe how different practice types perform in the quality tiering methodology. In particular, CMS can analyze the composition of the groups by different specialties, sites of service, PQRS reporting mechanisms, and whether the group has a total per capita and/or MSPB score.

**Detailed PQRS GPRO Reporting Options Comments**

CY 2015 is the first year that providers will not be able to receive an incentive for successfully reporting in PQRS. Instead, between the PQRS and VM programs, there is a threat for a 6 percent reduction in 2017 for not reporting on the 2015 performance year. The PFS proposed rule has several proposals which affect PQRS. Of particular interest to academic medical centers, are the proposed measure changes to group reporting options: GPRO Web Interface, which is the reporting mechanism for several large groups as well as for the MSSP and Pioneer ACOs, and Group Registry Reporting. Both reporting options have the requirement to report on new measures for 2015.

The AAMC appreciates that CMS needs some flexibility to add new measures and retire certain measures, but if the Agency wants to drive performance improvement then it has to provide some stability as well, so that providers can build systems to support the efforts. The AAMC cautions CMS on making too many measure and reporting requirement changes for CY 2015. With the upcoming ICD-10 conversion, most quality measures will need to be updated next year. Forcing physician practices to make the investment for one year, when the measures have to be updated the next year, does not make sense. CMS should work to make sure that existing measures are modified to meet the newest clinical guidelines and should retire measures that are not designed for physician performance. However, the AAMC recommends that other measure and reporting modifications be deferred for a later reporting cycle after a transitional period.

**GPRO Web Proposals**

GPRO Web Interface is unique in PQRS, because it is the only reporting option that requires all respondents to report on the same set of measures. Under the other PQRS reporting options, providers have the flexibility to select measures that are most relevant and can be effectively collected within their practice.
In GPRO Web, CMS attributes beneficiaries to a practice, then the groups must report the quality metrics on a sample of the attributed patient population. In the rule, CMS proposes the following modifications to the GPRO Web reporting option:

- Removal and addition of several measures;
- Proposal to change the sample size for all groups to 248. Previously, groups with 100 or more EPs had to report on 411 patients and groups with 25-99 EPs had to report 218;
- Proposal to adopt changes to the attribution methodology to be consistent with what is being proposed for the VM cost measure, and;
- Proposal to continue to require the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey for groups with 100 or more EPs. In addition, groups would have to pay for the survey administration for the first time.

Comments on Measure Changes

**MAP Should Review Proposed Measures Specifically for the GPRO Web/MSSP ACO Measure Set**

Because all practices reporting GPRO Web (including all MSSP ACOs and Pioneer ACOs) have no flexibility in reporting, it is essential that this dataset be reviewed cohesively as a set. This review is currently done by the MAP when it considers measures for the “MSSP ACO” program. The review considers whether the measures add value and are operationally feasible. Most of the proposed measures for GPRO Web have been reviewed by MAP for the general PQRS program (where providers have flexibility to select measures), but they were not reviewed for the GPRO Web/ACO data set. The AAMC is disappointed not to have feedback from this group and has concerns about the operational feasibility of adding certain measures into the GPRO Web measure set.

**AAMC Supports Recommendations to Remove Certain Measures from the GPRO Web Measure Set**

CMS proposes to remove several measures from the GPRO Web Interface:

- Four of the five components of the optimal diabetes care composite because they were either duplicative of other measures or the guidelines for the measure have been changed;
- Three lipid measures because the guidelines have changed; and
- A medication reconciliation measure (which is replaced by a medication documentation measure).

The AAMC supports the removal of these measures and appreciates CMS’ efforts to keep measures current and to remove measures which are duplicative and/or that are not appropriate for physician group practices.
AAMC Does Not Support All of the Proposed New Measures for the 2015 GPRO Web Interface Measure Set.

CMS proposes to add or modify nine measures in the GPRO Web measure set. These measures include

- four diabetes measures (which are proposed to be compiled in a new composite measure);
- three coronary artery disease (CAD) measures (which are proposed to be included in a new composite);
- documentation of current medications in the medical record; and
- depression remission at twelve months.

The AAMC believes the proposed diabetes and CAD measures represent current clinical guidelines but add marginal value to the existing set of measures. One measure (CAD Symptom Management) is not e-specified, and does not have the underlying coding infrastructure to integrate the measure easily into the EHR. In addition, two measures, the diabetes eye and foot exam, were rated lowest importance by a Physician Compare technical panel for publicly reporting measures.\(^5\) So while the AAMC does not oppose these measures, they do not add value to the existing measure set for diabetic and CAD patient care.

The AAMC opposes the proposal to create new composites for diabetes and for CAD. CMS does not describe how the composite would be created or tested. Just because individual components of a composite are tested and endorsed by NQF, does not mean a composite is tested and validated. In our “Guiding Principles for Public Reporting of Provider Performance,” the AAMC states that “creating composites from disparate measures for ease of display should be avoided. Composite measures that receive NQF endorsement should be used.”\(^6\) The AAMC recommends that CMS test its composite measures and submit the composite to NQF for endorsement.

AAMC does not support inclusion of the proposed depression outcome measure, Depression Remission at Twelve Months, because the measure would be operationally difficult to implement within the GPRO Web Interface. The timing of the measure spans more than the twelve-month reporting cycle, making clinical and operational attribution difficult. The cohort identification and outcome reporting require a survey administration, which is not easily connected to secondary sources. Because the GPRO Web cohort is assigned retrospectively based on claims data, CMS would not have the necessary information to identify the appropriate sample. More importantly, depression is not a simple condition where a single number can demonstrate “remission” or “control.” It is a disease that runs a full spectrum. A depression scale can show improvement and indicate when someone may be depressed, but it cannot demonstrate true remission (absence of a disease at a point in time). The AAMC is concerned that this measure could incorrectly label patients as “cured” which

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\(^6\) [https://www.aamc.org/download/370236/data/guidingprinciplesforpublicreporting.pdf](https://www.aamc.org/download/370236/data/guidingprinciplesforpublicreporting.pdf)
could lead to unintended consequences. For these reasons, the AAMC does not support inclusion of this measure for the 2015 GPRO Web measure set.

The AAMC strongly supports the practice of proper medication documentation and reconciliation, but does not believe the proposed medication documentation measure is the most appropriate way to measure medication management, nor does the administrative burden add value to patient outcomes. EPs are already required to do medication reconciliation as a Meaningful Use (MU) Stage 2 objective, which is similar to this PQRS measure. However, a major difference between the MU Stage 2 objective and this quality measure is the timing of the documentation. For MU Stage 2, EPs are required to do medication reconciliation when there is a transition of care or a relevant encounter. In contrast, the PQRS measure requires detailed medication documentation for each visit for all providers.

A second concern is properly documenting the work to ensure a physician receives credit when medication is properly managed and documented. While the clinician is ultimately responsible for ensuring proper medication management, the actual medication documentation may be done by other team members, such as pharmacists, care managers, or other people on the care team. The AAMC is worried that based on how the information is captured in the EHR, the physician may not receive credit (due to the measure specifications) for work that is being done.

Finally, the AAMC believes that this measure is not able to distinguish true performance differences in medication management. For example, some practitioners do a detailed review every visit, but other practices may simply ask a patient if their medications have changed. If the patient says “No” then the provider can click a box acknowledging the patient medication list is accurate. The EHR measure as proposed is not able to adequately discern differences in performance. Fundamentally, this is a process measure that does not reflect patient oriented outcomes that matter.

Because of the potential burden and operational and performance concerns with this measure, the AAMC does not recommend this measure for the core set of ACO/GPRO Web reporting for 2015. This measure should remain an optional measure for individual and group PQRS reporting. Because reconciliation is required for Stage 2 reporting, the AAMC believes the incentive to do appropriate medication documentation exists. In the future, CMS can reassess a medication documentation measure after evaluating information from the Stage 2 reporting. CMS also should ask the MAP to review this measure and to consider whether all EPs need to report this measure or if the measure should be reported when there is a change to the medication regimen.

Proposal to Change Sample Size
The AAMC supports CMS’ proposal to reduce the sample size for GPRO Web reporting for large group practices from 411 patients to 248. This change will simplify reporting and reduce some of the burden to identify and report these patients.
CG-CAHPS
To get credit for GPRO Web, CMS proposes to require CG-CAHPS reporting for groups with 100 or more EPs. The requirement is optional for groups of 25-99 EPs for the 2015 reporting period, but would be mandatory in following years. And, unlike previous years, CMS is requiring all groups to pay for the survey administration using a certified vendor.

The AAMC supports CG-CAHPS reporting if it can be done efficiently and effectively and supports voluntary reporting of this survey for the 2015 PQRS performance period. The AAMC does not support mandatory reporting for large group practices in 2015 until it is clear how much this will cost physician groups. CMS has not provided an estimate of the cost to administer the survey, nor has it published the list of certified vendors, so groups are not able to properly estimate and budget the cost. Most academic practices routinely conduct ambulatory patient experience surveys, but that data cannot be submitted for PQRS credit because PQRS has very specific sampling and attribution requirements for the Medicare population. Any PQRS CG-CAHPS survey administration would be an additional cost solely for the purpose of PQRS reporting. CMS should not finalize this as a mandatory requirement until groups have the ability to estimate the cost and comment on the potential financial burden. Groups should also have the opportunity to budget for the survey administration.

Finally, the AAMC asks CMS to clarify whether CG-CAHPS is automatically included in the VM calculation or not. Currently, 2013 GPRO Web participants are awaiting the results of the survey administration. Because groups have yet to see their performance, the Association recommends CG-CAHPS should be optional for quality tiering in the 2017 VM.

AAMC Supports Earlier Group Registration Deadline If Certain Conditions Are Met
CMS proposes to move the registration date for group reporting from September 30 to June 30. The AAMC supports this earlier registration date if the following conditions are met:

- Groups need to know well before June 30 which registries are available for PQRS group reporting. Based on our FPSC work, registry and GPRO Web are the two most common reporting mechanisms. Groups need time to meet with registries and understand the costs before they finalize their reporting options.
- CMS must have a process for groups that form after June 30, so that they either have an opportunity to report as a group or can be exempt from the automatic PQRS and VM penalties. Health care markets are constantly changing, and forcing a TIN that starts after June 30 to do individual reporting to avoid the VM and PQRS penalties is counter-productive.
- CMS must also provide guidance on PQRS requirements for groups that enter or leave an ACO after June 30, so that the groups understand their obligations.

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7 A list of providers was not displayed on the PQRS CG-CAHPS webpage, [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Certified-Survey-Vendor.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/CMS-Certified-Survey-Vendor.html), viewed on August 28, 2014. ACO approved vendors were recently published on the ACO website.
New Reporting Requirements for Registries and Group Registry Reporting Option

CMS Should Phase In New GPRO Registry Reporting Requirements

CMS proposes that to avoid penalties, groups must report 9 measures across 3 domains. This proposal includes a new requirement for reporting at least two cross-cutting measures if the practice has at least one face-to-face encounter with a patient. This is a three-fold increase from 3 measures/1 domain required in 2014 to avoid the payment adjustment. Again, the AAMC believes CMS should not adding new reporting requirements without providing sufficient time to implement the changes.

CMS Should Create an Exception for the Cross-Cutting Measures Requirement for Closed Registries (That Is, Those Not Open to Any EPs)

To facilitate the new cross-cutting measure requirement, CMS is proposing to require all registries to be able to report all measures. In general, the AAMC supports this requirement but believes that an exception should be made for closed registries. Some faculty practices have opted to be their own registry to facilitate group reporting. The registry is not open to the public, so the requirement to implement all 18 measures is burdensome and unnecessary. The registry should be able to implement the necessary cross-cutting measures needed to support its membership.

Group EHR Reporting Is Not Possible for Most Academic Practices

CMS does not make changes to the GPRO EHR Reporting option; however, the AAMC remains concerned that our academic centers have not received support from their EHR vendors to do EHR or GPRO Web reporting. In particular, the largest vendors have explicitly said they will not support the EHR reporting option. CMS needs to work with the vendor community to resolve any issues so that group practices have the option to report EHR quality metrics. If that is not possible, CMS should allow practices that report quality data through the EHR Incentive program to receive credit for PQRS reporting and not be subjected to automatic penalties.

Physician Compare Website

CMS proposes that all data reported through PQRS in 2015 have the potential to be posted to the public website if technically feasible. The Agency also plans to add benchmarks and has laid out a calendar for reporting more PQRS performance data.

The AAMC recently published guidelines for public reporting of provider performance information. Public reporting should have a clear purpose, be transparent, and be valid. The current Physician Compare website is just starting to report quality data, and the AAMC believes there could be better communication about the measures and interpretation of the performance. The AAMC encourages CMS to actively engage stakeholders – including providers and consumers – as the Agency implements these changes.

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changes. CMS should also advertise the technical expert panel meetings, so that the public has the opportunity to comment and inform the discussion.

MEDICARE SHARED SAVING PROGRAM PROPOSALS

The PFS rule has several proposals to update the quality reporting requirements, benchmarks, and reporting requirements for MSSP ACOs. The AAMC’s comments are divided into the following sections.

1. Changes to the ACO measure set
2. Transition period for new measures; new ACOs
3. Stabilizing the benchmark performance period;
4. Clarifying the requirements for EHR reporting; and
5. Modifying the quality scoring to reward performance improvement

MSSP Proposal 1: Change in ACO Measures

MSSP ACOs have measures from multiple different sources:
- Measures reported through the GPRO Web Interface
- CG-CAHPS, or patient experience data, from surveys
- Admission and readmission measures calculated from Medicare claims data; and
- Attestation information from the EHR Incentive Program

GPRO Web for MSSP ACOs Should Continue to Align with GPRO Web for PQRS Group Reporting

Previously, CMS aligned the GPRO Web and MSSP ACO reporting requirements. For 2015, CMS will continue the alignment. Many of the proposed changes to GPRO Web, including changes in the measures and sample size requirements, are also being proposed for the MSSP ACO measure set. The AAMC supports this continued alignment. Please refer to the comments in the GPRO Web portion of the letter to see specific recommendations on the individual proposed measures.

New CAHPS Measure for Stewardship of Patient Resources Should Be Used for Reporting Only

CMS proposes to include for scoring purposes a new question in the CAHPS measure which asks the patient if the care team discussed or talked about prescription medicine costs. The AAMC strongly believes that providers should be more proactive about understanding the patient’s medical expenses and access to needed medications. This measure is collected in the current survey administration and this information should be reported.

The AAMC does not recommend that this measure be used for the scoring methodology for shared savings. This is an intermediate outcome that reflects concern about medications on the basis of cost and

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9 Note: one difference between GPRO Web and MSSP is the proposed change in attribution methodology. The methodologies will be similar, but not exact.
does not reflect adherence or regimen complexity, which are at least as important as financial access. The AAMC encourages CMS to distribute the outcomes of this measure for public comment before including it for shared savings.

**Claims Measures Should Be Tested, Risk-Adjusted, and Align with the Value Modifier**

CMS proposes to add several new claims-based measures:

- Skilled Nursing Facility (SNF): 30-day All-Cause Readmission Measure
- All-cause Unplanned Admissions for Patients with Diabetes
- All-cause Unplanned Admissions for Patients with Heart Failure
- All-cause Unplanned Admissions for Patients with Multiple Chronic Conditions

The AAMC does not support inclusion of the SNF 30-Day All-cause Readmission Measure. While the AAMC agrees that ACOs need to monitor and reduce unnecessary admissions and readmissions to be successful, CMS already has a 30-day hospital readmission measure for the population which creates an incentive for ACOs to work with post-acute care (PAC) providers. The AAMC does not understand how a SNF readmission measure would be implemented in an ACO program, nor does the Association understand what additional information the SNF readmission rate performance would add that the current readmission rate does not provide. The AAMC does see informational value in CMS’ reporting readmission rates by SNF provider to ACOs for their internal operations, but reporting an aggregate rate does not provide additional quality incentives or actionable information.

The AAMC also believes it is premature to include the three unplanned admission measures that under development at Yale. These measures should be tested and endorsed by NQF before being used for performance and should not be finalized until there is a final measure to review.

The AAMC is concerned that none of these measures is adjusted for sociodemographic factors. A recent NQF expert panel recommended that it is appropriate to adjust certain measures for sociodemographic status to ensure fair accountability. NQF is in the process of developing a trial period of testing such an adjustment, and readmission measures most likely will be a priority. The AAMC believes the admission and readmission measures should be adjusted as well.

The AAMC also urges CMS to align the claims measures for the ACO program and the VM. Currently, the admission measures and readmission measures are completely different. While the AAMC recognizes the two programs serve different functions, this disconnect in measures does not make sense as both programs have similar attribution methodologies.

For these reasons, CMS should not finalize the proposal to include these measures. CMS should test measures for physician groups with appropriate risk adjustment for clinical and sociodemographic factors, and then align the measures with the VM.
MSSP Proposal 2: Transition Period for New Measures; New ACOs

In the proposed rule, CMS clarifies that existing ACOs will receive full credit simply for reporting the new measures for the first year (or in some cases two years). After the reporting period, the ACOs will be measured on their performance. The AAMC supports the idea of a transition period to implement new measures. The Association also believes that ACOs and group practices should have feedback on performance prior to the start of the measurement period that affects payments. Because it takes up to 18 months to establish processes, receive feedback and incorporate the feedback, the AAMC requests that ACOs be given two years to report the measures before they are measured on performance. Additionally, whatever transition time is finalized for ACOs should apply to ACOs and GPRO Web participants in the VM program as well.

CMS also restated that new MSSP ACOs have a transition schedule that permits pay-for-reporting in the first year and then transitions to pay-for-performance in later years. The Agency proposes that ACOs that are renewing their 3-year contracts would not have this transition period except for new measures. The AAMC supports this proposal and requests that the VM program adopt a similar policy that allows group practices at least one year to develop and establish processes for reporting.

MSSP Proposal 3: Stabilizing the Performance Benchmark

To provide more stability in the quality performance benchmarks, CMS proposes to update the benchmarks every two years. The AAMC supports this proposal. It provides ACOs a stable target for their performance metrics.

MSSP Proposal 4: Clarifying Requirements for EHR Reporting

CMS proposes to make an adjustment to the ACO regulations to clarify that groups that submit data to an ACO for GPRO reporting from their certified EHR can get credit for reporting quality measures in the Medicare EHR Incentive Program. The AAMC supports this change and believes it helps align the ACO and EHR Incentive Programs.

MSSP Proposal 5: Rewarding Improvement in Quality Performance

Currently, part of the ACO shared savings rate is determined by the ACO’s performance on quality measures. Because the system exclusively focused on performance, there was no bonus for groups that improved over time. To address this, CMS proposes a methodology where ACOs can get extra credit toward their reporting if they show a statistically significant improvement.

The AAMC strongly supports inclusion of an improvement score and believes this is a good first step. If this process appears to work well, CMS should consider adding an improvement credit to the VM program as well.
SECTION II: OPEN PAYMENTS SUNSHINE ACT

Reports of Payments or Other Transfers of Value to Covered Recipients

The AAMC is very concerned about the proposal to remove §403.904(g)(1) from the regulations implementing the “Open Payments Sunshine Act” program. This provision was appropriately included in the final rule and made explicit CMS’ understanding that when a physician is compensated for speaking at an accredited continuing medical education (CME) program and is not chosen or directly compensated by an applicable manufacturer, there is no financial relationship between the physician and the manufacturer, and, therefore, industry support of the event should not be reported as an indirect payment to that physician speaker. The removal of this provision and CMS’ reliance on a new interpretation of whether an applicable manufacturer is “unaware” of the recipient of CME program funding would lead to additional confusion on the part of applicable manufacturers and the inappropriate reporting of indirect payments to physicians. The CME accreditation standards in place already include effective firewalls created to safeguard against this relationship. The provision was included in the final rule precisely to avoid this situation.

In response to the proposed change to the continuing education exclusion, the AAMC urges the following:

1. CMS should retain §403.904(g)(1) in some form, and explicitly exclude from reporting the compensation to speakers for accredited Continuing Medical Education (CME) programs whose selection, compensation, and presentations are all independent of direct relationships with applicable manufacturers.

2. CMS should not rely on an interpretation of §403.904(i)(1) to achieve the goals of the current accredited CME exclusion, because this will result in misreporting and inconsistent implementation of when an applicable manufacturer is considered “unaware” of the recipient of commercial support for accredited CME.

3. CMS should consider delaying a decision on how best to address the concerns with §403.904(g)(1) until after the Open Payments database has been made public and stakeholders have had an opportunity to understand how §403.904(g)(1) and §403.904(i)(1) have been interpreted and implemented during the first reporting period.

AAMC strongly urges CMS to retain the exemption in §403.904(g)(1) for accredited CME and concurs with other organizations that have also warned against removing this provision entirely. Retaining an explicit exclusion from reporting compensation to speakers at accredited CME programs is in line with congressional intent, provides consistency in the application of the rule, respects the careful process that led to the inclusion of §403.904(g)(1) in the February 8, 2013 final rule (78 Fed. Reg. 9458), and
contributes to the accuracy and transparency of the information reported to the public on the Open Payments database.

The AAMC shares the goals that CMS has expressed to exclude from reporting payments that do not create a relationship of any kind between an applicable manufacturer and an individual physician, as in the case of a physician who is a speaker at an accredited and certified CME program. As the Association wrote in a February 17, 2012 letter to CMS in response to the proposed rule (76 Fed. Reg. 78742):

“Reporting such engagements as indirect payments from applicable manufacturers to the faculty physicians would result in information that would be inaccurate, misleading, and could serve to weaken public trust in the medical education of our healthcare workforce by suggesting a financial relationship between industry sponsors and faculty members that does not exist. Institutions that encourage their faculty to participate in accredited CME events often do so precisely because the link to commercial sponsors is broken by an accredited CME provider.”

As the Association further explained, “we agree that when a manufacturer directly contacts and compensates a physician for serving as a faculty member or speaker, this interaction should be included in a publicly available database intended to provide transparency into relationships between physicians and industry. We support this transparency measure as well as real-time disclosures to ensure that the audiences of these events are made aware of the funding source for the speaker.”

Both in the preamble to the final rule and in the current proposed rule, CMS has expressed its comfort with applicable manufacturers not reporting payments made to a continuing education provider as indirect payments to a speaker when certain criteria of independence are met. “[I]f a manufacturer conveys ‘full discretion’ to the continuing education provider, those payments are outside the scope of the rule (78 FR 9492).” (79 Fed. Reg. 40383) These requirements reflect two of the key components for independence in the Standards for Commercial Support promulgated by the Accreditation Council for Continuing Medical Education (ACCME) and adopted or endorsed by many other providers of CME. The Association recognizes that CMS is reluctant to appear to be evaluating professional standards or endorsing specific organizations, but the AAMC suggests that these well-developed and widely-implemented standards have served the CME community well. The Association does not believe that CMS should be inserting itself in the professional self-regulation of the CME community, but instead make clear the types of payments that should be included in the Open Payments program and the considerations that should guide those decisions. The Association believes that the inclusion of the ACCME Standards for Commercial Support in the rule would serve as an acknowledgement of the reach of these standards in the community and not an explicit endorsement by CMS.

If CMS does not want to name specific accrediting organizations or standards in the rule, AAMC urges CMS to slightly revise §403.904(g)(1), using the criteria that CMS intended to have manufacturers apply in determining if a payment was within the scope of the rule.
A revised provision §403.904(g)(1) could read as follows (current section (g)(1)(i) deleted and additions or changes noted below in bold):

(g) Special rules for payments or other transfers of value related to continuing education programs.
(1) Payments or other transfers of value provided as compensation for speaking at a continuing education program are not required to be reported, if all of the following conditions are met:
(i) The applicable manufacturer does not pay the covered recipient speaker directly.
(ii) The applicable manufacturer does not select the covered recipient speaker or provide the third party (such as a continuing education provider) with a distinct, identifiable set of individuals to be considered as speakers for the continuing education program.
(iii) The applicable manufacturer does not select or control the content for the continuing education program.

2. CMS should not rely on the definition of “unaware” in §403.904(i)(1) to achieve the goals of the explicit exclusion in §403.904(g)(1)

The AAMC believes that reliance on an interpretation of the rule’s knowledge standard at §403.904(i)(1) consistent with CMS’ direction in the Federal Register will not achieve the agency’s goals as described in this proposed rule. In February, 2012, the AAMC explained to CMS why, in its estimation, the proposed section now codified at §403.904(i)(1) would lead to the misreporting of certain CME-related payments. The AAMC’s concerns described below were fully addressed by the addition of §403.904(g)(1) in the final rule, and return with this proposed removal of §403.904(g)(1):

“We are concerned, however, that the rule will be interpreted by manufacturers as requiring them to ascertain the identity of speakers chosen by accredited CME providers and report an unrestricted grant as a payment to a physician through a third party. Without a change to the rule, it is likely that when a physician is paid to serve as a faculty member for an accredited CME event supported by an unrestricted grant from a manufacturer, that compensation will be reported erroneously as an indirect payment to the physician from the manufacturer. In the proposed rule, no report of payment or transfer of value is required for indirect payments when the applicable manufacturer is unaware of the identity of the covered recipient. Although the commercial sponsor of an accredited CME program has no control over or input into the content or speakers presenting the material and is thus unaware of who will be asked to speak at the event, the identity of the speakers is readily available once the program has been finalized and is publicly announced. Applicable manufacturers may become aware of the identity of the speaker after the announcement or after the program, and may also be concerned that failure to seek out the names of the faculty would constitute “deliberate ignorance” or “reckless disregard” of their identities, under the definition of know in §403.903 of the proposed rule. The reporting of an unrestricted grant to an accredited CME provider as an indirect payment made by a manufacturer to a physician speaker would mislead the public by suggesting that ACCME standards had been violated, the manufacturer had selected the speaker, and the educational content was potentially driven by the manufacturer. In order to ensure that the information in the public database represents accurate and reliable information, unrestricted grants to accredited CME
providers should be specifically excluded from the reporting requirements of the regulations.”

Based on feedback from AAMC member institutions about their limited review of the reported payments in the Open Payments review and dispute process and their communications with applicable manufacturers, this provision is already being interpreted in a variety of ways. Inconsistency in interpreting the rules is as damaging to the overall goal of transparency as underreporting or overreporting.

Already AAMC member institutions have received communications from applicable manufacturers requesting names of physicians whose salaries might have been covered in some part by contributions that the manufacturers have made to the institutions, even when the policies and processes at the institutions clearly separate the source of funds from any connection with or knowledge about the physicians who may indirectly benefit from these funds at some point in the future. The plain language of §403.904(i)(1) seems to have been interpreted by some manufacturers as a mandate to actively seek out the identities of physicians who might have received industry funding in any capacity, regardless of how many safeguards or firewalls were between the two parties. This activity alone is creating relationships and connections to physicians where none had previously existed. The Association does not believe that this type of information gathering aligns with Congressional intent in enacted Section 6002 of the ACA, and that relying on this section alone to determine the reportability of compensation for speakers at accredited CME programs will only exacerbate these problems.

3. CMS should not make any changes to the regulations before the first set of data has been released

The request from CMS for input on proposed changes to this rule comes at a time when the first set of reported payments from part of 2013 has not yet been made public. CMS has proposed a number of potential solutions to address the concerns raised in the commentary with the proposed changes to the rule. The impact and effectiveness of each potential solution might be better assessed once there has been an opportunity to review how the section has been applied as codified in the final rule. As discussed earlier, the AAMC believes that relying on an interpretation of §403.904(i)(1) to accurately distinguish indirect payments that reflect a meaningful relationship between a manufacturer and a teaching hospital from those that represent no relationship (as in the case of accredited CME) will not address CMS’ concerns and will lead to an increase in inaccurate and misleading reports in the Open Payments system. Waiting until after the public database is released will allow CMS and other stakeholders to see firsthand whether this section is being consistently interpreted and whether it is leading to overreporting or underreporting.

SECTION III: CMMI REQUEST FOR IDENTIFIABLE DATA

CMS notes that it will be conducting qualitative and quantitative analyses of the impact of models conducted by the Center for Medicare & Medicaid Innovation (CMMI) on quality of care, program expenditures and other factors. To do this, CMS says it must be able to determine specifically which individuals are receiving services from or are the subjects of the intervention being tested by the entity
participating in the model and, therefore, must have access to patient records not generally available to the Agency.

CMS proposes to establish requirements for states and other entities participating in the testing of past, present, and future models by CMMI to collect and report information that CMS has determined is necessary to monitor and evaluate such models. This means that model participants, providers, and suppliers working under the models, would be required to produce individually identifiable health information and other information as the Secretary identifies as being necessary. CMS further proposes to require the submission of identifiable health and utilization information for patients of private payers treated by providers/suppliers participating in the testing of such models when an explicit purpose of the model test is to engage private sector payers. CMS adds that if finalized, this regulation will provide clear legal authority for Health Insurance Portability and Accountability Act (HIPAA) covered entities to disclose any required protected health information, which is intended to be the minimum data necessary to carry out statutorily mandated research work relating to model impact.

AAMC strongly supports CMMI’s mission to test and evaluate new innovative care models. The Association is a facilitator convener under the Bundled Payment for Care Improvement (BPCI) initiative. AAMC recognizes that evaluation of patient-level data is an important mechanism to assess the impact of the models on quality of care and healthcare expenditures, however, the specific evaluation plan is not clear or transparent. Additionally, the timing and administrative burden of the requests is not clear, raising issues such as the mechanisms for transmission of the information to CMS or its contractors and the magnitude of such requests. AAMC is concerned that such an open-ended mandate will be problematic, especially for data that CMS does not automatically receive from other payers.

With no notice or comment period required as part of the demonstrations, there will be no opportunity for stakeholders to weigh in with their perspectives on what constitutes the minimum necessary information to achieve the CMS evaluation goals. With such a broad proposal of CMS requests, it is difficult to determine in advance what will truly meet the HIPAA standards unless each program is considered individually, and the burden of additional individual consent is unknown. The AAMC is concerned that CMS has provided insufficient information to assure providers that, in responding to these broad data requests, they would be in compliance with HIPAA requirements for the use and disclosure of protected health information (PHI). Since the Office for Civil Rights (OCR) is responsible for enforcing HIPAA, the AAMC urges the Agency to work with OCR to ensure entities have appropriate coverage.

Many of the current demonstrations (like BPCI) are not funded at the organization level, as suggested by CMS, leaving the participants to absorb the costs of the additional administrative burden. CMMI’s decision to no longer mandate the use of the B-CARE tool in the BPCI program should sound a cautionary note for CMS. The AAMC is concerned that CMS’s current proposal will invite some of the same issues bundlers experienced with the B-CARE tool (delivering data to CMS not linked to EHRs, using an untested portal, no clear evaluation plan) to all CMMI programs/demonstrations. This is especially
true given that CMS outlines in its proposal some of the same elements that were included in or related to the B-CARE tool. As CMS is committed to rigorous evaluation, there is an opportunity to gain the support of participants in models by recognizing the administrative burden of such requests and consistently using information collected as part of the natural workflow and captured as part of EHRs.

To avoid similar problems, CMMI should first make the evaluation plan transparent to increase engagement and determine only the specific data elements that are required for evaluation purposes for the existing programs and have the tightest link to existing evidence/science. This information should be shared with participants who should, at minimum, be given an opportunity to provide comment on the required inputs for which they will be responsible as part of the evaluation. Moving forward, CMMI should develop such requirements in advance of program initiation. The AAMC strongly recommends that CMS request and open for comment the necessary data elements on a program-by-program basis rather than establishing a blanket approval, or, at minimum, limit the scope of the approved data requirements and uses to those elements which can be secondarily collected through claims or EHR uploads.

SECTION IV: OTHER PAYMENT PROPOSALS

AAMC Urges Caution, More Clarity and Postponed Effective Date in Collection of Information on Off-Campus Provider-Based Facilities

CMS states that the Agency 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. In the CY 2014 PFS and OPPS proposed rules, CMS asked whether a claims-based approach or a cost reporting approach to collecting information about off-campus departments (i.e., those departments located beyond 250 yards of the provider’s main buildings) would be preferable, but comments the Agency received reached no consensus on a preferred approach. In this year’s rule, to collect data on the frequency, type, and payment for services furnished in off-campus provider-based departments, CMS proposes to require hospitals and physicians to report a new HCPCS modifier with every code for physician services and outpatient hospital services furnished in off-campus provider-based departments on forms CMS-1500 (for physician services) and UB-04 (CMS Form 1450, for hospital outpatient services), effective January 1, 2015.

The AAMC is concerned about the administrative burden associated with such a proposal and the extremely short timeline for implementation. 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. The AAMC urges CMS to consider, however, that requiring this new modifier will necessitate significant changes to internal billing processes at hospitals and practices, which will require substantial time, effort, and resources. AAMC member hospitals report that many
charge codes would need to be adapted for the new modifiers, systems would need to be built for Medicare-specific claims edits, coordinating with professional billing will be a challenge, and communicating the changes to large numbers of employees will take time. If CMS implements this proposal, the AAMC urges the Agency to postpone the effective date by at least one year.

Given 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 this proposal, AAMC members raised granular issues with implementation that are best identified by providers themselves and must be resolved by CMS before implementing this proposed policy. 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 and a single claim is submitted for services provided in both locations. The Agency should consider the appropriateness of the current definition of a “campus,” given the varying definitions of this term from state to state and that some departments just beyond 250 yards of the main buildings may be treated as a real and functional part of the provider’s campus. 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) conducted 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.

The AAMC notes with appreciation CMS’ assessment in the CY 2014 proposed rule that the Agency “expect[s] hospitals to have overall higher resource requirements than physician offices because hospitals are required to meet the conditions of participation, to maintain standby capacity for emergency situations, and to be available to address a wide variety of complex medical needs in a community.” 78 Fed. Reg. 403534, 43627 (July 29, 2013). These costs for hospital outpatient departments (HOPDs) are real and are documented annually through an audited cost report. HOPD costs also stem from the unique role the hospital has 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 provide services in the HOPDs; provide outstanding team-based, patient-centered care (the gold standard of care); and include wrap around services, such as translators.

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 what services are being provided and the characteristics of patients who are treated in provider-based facilities.

**CMS Should Not Adopt Interim G-Codes for New and Revised CPT Codes**

In this year’s proposed rule, CMS notes that several stakeholders have expressed concern with the process CMS uses to recognize new and revised CPT codes, particularly with the lack of opportunity for public comment prior to the January 1 implementation date for these codes. In both the OPPS and PFS rules, CMS proposes to implement a revised process for 2016 that would create and use temporary HCPCS G-Codes that mirror predecessor CPT codes and would retain the current APC and status indicator assignments for one year until CMS could include proposed assignments in the following year’s proposed rule.

While AAMC appreciates CMS’ willingness to provide stakeholders with a proper opportunity to comment on new and revised codes, the Association strongly urges CMS not to finalize this proposal. The administrative burden of this proposal far outweighs any potential benefits of an increased comment period, given that hospitals will be required to implement new, temporary codes that are only effective for several months and will only be used for Medicare billing purposes. Instead, the AAMC encourages CMS to adopt the proposed revised process submitted to CMS by the American Medical Association (AMA) and supported by other physician organizations, including the AAMC.¹⁰

**AAMC Supports Several Modifications to Improve the Chronic Care Management Code, yet Has Continuing Concerns about Administrative Difficulty**

In the CY 2014 Physician Fee Schedule Final Rule, CMS finalized several policies for a new care coordination code that would pay providers a separate fee starting in 2015 for providing chronic care management (CCM) services. In this rule, CMS continues to develop the policies around this code, including the following changes:

- Modifying the “incident to” services exception
- Adding a new requirement to use certified EHR Technology
- Electing not to implement additional practice standards

The AAMC supports the two proposals related to counting clinical staff time toward the minimum amount of service time required for billing the code. Typically, services that are “incident-to” a professional service must be provided under the direct supervision of the billing professional. Last year, CMS created an exception to permit general supervision for services provided outside of normal billing hours if the clinical staff are direct employees of the practice. In this rule, CMS proposes to expand that exemption so that clinical staff time under general supervision can be counted at any time AND the

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¹⁰ [https://www.aamc.org/download/401884/data/aamcrucandcpttimelinesignonletter.pdf](https://www.aamc.org/download/401884/data/aamcrucandcpttimelinesignonletter.pdf)
employees do not need to be direct employees of the practice. The AAMC strongly supports both of these modifications.

The Association also supports CMS’ proposal to add use of certified electronic health records technology (CEHRT) to the scope of service requirements. The AAMC agrees that CEHRT is an essential tool for care coordination and does not believe the new CEHRT requirement will provide an additional burden.

The AAMC applauds CMS’ decision not to require additional practice standards. In last year’s final rule, CMS planned to propose standards. However, after speaking with stakeholders and reviewing standards, the Agency realized many proposed standards would be duplicative of existing scope of service or billing requirements. The AAMC agrees with CMS’ assessment.

While the Agency has made several improvements to CCM requirements, the AAMC has several concerns about practices’ ability to bill for the services. First, the remaining scope of service and billing requirements are administratively burdensome, and it will be difficult for physicians to document that they are adequately providing these services. Additional guidance is needed for providers so that they can clearly understand what is expected of them in terms of documentation in the medical record for the non-face-to-face services.

The AAMC is also concerned about CMS’ estimates for this service. Because changes to relative value units over $20 million are required to be budget neutral, any overestimation of service utilization for CCM would inappropriately reduce the relative values and Medicare payments for all other services in the PFS. Currently, CMS assumes the utilization of the new CCM code at 4.9 million services per year. CMS also assumes a beneficiary acceptance rate of 30 percent and an average of 6 CCM services per year. Given the modest billing of the similar transitional care management (TCM) codes which started in 2013, and the potential impact on budget neutrality, the AAMC asks that CMS use a more modest estimate.

**CMS Should Not Finalize the Proposal to Transition 10- and 90-Day Global Codes to 0-Day Global Codes**

CMS proposes to transition all 10-and 90-day global surgical packages to 0-day global surgical codes in a few years. Specifically, CMS would transition all 10-day global codes in CY 2017 and all 90-day global codes in CY 2018. The Agency believes the current values used as the foundation of these global surgical codes may not be accurate, because CMS relies on assumptions of the “typical case” for each individual service that is a part of the bundled package. If data for the “typical case” is inaccurate, payment can be skewed to over-reimburse certain individual physicians and under-reimburse others. CMS cites OIG reports that have shown values within the post-operative global codes may not be an accurate representation of the number and level of post-op evaluation and management (E/M) services. Under this proposal medically reasonable and necessary visits would be billed separately during the pre and post-operative periods outside the day of the surgical procedure.
The Association supports efforts to increase accuracy in the physician fee schedule; however, the AAMC cannot support finalizing a proposal that affects over one-third of existing CPT-codes without additional stakeholder discussions and analysis. CMS needs to understand all the data and services that are covered through the post-operative care, how those services are delivered, and potential reasons for variation. Additionally, the AAMC is interested in how this proposal could affect teaching supervision guidelines for surgeons.

Rather than finalize this proposal now, CMS should engage stakeholders to understand their perspectives, and analyze the potential impact of such a transformative policy.

SECTION V: SUSTAINABLE GROWTH RATE (SGR)

Unless there is Congressional action, physician fees will decrease 20.9 percent on April 1, 2015. The AAMC remains concerned with the projected negative update and supports a full repeal of the SGR. The AAMC encourages CMS to work with Congress to revise the physician payment formula so that physicians will no longer face an annual negative update. The Association also encourages CMS to find ways of funding this repeal that does not harm other providers.

CONCLUSION

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,

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