MEDPAC Medicare Payment Advisory Commission

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Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1600–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: File code CMS-1600-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Center for Medicare and Medicaid Services (CMS) proposed rule entitled "Medicare Program; Revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, and other revisions to Part B for CY 2014," published in the *Federal Register*, vol. 78, no. 139, pages 43282 to 43532. We appreciate your staff's ongoing efforts to administer and improve payment systems for physician and other services, particularly considering the competing demands on the agency.

Our comments address the following provisions in the proposed rule:

- Resource-based practice expense (PE) relative value units (RVUs)
- Misvalued codes
- Complex chronic care management services
- Clinical laboratory fee schedule
- Value-based payment modifier and physician quality reporting system

Resource-based PE RVUs

Using OPPS and ASC rates in developing PE RVUs

Services covered under the physician fee schedule (PFS) generally have two practice expense RVUs: the nonfacility RVU applies when a service is provided in a nonfacility setting (e.g., a freestanding physician's office) and the facility RVU applies when the service is furnished in a facility setting (e.g., a hospital or ambulatory surgical center). The nonfacility RVU is usually

higher than the facility RVU because physician practice costs are higher when physicians provide care in their offices instead of in facilities because they have to cover their direct costs (e.g., equipment, supplies, and staff) and have higher office overhead costs. When a service is provided in a physician's office, there is a single fee under the PFS for the service. However, when a service is provided in a facility, Medicare makes a separate payment to the facility in addition to the physician's fee. When a service is furnished in a facility, the total Medicare payment (facility fee plus physician's fee) is typically higher than the payment for the same service furnished in a physician's office (physician's fee only).

CMS believes that this payment difference reflects the higher costs incurred by facilities compared with physicians' offices. According to CMS, hospitals incur higher overhead costs than practitioners because they furnish services 24 hours a day and 7 days a week, serve higher acuity patients, comply with the Emergency Medical Treatment and Active Labor Act, and must meet Medicare's conditions of participation.

CMS has found cases in which the total payment for a service furnished in an office exceeds the total payment when it is furnished in a hospital outpatient department (HOPD) or ambulatory surgical center (ASC). When this occurs, CMS believes that this is due to inaccurate data used to develop practice expense RVUs rather than appropriate payment differences between settings. CMS states that it often relies on incomplete, potentially biased, and outdated information to develop the practice expense RVUs. For example, a service that uses a new technology tends to become less expensive over time as the service diffuses into clinical practice and the price of the technology declines. However, the price estimates of new products are not routinely updated. These inaccuracies can distort the practice expense RVUs. By contrast, OPPS rates are based on auditable hospital data and are updated annually.

To address these payment differences, CMS proposes to compare the nonfacility PFS rate for a service provided in a physician's office to the total payment amount (facility PFS rate plus the HOPD or ASC amount) for the service when it is furnished in an HOPD or ASC. If the nonfacility PFS rate exceeds the total payment amount for a service provided in a facility, CMS would reduce the nonfacility PFS rate so that it equals the total payment amount for a service provided in a facility.

CMS proposes several exceptions to this policy. For example, CMS would exclude imaging services that are are capped at the HOPD rate under the Deficit Reduction Act of 2005. The agency would also exclude codes that have low volume in HOPDs or ASCs (less than 5 percent of total volume in those settings). Accounting for these exceptions, 211 codes would be subject to this proposed policy.

CMS states that facilities have significantly higher indirect resource costs than physicians' offices and are therefore a reliable upper limit for payment rates for services furnished in offices. The agency also cites the Commission as saying that Medicare should pay similar amounts for similar

services across settings, accounting for differences in the definitions of services and patient severity.[1]

Comment

In two recent reports, the Commission has discussed how Medicare's payment rates often vary for the same ambulatory services provided to similar patients in different settings, such as physicians' offices or HOPDs.[2] As an example of payment differences, in 2013, Medicare pays 141 percent more for a level II echocardiogram in an HOPD than in a freestanding physician's office. These variations raise questions about how Medicare should pay for the same service when it is delivered in different settings.

The Commission's view is that if the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than in another. Payment variations across settings may encourage arrangements among providers that result in care being provided in higher paid settings, thereby increasing total Medicare spending and beneficiary cost sharing. In general, the Commission believes that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting, adjusting for differences in patient severity to the extent that severity differences affect costs. In the absence of comparable data on costs and quality across settings, Medicare should base payment rates on the setting where beneficiaries have adequate access to care at the lowest cost to the program and beneficiaries.

Payment variations across settings urgently need to be addressed. Many services have migrated from physicians' offices to the HOPD setting as physicians have increasingly become employed in the higher-paid ambulatory setting. From 2010 to 2011, for example, the share of E&M office visits provided in HOPDs increased from 8.9 percent to 9.7 percent, the share of echocardiograms provided in HOPDs grew from 25.0 percent to 29.6 percent, and the share of nuclear cardiology tests provided in HOPDs increased from 27.1 percent to 33.0 percent. This shift towards HOPDs results in higher program spending and beneficiary cost sharing without significant changes in patient care.

One way to address payment variations between physicians' offices and HOPDs is to revise payment rates in the hospital outpatient prospective payment system (OPPS) so that payments are equal whether a service is provided in a freestanding physician office or in an HOPD. However, for many services, equal payment rates would fail to account for some important differences between physicians' offices and HOPDs that can lead to higher costs in HOPDs. First, as CMS describes in the proposed rule, hospitals incur costs to maintain standby capacity for handling emergencies and to comply with additional regulatory requirements. Second, patient severity may be greater in the HOPD, and it may cost more to treat sicker patients. In addition, the OPPS is more likely than the PFS to combine the cost of a primary service (such as a procedure) with

[1] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.
[2] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC; and Medicare Payment Advisory Commission. 2013. *Medicare and the Health Care Delivery System.* Washington, DC: MedPAC.

ancillary services and supplies into a single payment. This concept is known as packaging. The PFS tends to pay separately for each component of a service.

In our March 2012 report, we focused on nonemergency E&M office visits because they are largely unaffected by these differences between HOPDs and freestanding offices. The Commission recommended that the total payment rate (professional fee plus facility fee) for an E&M office visit provided in an HOPD should be reduced to the amount paid when the same visit is provided in a freestanding office, which is the lower cost setting.

In our June 2013 report, we moved beyond E&M services and examined other ambulatory services frequently performed in freestanding offices or ASCs that receive higher Medicare payments in HOPDs. Although we explored options for reducing variations in payment rates across settings, we did not recommend payment changes in this report. We identified 66 groups of services provided in HOPDs and offices that meet the Commission's principles for aligning payment rates across settings. For each group, the services within the group are frequently performed in physicians' offices, which indicates that they are likely safe and appropriate to provide in a freestanding office and that PFS payment rates are adequate to assure beneficiaries' access; are infrequently provided with an emergency department (ED) visit when furnished in an HOPD (such services are unlikely to have costs that are directly associated with operating an ED); have average patient severity that is no greater in HOPDs than freestanding offices; and do not include a high share of 90-day global surgical codes. We also considered whether the level of packaging is similar across settings. For most of these groups of services, aligning the payment rates across settings would reduce the OPPS rate (when the total payment rate for a service in an HOPD exceeds the PFS rate). For some of these groups of services, however, the OPPS rate would increase (when the total payment rate for a service in an HOPD is below the PFS rate).

We also explored a policy that would equalize payment rates between HOPDs and ASCs for certain ambulatory surgical procedures. In most cases, Medicare currently pays 78 percent more in HOPDs than ASCs for the same procedure, and this payment gap has increased over time. We identified 12 groups of services that are commonly performed in ASCs for which the HOPD payment rates could be reduced to the ASC level. These services are rarely provided with an ED visit when furnished in an HOPD and have average patient severity that is no greater in HOPDs than in ASCs.

We disagree, however, with CMS's premise that all hospital services should have higher payments in all instances. We encourage CMS to seek legislative authority to implement our recommendation to equalize the total payment rates for E&M office visits across settings. CMS should also examine options to reduce variations in payment rates across settings for other services using the principles and criteria described in our June 2013 report.

That said, CMS has identified over 200 codes in which the total payment rate for a service furnished in an office exceeds the total rate when it is furnished in a HOPD or ASC. We agree that these differences likely indicate that the practice expense RVUs for many of these codes are overvalued. CMS and the RUC should expedite the review of the practice expense RVUs for these codes to ensure that they are valued accurately. As part of this process, CMS should collect

objective data on the time it takes to perform services from a cohort of efficient practices, as we recommended in our letter to the Congress on moving forward from the sustainable growth rate system.[3] CMS should also regularly update the prices of high-cost equipment and supplies, which are important practice expense inputs.[4] During the review of the practice expense RVUs for these codes, CMS should reduce the RVUs for these codes so that the nonfacility PFS rate equals the total payment amount when the service is provided in a HOPD or ASC. These interim RVUs would be in effect while the RUC and CMS perform their review. CMS should reallocate the savings from these reduced RVUs to other PFS services. This step will help rebalance the PFS from overpriced services to underpriced services. It would also help CMS achieve an annual numeric goal of RVU reductions; the Commission has recommended that annual RVU reductions should equal at least 1.0 percent of fee-schedule spending.[5] The review conducted by the RUC and CMS could lead to new PFS rates for these codes that are higher or lower than the interim values established by CMS.

Collecting data on services furnished in off-campus hospital provider-based departments

There has been a trend in recent years for hospitals to acquire physician practices, which has resulted in a shift of services being billed in freestanding physician offices to HOPDs. The Commission has discussed this issue in two recent reports that investigate options to align payment rates for ambulatory services across settings.[6]

When hospitals acquire physician practices, they often treat the practices as off-campus provider-based departments of the hospitals. Under this construct, hospitals can bill Medicare for the physicians' services under the Medicare physician fee schedule (PFS) and also bill Medicare for hospital facility expenses under the OPPS. For most services, the combined payment from the PFS and the OPPS is greater than the single payment Medicare care would make under the PFS if the same service had been provided in a freestanding physician's office.

To better understand the trend toward hospital acquisition of physician practices and the treatment of them as off-campus provider-based departments, CMS is considering collecting data to analyze the frequency, type, and payment for services provided in off-campus provider-based departments. CMS describes two general methods it could use to collect this information:

- A claims-based approach that could include creating a new place of service code or a HCPCS modifier that could be reported with services furnished in off-campus provider-based departments.

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[3] Medicare Payment Advisory Commission. 2011. Moving forward from the sustainable growth rate (SGR) system. Letter to the Congress. October 14. http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf.
[4] Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.
[5] Medicare Payment Advisory Commission. 2011. Moving forward from the sustainable growth rate (SGR) system. Letter to the Congress. October 14. http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf.
[6] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC; and Medicare Payment Advisory Commission. 2013. *Medicare and the Health Care Delivery System.* Washington, DC: MedPAC.

- A cost-report approach in which hospitals would break out the costs and charges for their provider-based departments as outpatient service cost centers on hospital cost reports.

Comments

As described above, we have found that many services have been migrating from physicians' offices to the usually higher paid HOPD setting, which has resulted in higher spending for the Medicare program and higher cost sharing for Medicare beneficiaries without significant changes in patient care. Therefore, payment variations across ambulatory settings urgently need to be addressed. CMS's proposal to collect data on services provided in off-campus provider-based departments is insufficient to address this problem. The proposal does not deal with the central issue: payment rates for many services are higher in HOPDs than freestanding offices and ASCs, which encourages the migration of services to HOPDs. Although it is reasonable to pay higher rates in HOPDs for certain services, we have developed criteria to identify services for which payment rates could be equalized across settings or the differences could be narrowed.

As stated above, we encourage CMS to seek legislative authority to implement our recommendation to equalize the total payment rates for E&M office visits across settings.[7] CMS should also examine options to reduce variations in payment rates across settings for other services using the principles and criteria described in our June 2013 report.[8]

Regarding the proposal to collect data on services provided in off-campus provider-based departments, there may be some limited value in collecting these data to validate the accuracy of site-of-service reporting in circumstances where the physician office is off-campus but billing as an HOPD. However, it would have been more valuable if CMS had tracked the growth of off-campus provider-based departments for the last several years because this could have provided an early indication that hospitals were purchasing physician practices and converting them to HOPDs. In any case, this data collection effort should not prevent CMS from developing policies to align payment rates across settings.

In addition, Medicare's rules for provider-based status have not slowed the migration of ambulatory services to HOPDs. These rules are not particularly stringent, and CMS does not require hospitals to attest that they are complying with the rules. In any case, rules for establishing provider-based departments do not address the problem that Medicare pays higher rates for many services in HOPDs than in other ambulatory settings.

Misvalued codes

The proposed rule addresses two topics related to misvalued codes in the physician fee schedule: identifying, reviewing, and validating the RVUs of potentially misvalued services; and the multiple procedure payment reduction policy.

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[7] Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare Payment Policy.* Washington, DC: MedPAC.
[8] Medicare Payment Advisory Commission. 2013. *Medicare and the Health Care Delivery System.* Washington, DC: MedPAC.

Identifying, reviewing, and validating the RVUs of potentially misvalued services

Since inception of the physician fee schedule in 1992, the statute has directed the Secretary to conduct a periodic review, at least every five years, of the RVUs. The Patient Protection and Affordable Care Act (PPACA) expanded on this requirement and directed the Secretary to periodically identify and review potentially misvalued services in categories such as those with the fastest growth, services established for new technologies, and other such criteria. If, upon review, services are found to be misvalued, the Secretary may make appropriate adjustments to their RVUs. The PPACA further required the Secretary to establish a formal process to validate the fee schedule's RVUs. This validation may include elements of the work of physicians and other health professionals—elements such as time, effort, and stress. The Secretary may conduct the validation by conducting surveys, other data collection activities, studies, or other analyses she determines to be appropriate.

As discussed in the proposed rule, CMS has begun to broaden the process for identifying potentially misvalued services by soliciting input from contractor medical directors. Based on this consultation, the agency is proposing 21 services as potentially misvalued.

The proposed rule also includes a progress report on steps CMS has taken to fulfill the PPACA requirement to validate the fee schedule's RVUs. First, the agency has established a contract with the RAND Corporation for development of a model to predict work RVUs and the components of those RVUs, time and intensity. The contractor will use a model design informed by the statistical methodologies and approach used to develop the RVUs initially. The contractor will then test the model with a representative set of CMS-provided billing codes. During the project, the contractor will consult with a technical expert panel for advice on model design issues and interpretation of results. Second, CMS has established a contract with the Urban Institute for collection of time data from several physician practices. As part of the project, the contractor will use the data collected to develop objective time estimates. The contractor will then convene groups of physicians from a range of specialties to review the new time data and their implications for the fee schedule's work RVUs.

Comment

The Commission supports CMS's efforts to identify, review, and validate the RVUs of potentially misvalued services. Reports of overvalued services continue to accumulate. As discussed in our reports to the Congress and previous comment letters, research for CMS and the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services has shown that the time estimates for some services are likely too high. Overstated time estimates can cause a service to be overvalued and—because changes in fee-schedule payment rates are budget neutral—other services to be undervalued. In addition, research by the Government Accountability Office (GAO) has found that Medicare's physician fee schedule does not adequately account for efficiencies that occur when a physician furnishes multiple services for the same patient on the same day. Most recently, the *Washington Post* reported on its analysis of data from ambulatory surgical centers which showed that, for services furnished by gastroenterologists,

ophthalmologists, and orthopedic surgeons, the fee schedule's time estimates are much higher than actual hours worked.[9]

Specific to discussion in the proposed rule about soliciting input on potentially misvalued services from contractor medical directors, we agree that such input is valuable given the wealth of knowledge these physicians have about current medical practice and local coverage decisions. We support also the work underway to validate RVUs, particularly the work discussed in the proposed rule to improve the accuracy of the fee schedule's time estimates. As discussed in our comment letter last year on the proposed rule for CY 2013, while the time estimates explain most of the variation in the work RVUs, the process for developing the estimates relies on surveys conducted by physician specialty societies. Those societies and their members have a financial stake in the process, and the Commission has presented evidence that the process is biased.[10]

Among the alternatives that might be considered for validating the time estimates, we have recommended an approach that includes, first, collecting data on service volume and work time from a cohort of efficient practices.[11] Aggregated to the level of the individual practitioner, the data could then be used to compare actual hours worked with hours worked based on the time estimates. If inconsistencies are found, information could be provided to the RUC for a detailed assessment. A Commission contractor has assessed this approach to validating RVUs and has found it to be feasible, as discussed in detail in last year's comment letter.[12]

Of course, accurate time estimates are not the only objective. When time estimates are decreased during the validation process, work RVUs should decrease accordingly given that the time estimates explain most of the variation in work RVUs.[13] We are concerned however that a number of services have been found to be overvalued under the potentially misvalued services initiative but that the work RVUs for some of them may not have been reduced sufficiently, consistent with decreases that have occurred in the time needed to furnish the services. Analysis of work RVUs and work-time estimates for 2008 to 2012 shows that 329 services had decreases in work RVUs, time estimates, or both.[14] While the time estimates for these services decreased by an average of 20.4 percent, their work RVUs decreased by an average of only 7.3 percent (Table 1).

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[9] Whoriskey, Peter and Dan Keating. 2013. Medical panel uses data that distort doctors' pay. *Washington Post*, July 21, A1.

[10] Hackbarth, G. M. 2010. Letter from Glenn Hackbarth, Medicare Payment Advisory Commission, to Donald Berwick, Centers for Medicare & Medicaid Services, Department of Health and Human Services, August 23. http://medpac.gov/documents/CMS-1503-P.pdf.

[11] Medicare Payment Advisory Commission. 2011. Moving forward from the sustainable growth rate (SGR) system. Letter to the Congress. October 14. http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf.

[12] Zismer, D. K., J. L. Zeglin, and S. A. Balukoff. 2012. *Collecting data on physician services and hours worked.* A report to the Medicare Payment Advisory Commission by the University of Minnesota School of Public Health, Division of Health Policy and Management. Minneapolis, MN: MedPAC. http://medpac.gov/documents/Aug12_CollectingDataPhysicanServices_Contracor.pdf.

[13] Medicare Payment Advisory Commission. 2011. Report to the Congress: Medicare and the health care delivery system. Washington, DC: MedPAC. http://medpac.gov/chapters/Jun11_Ch01.pdf.

[14] The 329 services in the analysis are not the only services that had changes from 2008 to 2012 in their coding or valuation. During the interval, 263 billing codes with work RVUs were dropped from the fee schedule—some because of reviews under the potentially misvalued services initiative, and 484 billing codes with work RVUs were added to the fee schedule. Some of the changes in coding were due to establishment of comprehensive codes—replacing

Table 1. Decreases in work RVUs and time estimates of misvalued services, 2008-2012

	Number of services	Average percent change
Work RVUs	329	-7.3 %
Time estimates	329	-20.4

Note: RVU (relative value unit). Services considered are those with a decrease in work RVUs, a decrease in work time estimate, or both.

Source: MedPAC analysis of physician time and RVU files from CMS.

The reductions in time estimates suggest much larger reductions in work RVUs than those that actually occurred. The Commission is becoming concerned that the RUC may be recommending reductions in time estimates for overvalued services but then offsetting the impact by increasing the other factor that influences the level of work RVUs: intensity. The Medicare statute defines the work of physicians and other health professionals—for purposes of determining RVUs—as time and intensity. CMS has extended this definition and defined intensity as the technical skill, mental effort, and psychological stress involved when physicians and other health professionals furnish a service. Otherwise, intensity is not identified explicitly during the valuation process except as it influences a service's work RVU. It is possible, however, to quantify the level of intensity implied by work RVUs. The ratio of work RVUs to time is a measure of intensity.[15] Services with an unusually high or low ratio of work RVUs to time may be outliers warranting further assessment.

To fully address this issue, CMS could analyze the work RVU-to-time ratios of services and look for statistical outliers.[16] For instance, among the 329 services discussed earlier, 60 are in the

multiple codes for services often furnished together with a single code. (Recent examples of services for which comprehensive codes have been established include echocardiography, imaging stress tests, and computed tomography.) From 2008 to 2012, 150 billing codes had increases in both their work RVUs and their work-time estimate.

[15] Mathematically, the relationship between the statute's definition of work and work RVUs is T x I = WRVU, where T is work time, I is intensity, and WRVU is the work RVU. Rearranging these terms, I = WRVU / T, the ratio of work RVU to time.

[16] Use of work RVU-to-time ratios to identify outliers is discussed in a report for CMS: McCall, N.T. et al. 1999. *Five year review of work relative value units*. Waltham, MA: Health Economics Research. http://www.rti.org/pubs/c_chapter2_part1.pdf.

service category, minor or ambulatory skin procedures. Of those 60 services, 44 have RVU-to-time ratios above the service category's median. Indeed, 24 of the 60 services have RVU-to-time ratios in the service category's 90th percentile. Work RVUs at such high levels could indicate that they should be reduced to make them consistent with the reductions in time estimates. This is an area the Commission intends to consider further.

The Commission is aware that action on some of our comments would require additional resources, an issue we have addressed repeatedly in reports to the Congress. We urge CMS to support our recommendations and seek the necessary resources.

Multiple procedure payment reduction policy

When outpatient therapy or surgical services are furnished to the same patient on the same day, Medicare reduces payments for the second and subsequent service to account for efficiencies in practice expense or physician work. This policy is known as the multiple procedure payment reduction (MPPR). Similarly, Medicare reduces payments for the professional component and technical component of multiple imaging studies that are performed in the same session (the technical component includes the cost of the nonphysician staff who perform the test, medical equipment, medical supplies, and overhead expenses; the professional component includes the physician's work involved in interpreting the study's results and writing a report). The MPPR applies to computed tomography (CT), magnetic resonance imaging (MRI), certain ultrasound, and nuclear medicine studies but not other types of imaging. In the final rule for 2013, CMS expanded the MPPR to the technical component (but not the the professional component) of certain cardiovascular and ophthalmology diagnostic procedures. Although CMS has not proposed new MPPR policies for 2014, it continues to consider expanding the MPPR based on efficiencies when multiple procedures are furnished together.

Comment

We encourage CMS to identify other opportunities to expand the MPPR. In our comment letter on last year's proposed rule, we supported CMS's proposal to expand the MPPR to the technical component of cardiovascular and ophthalmology diagnostic tests. We encourage CMS to examine whether there are efficiencies in physician work that occur when multiple cardiovascular and ophthalmology tests are provided in the same session that would justify applying the MPPR to the professional component of these services. For example, when multiple tests are performed together, certain physician activities (such as reviewing the patient's medical records and discussing the findings with the referring physician) are likely to occur only once.

In the proposed rule for 2012, CMS asked for comment on whether it should apply the MPPR to the technical component and professional component of *all* imaging services based on expected efficiencies in practice expense and physician work (the MPPR currently applies only to CT, MRI, certain ultrasound, and nuclear medicine studies). As we stated in our comment letter on the proposed rule for 2012, the Commission recommended expanding the MPPR to both the technical component and professional component of all imaging services to account for efficiencies in practice expense and physician work that occur when multiple studies are performed in the same

session.[17] Our recommendations to apply the MPPR to imaging services performed in the same session were not limited to specific imaging codes. Given that there are efficiencies when CT, MRI, certain ultrasound, and nuclear medicine studies are provided together, it is reasonable to expect that similar efficiencies occur when other imaging services (e.g., other ultrasound, X-rays, and fluoroscopy) are furnished in the same session. CMS should expand the MPPR to additional imaging services and should apply this policy to both the technical and professional components to maintain consistency between the two portions of an imaging study.

CMS also asked for comment in the proposed rule for 2012 on whether it should apply the MPPR to the technical component of all diagnostic tests (beyond imaging services). As discussed in our comment letter on the proposed rule for 2013, we examined Part B claims data from 2010 to look for diagnostic tests that are frequently performed more than once on the same date for the same patient by the same physician; such tests could be included in the MPPR policy or combined into a bundled code. We analyzed anatomic pathology services because they account for a substantial and growing amount of Medicare spending: in 2010, for example, Medicare spent $1.3 billion on CPT code 88305 (Level IV, surgical pathology, gross and microscopic examination) and $241 million on CPT code 88342 (immunohistochemistry, each antibody).

We found that several surgical pathology codes are frequently billed with more than one unit of service on the same date. For example, one-third of the claims for CPT code 88305 contained more than one unit of service (or specimen) for that code. In addition, 57 percent of the claims for CPT code 88342 contained more than one unit of service for that code. In these cases, multiple specimens from the same patient were examined at the same time by the same pathologist. In a recent report, GAO found that Medicare's payment system provides a financial incentive to order a higher number of specimens per procedure.[18] For example, providers can double their payment by submitting four specimens from four tissue samples instead of combining the four tissue samples into two specimens. Although CMS revalued CPT code 88305 for 2013, which reduced the PFS payment rate for this service by about 30 percent, there is still a financial incentive to bill more units of this service because each additional unit generates additional revenue.

CMS should analyze whether there are efficiencies in practice expense or physician work that occur when multiple units of the same pathology test are performed at the same time. If so, CMS should consider applying the MPPR policy to these services or creating bundled codes that include multiple units or specimens from the same test. As described in GAO's report, in 2009, CMS began paying for the examination of multiple specimens from a prostate saturation biopsy through a single payment instead of paying for each specimen individually. For example, CMS makes a single payment for the examination of 1 to 20 specimens from the biopsy. CMS could apply this approach to other pathology services.

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[17] Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the Health Care Delivery System*; Medicare Payment Advisory Commission. 2005. *Report to the Congress: Medicare Payment Policy*.
[18] Government Accountability Office. 2013. *Action needed to address higher use of anatomic pathology services by providers who self-refer*. GAO–13–445. Washington, DC: GAO.

Complex chronic care management services

The rule proposes to establish HCPCS codes on the fee schedule for complex chronic care management services furnished to patients with multiple (two or more) complex chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. The new codes would cover complex chronic care management services for 90-day time periods. The proposed codes themselves would not require a face-to-face visit within the 90-day time periods, but CMS proposes that only a physician or qualified nonphysician practitioner who provided an Annual Wellness Visit with the patient in the past twelve months would be eligible to bill for the new codes. In addition, the practitioner must obtain the patient's consent to have these services provided, and the patient is subject to cost-sharing even when the services are not delivered face-to-face.

Comment

The Commission supports the proposal to establish billing codes for complex chronic care management, including the proposal to define qualified health care professionals in addition to physicians as eligible for payment for providing complex chronic care management services. It is the Commission's view that only practitioners who provide comprehensive on-going care to a beneficiary over a sustained period of time should be eligible to bill for the new codes. Toward that end, the Commission supports the requirement that the practitioner obtain the beneficiary's consent, but suggests that CMS consider an alternative to using the Annual Wellness Visit to determine whether the practitioner is eligible to bill for the new codes. Instead, CMS could use the plurality of qualified E/M visits furnished to a beneficiary—similar to the method used by the Pioneer ACO program.

To optimally allocate the resources of the Medicare program, the new codes should be targeted to those beneficiaries with substantial medical challenges requiring significant management. The Commission also considers it essential for practitioners who bill for complex chronic care management services to furnish primary care, conduct care management, use health IT for active clinical decision support, have a formal quality improvement program, maintain 24-hour patient communication and rapid access, and keep up-to-date records of beneficiaries' advance directives.

To prevent the new codes from increasing spending and the strain on taxpayers and beneficiaries, they should be implemented in a budget-neutral manner within the fee schedule. Finally, to prevent the duplication of payment for care management services, practitioners employed or under arrangement with hospice or home health agencies should not be eligible to bill for the new codes.

The new codes should be better targeted to those beneficiaries with substantial medical challenges requiring significant management
CMS explained in the proposed rule that generally the payment for non-face-to-face care management services is bundled into the payment for face-to-face E/M visits because care management is a component of those E/M services. However, for certain categories of

beneficiaries the E/M codes may not reflect all the services and resources required to furnish comprehensive, coordinated care management. The proposed rule defines one of those categories as patients with multiple complex chronic conditions.

However, according to an analysis by CMS cited in the proposed rule, over two-thirds of Medicare beneficiaries had two or more of the 15 chronic conditions examined (see http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf). The proposed rule's additional requirements, namely that the chronic conditions be "complex" and "last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline" may not be specific enough to narrow the proposed policy to those beneficiaries with substantial medical challenges requiring significant management. Under this proposal, the volume of claims for the new codes could greatly increase Medicare spending. Of more promise, in the Commission's view, would be to have the Secretary determine the criteria for beneficiary eligibility that best targets Medicare's resources to those beneficiaries requiring significant management.

The new codes should be implemented in a budget-neutral manner within the fee schedule.
The proposed rule describes the new care management codes as intended to improve quality of care while simultaneously decreasing costs through reductions in hospitalizations, use of post-acute care services and emergency department visits. The establishment of new billable codes could also increase spending by providing practitioners with additional services for which they could bill. When Medicare spending increases taxpayers and beneficiaries must contribute more to the program, and funds available for other priorities in the federal budget decline. To prevent the new codes from increasing spending and the resulting strain on taxpayers and beneficiaries, they should be implemented in a budget-neutral manner within the fee schedule redistributing payments from overpriced services to payments for care management services.

Practitioners employed or under arrangement with hospice or home health agencies should not be eligible to bill for the new codes.
Practitioners who are employed by or under arrangement with hospice or home health agencies are not allowed to bill separately for care plan oversight services, because those services are considered to be incorporated into the hospice and home health payments.[19] It follows, that the practitioners employed or under arrangement with hospice or home health agencies should also not be eligible to bill for the new chronic care management codes as those services should also be considered to be incorporated into the hospice and home health payments.

Clinical laboratory fee schedule

For most tests paid under the clinical laboratory fee schedule (CLFS), CMS lacks a mechanism to review payment amounts for tests and to adjust those amounts based on changes in technology and other factors. The only exception is new tests that were introduced in 2005 or later; CMS can

[19] Centers for Medicare and Medicaid Services. 2013. *Medicare Claims Processing Manual*. Washington, DC: CMS.

reconsider the payment amount for new tests one year after the national amount is initially set. CMS proposes a process to review payment amounts for tests that are no longer new to determine if changes in technology warrant a payment adjustment.

The CLFS consists of 56 different fee schedules established by carriers in 1984 in local geographic markets. The rates are based on what local labs charged at the time. In addition, there are national limits on lab payment rates, called national limitation amounts (NLAs), that cap the fee schedule rate for each test. The NLA is 74 percent of the median of all fee schedule amounts established for that test (or 100 percent of the median for new tests performed on or after January 1, 2001). The payment rate for each test is the lesser of the provider's charge, the fee schedule amount for the local geographic area, or the NLA. The payment rates for CLFS tests are adjusted annually based on changes in the consumer price index for all urban consumers and other statutory adjustments, such as the multi-factor productivity adjustment. However, CMS does not change the payment amount for an individual test when the cost of the test changes (with the exception of new tests one year after their national rate is set).

CMS describes the significant pace of technological change in clinical lab testing in the last several years. The development of new tests (such as genetic and genomic tests), advances in equipment and techniques, and the diffusion of information technology have made testing more efficient. Given these technological changes, CMS proposes to develop a process to reconsider payment amounts to account for changes to the tools, machines, supplies, labor, skills, techniques, and devices by which tests are produced. These changes can affect the resources and personnel required to perform a test, the volume of testing, and the site of service. The agency believes it has the statutory authority to adjust payment rates for CLFS tests based on technological changes.

Under CMS's proposal, starting in the proposed rule for 2015, CMS would begin reviewing codes that have been on the CLFS the longest because these codes have likely been most affected by changes in technology. Over time, CMS would review newer codes until it has reviewed all 1,250 codes on the CLFS. The agency would only review codes that have been on the CLFS for at least 5 years to allow time for technological change to influence the cost of tests. Similarly, CMS would not review codes that were reviewed in the previous 5 years. In addition, the public would be allowed to nominate codes for review. For each code reviewed, CMS would discuss how it has been affected by technological changes and propose an adjustment to the payment rate to reflect those changes. Payment rates for tests under review could increase or decrease but CMS expects that most rates will decrease because technology tends to become cheaper over time after it has diffused into the market. CMS does not explain what data it would use to examine technological changes and adjust payment rates for specific codes; however, they would solicit information from the public.

Comment

We support the direction of CMS's proposal to examine whether technological changes have affected the cost of CLFS tests. As with other types of health care services, such as surgical procedures and diagnostic imaging, advances in technology can change the time it takes to perform

a service, increase or decrease the cost of equipment and supplies, and alter the mix of clinical staff who perform the service. Since the CLFS was established in 1984, it is likely that the resources used to perform many tests have changed. It is also important for CMS to evaluate the accuracy of payment rates for CLFS tests because Medicare spending for these tests grew by 9.1 percent in 2012, to $9.7 billion.[20] It is possible that some of this rapid growth was driven by inaccurate payment rates. We offer comments on the sources of data that CMS could use to adjust payment rates for tests and how CMS should prioritize codes for review.

We suggest two approaches that CMS could use to evaluate technological changes and adjust payment rates for tests:

- Make use of the Medicare administrative contractors (MACs), which currently collect data to set payment rates for new tests; and
- Examine rates paid by other payers, such as Federal Employees Health Benefits (FEHP) plans or the Veterans Health Administration (VHA).

When CMS adds a new test to the CLFS that reflects a break-through technology for which there are no similar existing tests, CMS relies on a "gapfilling" method in which MACs independently set rates for the first year of use. Each MAC researches and sets its own payment amount based on the following data sources: charges for the test and discounts to charges; resources required to perform the test; data from other payers; and charges, rates, and resources used for comparable tests. After one year, CMS sets the national rate at the median of the MAC rates. For example, CMS recently directed the MACs to use the gapfilling process to set payment rates for 114 new molecular pathology codes. Because each MAC has developed a mechanism and data sources for establishing prices for new tests, CMS could direct them (or a subset of MACs) to also review payment rates for existing tests. CMS would probably need to provide MACs with additional resources to handle this responsibility. The gapfilling method allows MACs to use a wide range of information to set rates for new tests. Therefore, if CMS decides to ask the MACs to review and adjust rates for existing tests, it should explain which specific data sources were used.

An alternative approach would be to examine payment rates paid for CLFS tests by other payers, such as FEHB plans or the VHA. A recent report by the Office of Inspector General (OIG) found that rates set by FEHB plans may better reflect technological changes than Medicare's rates. [21] Although most FEHB plans use Medicare's CLFS as the basis for their payment rates, some FEHB plans account for technological changes (e.g., the cost of new tests) and market information in setting their rates. OIG compared Medicare's CLFS payment rates with rates paid by 3 FEHB plans for 20 high-volume, high-expenditure tests in 2011. They found that the rates paid by the FEHB plans were lower than Medicare's rates for more than half of the tests. For example, Medicare's rate for a comprehensive metabolic panel (CPT 80053) was 66 percent higher than the lowest FEHB plan rate. These differences suggest that FEHB plan payment amounts may better

[20] Medicare Payment Advisory Commission. 2013. *Health Care Spending and the Medicare Program*. Washington, DC: MedPAC.
[21] Office of Inspector General, Department of Health and Human Services. 2013. *Comparing lab test payment rates: Medicare could achieve substantial savings.* OEI–07–11–00010. Washington, DC: OIG.

account for cost-reducing changes in technology than Medicare's amounts. In a separate report, OIG noted that the VHA has national contracts with four reference labs.[22] Each contract contains a list price for each test, which are available on the General Services Administration website. CMS could consider comparing Medicare rates to the VHA list prices.

CMS proposes to prioritize codes for review based on how long they have been on the CLFS because older codes may have been most affected by changes in technology. However, the oldest codes may account for only a small share of volume or spending. In addition, the pace of technological change may vary among different types of tests (e.g., an old test may change little over time, while a newer test may experience significant advances). Given CMS's limited resources to conduct these reviews, we suggest three methods to prioritize codes for review (these methods are not mutually exclusive):

- focus on tests that account for the largest share of spending,
- focus on tests with rapid spending growth, particularly those that account for a significant share of overall spending growth, and
- examine tests that are paid much more by Medicare than other payers.

First, targeting high-expenditure tests for review should have a larger impact on overall CLFS spending than focusing on low-expenditure tests. Second, rapid spending growth for a test may signal that Medicare's payment rate is too high. Among codes with rapid growth, CMS should focus on those that account for a large share of overall spending growth (e.g., tests that start with a high level of spending and grow quickly). Third, CMS could look at tests that have much higher payment rates in Medicare than among other payers. These differences may indicate that the tests have experienced technological changes that have reduced their costs.

If CMS is unable to implement its proposal to review payment amounts for tests and adjust the amounts to reflect cost changes, the agency may wish to consider seeking legislative authority to develop a competitive bidding program. Under competitive bidding, labs would submit the prices they are willing to accept for different tests, and Medicare would select the winning bidders based on a combination of price, quality, and access. CMS developed a competitive bidding demonstration but the program was eliminated by legislation in 2008 before the winning bids were selected. The Commission may also consider other approaches to improve the accuracy of payment rates, such as competitive bidding.

Value-based payment modifier and physician quality reporting system

CMS is required by statute to establish a budget-neutral "value-based payment modifier" under the Medicare fee schedule. The statute is prescriptive. The value-based payment modifier will increase or decrease fee schedule payments to physicians or groups of physicians based on the relative

[22] Office of Inspector General, Department of Health and Human Services. 2012. *Memorandum report: Coverage and payment for genetic laboratory tests.* OEI–07–11–00011. Washington, DC: OIG.

quality and cost of their care. The modifier must be applied to at least some physicians and groups of physicians, as defined by the Secretary, starting in January 2015, and must be applied to all physicians and groups of physicians paid under the fee schedule starting January 2017. In 2015, the amount of payment at risk under the value-based payment modifier is 1.0 percent, that is, the maximum bonus or penalty will be 1.0 percent of a physician's or group's total payments under the fee schedule. This maximum increases to 2.0 percent in CY 2016.

The value-based payment modifier will be composed of a quality component and a cost (i.e., program spending) component. CMS is building the quality component on the foundation of the Physician Quality Reporting System (PQRS). The PQRS is a voluntary quality reporting program that makes certain adjustments (defined in statute) to Medicare fee schedule payments to physicians and other eligible professionals, based on whether or not they satisfactorily report data on quality measures for covered professional services.[23] Successful participation is defined in 2013 as correctly reporting on at least three quality measures, unless there are fewer than three measures total for the physician's specialty. CMS proposes to increase the minimum number of measures that must be reported from three to nine in 2014.

A physician's or group's actual performance on its submitted quality measures is not taken into account when determining successful PQRS participation. But under the value-based payment modifier, a physician group's performance on its submitted quality measures will be combined into a composite rate, combined with the group's performance on three claims-based outcome measures,[24] and used to assign the group and all of its affiliated physicians to one of three quality tiers: high, average, or low. Each group is assigned to a tier based on whether its overall quality composite is one or more standard deviations above or below the mean for all groups.

Using terminology in the proposed rule, the "cost" component is based on one year of Medicare spending for Part A and Part B services (excluding hospice) for all full-year FFS beneficiaries that are attributed to the physician group.[25] In the value-based payment modifier's first year (2015), CMS will use 2013 spending for each group's attributed FFS beneficiaries to calculate five cost measures for the group: total per capita costs and per capita costs for treatment of four chronic conditions.[26] Costs will be standardized (to remove spending variations attributable to geographic input price differences) and risk-adjusted. CMS then will compute the overall cost component of the value modifier, first by calculating the average of the four condition-specific cost measures, then computing the average of that average and the total cost measure (in effect, this process gives the total cost measure four times as much weight than each of the condition-specific cost

[23] Under current law, physicians and groups that successfully participate in PQRS in 2013 or 2014 will receive a positive 0.5 percent adjustment on their fee schedule payments, and then the adjustment will be negative for those that do not successfully participate: –1.5 percent in 2015 and –2.0 percent in 2016 and after.
[24] The three outcome measures are: (1) composite rate of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease (COPD), and diabetes; (2) composite rate of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia; and (3) rate of all-cause hospital readmissions. The rates will be calculated by CMS using claims data for each group's attributed Medicare patients.
[25] A beneficiary's spending will be attributed to a physician group (defined as a single TIN) that a) billed for at least two office or other outpatient E&M services for the beneficiary and b) billed for a plurality of the total amount of E&M services (measured by Medicare allowed charges) provided for the beneficiary during the year.
[26] The four chronic conditions are COPD, heart failure, coronary artery disease, and diabetes.

measures). As with the quality component of the modifier, each physician group will be assigned to one of three tiers (high, average, or low) based on whether its overall cost measure is one or more standard deviations above (high cost) or below (low cost) the average for all groups. The impact on a physician group's fee schedule payments of the modifier's quality and cost components will be determined according to the group's combined quality and cost performance, as shown in Table 2:

Table 2. Value-based payment modifier adjustments in 2015

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

Note: Because the impact of the modifier overall must be budget-neutral, the final upward adjustment percentages in the cells with an "x" will depend on the total of the downward payment adjustments. CMS will not be able to calculate "x" until after the performance period has ended.

*Groups with these results are eligible for an additional +1.0x adjustment if (1) they are reporting quality measures via a CMS web-interface or CMS-qualified registry, and (2) their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

In the current proposed rule, CMS proposes several changes to the value-based payment modifier that would take effect in 2016:

- Apply the modifier to groups with 10 or more eligible professionals. In 2015, the modifier will apply to groups of physicians with 100 or more eligible professionals.

- Eliminate the option available in 2015 for groups to opt out of quality measurement (meeting only minimal reporting requirements) without incurring a negative payment adjustment. Groups with between 10 and 99 eligible professionals would be held harmless (could not be penalized) for low-quality performance, but could receive a neutral or positive adjustment under the quality-tiering methodology. Groups with 100 or more eligible professionals would be subject to the full range of positive, neutral, or negative adjustments.

- Add a Medicare Spending Per Beneficiary (MSPB) measure to the calculation of the cost component of the modifier. This measure is similar to the one that CMS has incorporated into the Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing programs. It includes all Medicare Part A and Part B payments around an inpatient hospitalization episode, starting three days prior to an admission through 30 days post-discharge, with certain exceptions (e.g., transfers). It is risk-adjusted for patient age and severity of illness.

- Change the cost measure benchmarking methodology to account for the clinical specialties of the physicians in the group (i.e., a physician group's per-capita and MSPB costs would be compared to those for groups with the same physician specialty mix).

- Increase the maximum amount of payment at risk under the value-based payment modifier from 1.0 percent to 2.0 percent. The resulting payment adjustment categories for different combinations of quality/cost performance would be as shown in Table 3:

Table 3. Proposed value-based payment modifier adjustments in 2016

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

Note: Because the impact of the modifier overall must be budget-neutral, the final upward adjustment percentages in the cells with an "x" will depend on the total of the downward payment adjustments. CMS will not be able to calculate "x" until after the performance period has ended.

*Groups with these results are eligible for an additional +1.0x adjustment if (1) they are reporting quality measures via a CMS web-interface or CMS-qualified registry, and (2) their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

Comment

Most of the Commission's concerns about the value modifier are concerns about the provision in the statute. As noted earlier, the statute constrains CMS to implementing a modifier that can be applied to groups of physicians and eventually to all physicians and that will apply to payments under the physician fee schedule. The Commission continues to believe that, in the long run, an approach of relying on the current fee-for-service (FFS) payment system may be incompatible with the delivery of integrated, coordinated, and reliably high-quality care.

Another way to pursue such a high-value health care system may be to apply payment incentives based on population-level outcomes, such as avoidable hospital admissions or emergency department visits within a hospital service area, and offer clinicians and hospitals the opportunity to avoid potential negative payment adjustments by opting into other payment systems, such as accountable care organizations (ACOs), medical homes, or other models where clinicians organize themselves into care delivery systems and accept financial responsibility for the holistic care of beneficiaries. For those clinicians remaining outside of such systems (that is, in FFS Medicare), Medicare could apply an outlier policy that penalizes physicians who deliver care using significantly more resources than their peers year after year. While the Commission has significant concerns about the statistical limitations of reliably measuring outcomes at the individual physician level, we have much more confidence in the ability of the Medicare FFS program to identify individual physicians who are persistent outliers in terms of resource use.[27]

The PQRS includes a large number of measures—approximately 260 for 2013, almost all of which are process and intermediate outcome (such as maintaining diabetic patients' blood glucose below

[27] Miller, M., J.M. Richardson, and K. Bloniarz. 2010. Correspondence: More on physician cost profiling. *The New England Journal of Medicine* 363 (November 18): 2075-2076.

a certain level) measures—as CMS works with specialty societies and quality measurement experts to ensure that physicians in almost all specialties have at least a few measures on which they can report. In the proposed rule, CMS proposes to add about 47 new measures to PQRS in 2014 and delete about an equal number. This action would fill some of the existing gaps in the measure set for currently under-represented specialties and eliminate some duplicative or infrequently-reported process measures.

The Commission remains concerned that the proposed changes to the measure set, while commendable on a technical level, miss the larger point that it is misguided to devote so much of the agency's and stakeholders' funding, time, and attention to developing, implementing, and reporting on process measures. Any performance-driven payment adjustment like the value-based payment modifier should above all evaluate providers' impact on the outcomes of care for beneficiaries. Even with the proposed changes for 2014, we remain concerned that many of the PQRS measures still will not address significant gaps in the quality of care for beneficiaries, either because they represent marginally effective care or because they measure the delivery of services that are basic standards of care.

The Commission's overarching concern about the complexity of the PQRS and the value-based payment modifier stems from the fundamental challenges in any effort to assess the performance of individual physicians and physician groups. Under the proposed measurement and quality/cost-tiering framework, physicians and other eligible professionals that receive a payment adjustment are unlikely to understand why their payments are getting adjusted and what actions they can take to improve their performance. For a pay-for-performance system to be effective, it must have clarity and credibility with front-line practitioners, and it must incorporate economic incentives of sufficient size and immediacy so that the motivation to improve quality and reduce costs is strong enough to change behavior.

Instead of straining Medicare's limited resources to implement dozens of process measures and slightly shorten reporting feedback times to providers, a more effective strategy could be for Medicare to measure and report on a) a small number of outcome measures that are important to beneficiaries and taxpayers, and b) per capita and per episode cost measures (appropriately standardized and risk-adjusted), and then encourage but leave it up to groups of physicians and other eligible professionals to internally measure, report, and develop their care delivery processes in such a way that they improve on those quality and cost measures. For outcome measures, CMS could use the ambulatory care sensitive condition measures that the agency already plans to use for the value-based payment modifier (rates of potentially preventable admissions for certain acute and chronic conditions, rate of potentially preventable readmissions). For cost measures, the Commission has supported the use of both per capita and episode-based measures (appropriately standardized and risk adjusted) for examining physicians' resource use.[28] Therefore, we support CMS's proposals to use both "total per capita" and Medicare Spending Per Beneficiary cost measures for the value-based payment modifier, and we encourage the agency to continue as quickly as possible its ongoing development of a Medicare-specific episode grouper. It is critical

[28] Medicare Payment Advisory Commission. 2009. Report to the Congress: Improving incentives in the Medicare program. Washington, DC: MedPAC.

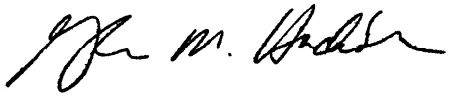
that, as with quality, CMS focus on a small set of key cost measures and strive to keep the measures used as transparent and understandable by physicians as possible.

Conclusion

The Commission appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, the Commission's Executive Director.

Sincerely,



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