

August 28, 2014

Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1612-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**RE: File code CMS-1612-P**

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Center for Medicare & Medicaid Services (CMS) 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 & Other Revisions to Part B for CY 2015,” published in the *Federal Register*, vol. 79, no. 133, pages 40318 to 40540. 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 relative value units
- Potentially misvalued services under the physician fee schedule
- Valuing new, revised, and potentially misvalued codes
- Reports of payments or other transfers of value to covered recipients
- Chronic care management services
- Physician quality reporting system and value-based payment modifier
- Quality measurement for accountable care organizations (ACOs) under the Medicare Shared Savings Program

## **Resource-based practice expense relative value units**

There has been a trend in recent years for hospitals to acquire physician practices, which has resulted in the billing of services shifting from freestanding physician offices to hospital outpatient departments (HOPDs). MedPAC has discussed this issue in three recent reports and recommended ways to align payment rates across ambulatory settings for certain services.<sup>1,2,3</sup>

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 hospital outpatient prospective payment system (OPPS). For most services, the combined payment from the PFS and the OPPS is greater than the single payment Medicare 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 conversion of these practices to off-campus provider-based departments, CMS proposes to collect data to analyze the type and frequency of services provided in off-campus provider-based departments. Specifically, CMS proposes to create a modifier that would be reported with every claim for physicians' services and hospital outpatient services furnished in off-campus provider-based departments.

### *Comments*

The proposal to collect data on services provided in off-campus provider-based departments through the claims process may have some value in helping policymakers understand the growing trend of hospitals acquiring physician practices. The information may also help CMS verify that PFS claims include the correct site of service. However, the proposal does not address the fundamental problem of unjustified payment differences between settings. The PFS payment rate is usually higher when a service is provided in a nonfacility setting (such as a freestanding office) than a facility setting (such as an HOPD). PFS claims for services furnished in provider-based departments should indicate that the service was provided in a facility and should therefore receive the lower facility amount. However, there may be cases where the claim incorrectly indicates that the service was provided in a nonfacility setting. If this occurs, CMS could use the proposed modifier to check whether the service was furnished in a provider-based department and pay the appropriate rate.

A greater concern is that the billing of many services has been migrating from physicians' offices to the usually higher-paid HOPD setting. This migration has resulted in higher spending for the

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<sup>1</sup> Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>2</sup> Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

<sup>3</sup> Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare program and higher cost sharing for Medicare beneficiaries without significant changes in patient care. Therefore, payment variations across ambulatory settings should be immediately addressed. Although it is reasonable to pay higher rates in HOPDs for certain services, we have developed criteria to identify services for which payment rates should be equal across settings or the differences should be narrowed.<sup>4</sup> We encourage CMS to seek legislative authority to implement our recommendations to set equal payment rates for evaluation and management (E&M) office visits across settings and to align payment rates across settings for additional, select groups of services.

### **Potentially misvalued services under the physician fee schedule**

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 improving the valuation and coding of the global package.

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

The Patient Protection and Affordable Care Act (PPACA) requires that the Secretary 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's efforts toward fulfilling the PPACA requirement include establishing 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.

CMS has also established a contract with the Urban Institute for collection of time data for specific services, with data collection anticipated to occur at several physician practices. The contractor will use the data collected to develop objective time estimates for the selected services and will compare those estimates to current time values in the fee schedule. 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.

With the proposed rule, CMS released an interim report from the Urban Institute that discusses numerous challenges the contractor has encountered in collecting objective time data. For example, two of the initial tasks to be performed under the contract—physician practice recruitment and selection of the services for which time data are to be collected—have taken much

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<sup>4</sup> Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

longer than anticipated. In addition, the contractor has discovered inconsistencies in the service definitions that the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) has developed for making RVU recommendations to CMS. These inconsistencies in turn have required the contractor to develop a data collection tool for direct observation that can accommodate variability on issues such as the tasks performed before, during, and after a patient encounter and who—whether a physician or someone else working in a practice—performs each task. The report also discusses plans for completing remaining tasks under the contract, including analysis of the data to be collected.

### *Comment*

The challenges of collecting time data discussed in the Urban Institute report are consistent with the Commission's conclusion that collection of time data in the manner described in the contractor's report would be burdensome for providers and CMS, potentially biased, and very costly.<sup>5</sup> Direct observation—one of the data collection methods described in the Urban Institute report—does not seem to be a viable national strategy due to cost, the time necessary to develop methods, and the potential for bias due to the Hawthorne effect (i.e., those observed change their behavior in response to observation). Electronic systems—the other data source considered in the contractor's report—may have potential, but collection of time data has not been a major focus of developers of these systems.

Our advice remains that the burden and cost of service-by-service, or “bottom-up,” approaches to collecting time data are unlikely to be approaches that can be implemented on a sufficiently broad and sustained basis. The better alternative would be to collect data with the physician or other health professional as the unit of analysis. Practices would submit two types of data:

- actual hours worked by a physician or other health professional during a specified period of time
- the array of services furnished by that professional (billable to all payers) during the time period and the volume of those services.

Such a “top-down” approach would give the Secretary sufficient data to assess the validity of the current RVUs and possibly to change RVUs. While the Commission is continuing to work on this approach, we believe it is feasible to validate RVUs in this way based on the work of a contractor.<sup>6</sup> When compared to bottom-up, a top-down approach has important advantages: it would be less burdensome, it would not be subject to bias from the Hawthorne effect, and it would be less costly, thereby permitting its more frequent use. If issues of methodology or data accuracy arise, information can be provided to the RUC for a more detailed assessment.

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<sup>5</sup> Hackbarth, G. H. 2012. Letter from Glenn Hackbarth, Medicare Payment Advisory Commission, to Marilyn Tavenner, Centers for Medicare & Medicaid Services, August 31.

<sup>6</sup> 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. Report available at <http://www.medpac.gov>.

With the interim findings in the Urban Institute already reinforcing the Commission's earlier conclusion about the bottom-up approach, we strongly urge CMS to abandon this approach. Instead, the agency now has the resources to mount an aggressive effort to validate the fee schedule's RVUs. Under the Protecting Access to Medicare Act of 2014, the Congress allocated funding for this work in the amount of \$2 million per year. CMS should use these scarce resources to change direction and develop a top-down approach to validating RVUs.

*Improving the valuation and coding of the global package*

Currently, the payment rate for many surgical services includes the procedure itself and certain services that are provided immediately before and after the procedure; CMS calls this group of services the global package. There are three categories of global codes based on the number of post-operative days included in the package:

- 0-day global codes, which include the procedure and pre-operative and post-operative physician services on the day of the procedure;
- 10-day global codes, which include the same services as the 0-day global codes plus physician visits related to the procedure during the 10 days after the procedure; and
- 90-day global codes, which include the same services as the 0-day global codes plus pre-operative services furnished one day before the procedure and post-operative services during the 90 days after the procedure.

CMS raises several concerns with the 10-day and 90-day global packages and proposes to convert 10-day and 90-day global packages to 0-day global packages. First, CMS highlights the difficulty of accurately valuing global packages that include post-operative visits after the day of the procedure. The number and type of visits in the package for a given code are likely to change over time as medical practice and the patient population changes. If CMS's assumption of the typical number and type of visits is inaccurate, the RVUs for the code will also be inaccurate. These inaccuracies would persist over time because CMS does not adjust PFS rates for each code every year.

Second, there is evidence that the current values for global codes may not reflect the typical number and level of post-operative visits. According to reports cited by CMS, the Office of Inspector General (OIG) reviewed a sample of medical records for several types of global surgical codes and counted the number of post-operative E&M visits that were actually provided by the surgeons. For a majority of the claims they examined, OIG found that physicians provided fewer E&M visits during the post-operative period than were included in the payment for the global package. OIG recommended that CMS adjust the number of E&M visits in the global payment rates to reflect the number that are actually provided. However, CMS points out that it does not have objective data on the number of visits actually provided during the global surgical period because it does not require surgeons to report the number of visits they furnish during this period.

Third, there is a lack of consistency in how the RVUs for global codes are constructed. For some codes, the work RVUs of the surgical procedure are added to the work RVUs of the pre-operative

and post-operative visits. Other codes, however, are not based on a sum of the values of the individual components; instead, there is a single value for all the services in the package. Therefore, it would be very difficult to adjust the values of these codes based on changes in the number and type of post-operative visits.

Fourth, global codes contribute to payment disparities between specialties. Physicians who bill for global codes are paid for E&M visits that are included in the global package even if they do not furnish them while physicians who do not bill for global codes are only paid for visits that they actually furnish. Another factor that may contribute to disparities between specialties is the possibility for global codes to be unbundled. If one physician performs the surgical procedure but a different physician provides the post-operative visits, there should be a formal transfer of care between the physicians. Each physician would bill for the same code using a modifier, and CMS would split the payment between the two physicians. If there is no transfer of care agreement, however, CMS would pay the full global payment amount to the surgeon who performed the procedure and also pay separately for each post-operative visit furnished by the second physician. In this case, Medicare spends more on the global surgery than if a single physician provided all of the care.

In addition, CMS notes that the values for global codes assume that all post-operative outpatient visits occur in the office setting rather than in a facility setting such as a hospital outpatient department. However, many of these visits likely occur in facilities. Because practice expense RVUs are higher for visits provided in offices than in outpatient departments, the assumption that all post-operative visits occur in offices may lead to practice expense RVUs that are too high.

Fifth, CMS asserts assumes global codes are not consistent with current medical practice. The global payment policy assumes that the same physician who performs the procedure also provides all of the post-operative care. However, CMS believes that care is shifting from individual practitioners to larger practices and teams. In addition, if global codes are misvalued, this may impede Medicare's ability to develop new payment models such as bundled payment or payment for episodes of care that are built on the values of individual codes.

As a result of CMS's concerns about the accuracy of the number and level of post-operative visits assumed to be provided during the global period, CMS proposes to convert all 10-day global codes to 0-day codes in 2017 and convert all 90-day codes to 0-day codes in 2018. After this change, providers would bill separately for all pre-operative visits and post-operative visits that occur after the day of the procedure. CMS's believes that this change would increase the accuracy of PFS payment rates, avoid duplicative payments when a beneficiary receives post-operative care from a different physician than the one who provided the procedure, eliminate differences in the RVUs for E&M visits that are part of global codes and E&M visits that are billed separately, and provide more accurate data for new payment models.

CMS asks for comment on its proposal to convert 10-day and 90-day global codes to 0-day codes and how to implement this change. CMS states that it would need to gather objective data on the number and level of post-operative E&M visits for each global code; the agency would use these data to value specific services and to make a budget neutrality adjustment that accounts for

changes to the RVUs of specific codes. CMS believes that the best approach to collect this information is through the claims process but asks for other suggestions.

CMS points out that its proposal would require revaluing a large number of codes (3,000) over a short timeframe, which would make it impractical to conduct surveys on the time and intensity of each global code. CMS believes that it can revalue these codes using data on the number and level of post-operative visits for each code in conjunction with other methods, such as revaluing the small number of codes that account for most of the volume of global codes and then using magnitude estimation to value other services within the same family of codes.

*Comment*

In general, the Commission supports moving Medicare in the direction of bundled payments to counter the volume incentives intrinsic to fee-for-service Medicare. However, it is essential that the individual services that make up a bundle have accurate values and that there is a mechanism to ensure that the services that are part of the bundle are not paid separately (unbundling). Otherwise, the payment rate for the entire bundle will be inaccurate. Therefore, we support CMS's proposal to improve the accuracy of the RVUs for surgical procedures by converting 10-day and 90-day global codes to 0-day codes.

However, we believe that CMS can make this change without collecting new data on the number and level of post-operative visits for each code. Instead, CMS could create new RVUs for many of the existing global codes by subtracting the RVUs related to the post-operative visits for each code from that code's total RVUs. We also discuss an option for revaluing global codes when there are no assumptions about the number and type of visits during the global period.

We agree with CMS's concerns about the current global surgical payment policy. Paying separately for post-operative visits would address many of these problems. Medicare would no longer make duplicative payments when a beneficiary receives post-operative care from a different physician than the one who provided the procedure without a transfer agreement between the two physicians. CMS would no longer have to estimate the typical number, type, and location of post-operative visits within the global period, which can lead to inaccuracies. To implement its proposal, CMS believes that it needs to collect objective data on the number and level of post-operative E&M visits for each global code. CMS indicates that the best approach to collect this information is through the claims process. Gathering such data could take several years and would be burdensome for CMS and providers. Moreover, the data reported by providers may be inaccurate. Because they are not currently paid separately for each post-operative visit within the global period, providers would have little incentive to report each visit.

We do not believe that CMS needs to collect data on the number and level of post-operative visits for each global code. Instead, CMS could create new RVUs for many of the existing global codes by subtracting the RVUs related to the post-operative visits from each code's total RVUs. For many global codes, CMS's database includes assumptions of the number and type of visits during the global period. For cataract surgery with intraocular lens insertion (CPT 66984), for example, CMS assumes that there are four post-operative visits after the patient is discharged from the

facility. CMS could subtract the RVUs for these visits from the total RVUs for the code. The remaining RVUs would apply to the procedure itself and pre-operative and post-operative services that occur on the day of the procedure. If specialty societies or the RUC believe that the new values for specific global codes are inaccurate, they could present evidence that the codes are misvalued to CMS.

CMS notes that, for some global codes, there are no assumptions about the number and type of visits during the global period. The RVUs for these codes are based on a single value for all of the services in the package. Therefore, the process we suggest above would not work for these codes. As an alternative, CMS could calculate interim RVUs for these codes based on the average percent reduction for other global codes in the same family with the same post-operative period (10 days or 90 days). Assume, for example, that a musculoskeletal procedure has a value of 20 RVUs but there are no assumptions about the number and type of post-operative visits during the 90-day global period. If the RVUs for the other 90-day global codes in the musculoskeletal family of codes are reduced by 25 percent, on average, CMS would also reduce the RVUs for this code by 25 percent. The new interim value for this musculoskeletal procedure would be 16 RVUs. The final RVUs for codes that are revalued through this alternative process could be based on objective data on the time it takes practitioners to perform these procedures. These data should be gathered from a cohort of efficient practices, as we recommended in our letter to the Congress on moving forward from the sustainable growth rate system.<sup>7</sup>

We reiterate our support for creating larger units of payment that include multiple services provided on the same day as well as bundled payments that include services furnished during an episode of care by multiple providers. The individual services that are part of a bundled payment need to have accurate values and there needs to be a mechanism to prevent unbundling. CMS should move forward with improving payment accuracy for global surgical codes while also developing bundled payments that incorporate services provided by practitioners and other providers during an episode of care.

### **Valuing new, revised, and potentially misvalued codes**

The proposed rule addresses elements of the current process for valuing new, revised, and potentially misvalued billing codes:

- the American Medical Association's Current Procedural Terminology (CPT) Editorial Panel defines new billing codes and revises existing billing-code definitions
- the RUC develops RVU recommendations for new and revised codes and for codes identified as potentially misvalued
- CMS reviews the RUC recommendations, establishes interim RVUs, and has the RVUs published in a final rule in November of each year

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<sup>7</sup> 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](http://medpac.gov/documents/10142011_MedPAC_SGR_letter.pdf).



- while there is a 60-day comment period for the interim RVUs published in November, physicians and other health professionals receive payment for services based on the interim RVUs—without change—for one year
- CMS adjusts the interim RVUs if necessary for the following year based on comments received.

As discussed in the proposed rule, stakeholders have concerns about the process. One concern relates to the timeliness of the notice stakeholders receive about impending payment reductions due to changes in the RVUs for existing services. Stakeholders have objected that they have not received notice of the reductions before the reductions occur. Another concern relates to transparency—the opportunity for comment on RVU changes. Stakeholders assert that, if the RUC has made recommendations on the RVU changes, there is no opportunity to respond to the recommendations because RUC actions and recommendations are not public. In addition, some stakeholders believe that they do not have an opportunity to meaningfully comment on interim RVU changes and for CMS to address the comments received.

CMS's position is that the current process for valuing new, revised, and potentially misvalued codes is appropriate given the incongruity between the agency's rulemaking schedule and the schedules of the CPT Editorial Panel and the RUC. For example, to prepare for coding changes to be implemented on January 1, 2016, the CPT Editorial Panel has met or will meet in May 2014, October 2014, and February 2015.<sup>8</sup> The RUC will consider these coding changes—and RVU recommendations for them—at meetings in September 2014, January 2015, and April 2015. With such a sequence of CPT Editorial Panel meetings and RUC meetings occurring through April of each year, CMS cannot consider all of the RUC's recommendations in time for a proposed rule normally published in July. Instead, the agency establishes interim final RVUs, published in November.

CMS proposes, however, to modify the current process in response to the concerns expressed by stakeholders, noting further that the agency has heightened its review of RUC recommendations. In place of the current sequence of interim RVUs in one year and final RVUs in the next year, CMS would establish an annual deadline of January 15<sup>th</sup> for receipt of RUC recommendations on RVUs for new, revised, and potentially misvalued codes.

- Codes with recommendations by the deadline would have proposed RVUs in the fee-schedule proposed rule published in the following July. For example, codes with recommendations by January 15, 2015, would have proposed RVUs in the proposed rule published in July 2015. The proposed rule, including the proposed RVUs, would be subject to a 60-day public comment period. CMS would review of the comments received, issue final RVUs in November, and use those RVUs for payment starting the following January 1st.
- Codes without recommendations by the January 15<sup>th</sup> deadline would have any changes in payment delayed by one year. During the delay, CMS would adopt coding policies and

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<sup>8</sup> American Medical Association. 2014. CPT Editorial Panel Process – AMA/Specialty Society RVS Update Process. June 26. <http://www.ama-assn.org/resources/doc/cpt/x-pub/cpt-ruc-calendar.pdf>.

payment rates for these codes that conform, to the extent possible, to the policies and rates in place during the previous year. CMS would also use rulemaking during the delay year—proposed rule in July and final rule in November—to propose RVUs and establish final RVUs for these codes, with payment based on the final RVUs to begin on the following January 1<sup>st</sup>.

*Comment*

We agree with the proposal to establish a deadline for receipt of RUC recommendations on RVUs for new, revised, and potentially misvalued codes. CMS can then propose RVUs for the codes in a proposed rule published in July, giving stakeholders ample notice of payment changes that may occur on the following January 1<sup>st</sup>. A 60-day comment period for the proposed RVUs would give stakeholders an opportunity to comment on the RVU changes. CMS could also work with the CPT Editorial Panel and the RUC to ensure that high-volume codes are given the priority necessary for the codes to meet the RUC-recommendation deadline.

We do not agree with the proposal as it applies to codes that do not meet the deadline for RUC recommendations. As discussed in the proposed rule, the proposal would have significant drawbacks:

- CMS would develop temporary G-codes to replace, for example, CPT codes that have been deleted by the CPT Editorial Panel. These codes would create an administrative burden for CMS and those billing Medicare.
- During the delay, payments would be inaccurate for codes known to be misvalued.

Instead of this proposal—for codes not meeting the RUC-recommendation deadline, we recommend a process similar to the current one but augmented (Table 1). CMS would continue to issue interim RVUs for such codes, with publication of the RVUs to occur in a final rule and with a 60-day comment period. Payment based on these RVUs would occur for one year as it does now. However, to give stakeholders more timely information about changes payment that would accompany use of these RVUs, we urge CMS to work with the CPT Editorial Panel and the RUC to better disseminate information about potential changes in coding and payment as far in advance as possible of use of the interim RVUs for payment.

The process can be further augmented through continued use of refinement panels.<sup>9</sup> The Commission's view is that refinement panels are analogous to the standing panel of experts the Commission has recommended to help CMS identify overvalued services and review recommendations from the RUC.<sup>10</sup> As such, refinement-panel membership should be limited to

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<sup>9</sup> As described in the proposed rule, refinement panels assist CMS in reviewing public comments on interim RVUs. They are convened after receipt of the comments and are composed of clinicians representing the specialty most identified with the codes in question, physicians in related specialties, primary care physicians, and contractor medical directors. As part of the proposal, CMS would eliminate use of refinement panels on the grounds that they would no longer be relevant in the absence of interim RVUs.

<sup>10</sup> Medicare Payment Advisory Commission. 2006. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

those without a financial stake in the process—contractor medical directors, experts in medical economics and technology diffusion, private payer representatives, and a mix of physicians and other health professionals not directly affected by the RVUs in question. We understand that continued use of refinement panels—in addition to other changes in the process for valuing new, revised, and potentially misvalued codes—may necessitate further resources for CMS. One option the agency could consider for acquiring such resources would be to establish a user fee for the refinement panel process. Specialty societies would pay this fee when requesting a refinement panel.

**Table 1. Valuing new, revised, and potentially misvalued codes**

<b>Codes meeting deadline for RUC recommendations</b>	<b>Codes not meeting deadline for RUC recommendations</b>
<ul style="list-style-type: none"> <li>• Proposed RVUs</li> <li>• 60-day comment period</li> <li>• Final RVUs</li> <li>• Final payment change</li> </ul>	<ul style="list-style-type: none"> <li>• Advance information on potential changes in payment</li> <li>• Interim RVUs</li> <li>• 60-day comment period</li> <li>• Interim payment change</li> <li>• Refinement panels, if requested</li> <li>• Final RVUs</li> <li>• Final payment change</li> </ul>

**Reports of payments or other transfers of value to covered recipients**

Section 6002 of the Patient Protection and Affordable Care Act of 2010 (PPACA) requires manufacturers of drugs, devices, biologicals, or medical supplies to annually report to the Secretary certain payments or transfers of value provided to covered recipients, or to an entity or individual at the request of or designated on behalf of a covered recipient. In addition, PPACA requires manufacturers and group purchasing organizations (GPOs) to report on physician ownership or investment interests. The Secretary is directed to publish the information submitted by manufacturers and GPOs on a public website.

CMS published the final rule to implement this section of PPACA in 2013, which it calls the “Open Payments (Sunshine Act)” program. In this proposed rule, CMS proposes to modify certain aspects of the program. The program currently requires manufacturers to report the marketed name of each drug or biological related to a payment or other transfer of value. However, it is optional for manufacturers to report the marketed name of each device or medical supply related to a payment or other transfer of value. Manufacturers of devices or supplies must report one of the following: the marketed name, product category, or therapeutic area. For example, they may choose to report the product category instead of the marketed name of the device or supply. CMS proposes to require manufacturers to report the marketed name of each device or medical supply, which would be consistent with the requirement that manufacturers report the marketed name of each drug or biological. CMS states that this change would make the data consistent across types of products and enhance consumers’ use of the data.

*Comment*

We support CMS's proposal to require manufacturers to report the marketed name of each device or medical supply, in addition to the marketed name of each drug or biological. In our March 2009 report, we recommended that manufacturers publicly report the name of the drug, device, or supply that is related to a payment or transfer of value.<sup>11</sup> We agree with CMS that this requirement would make the data on the public website more useful to consumers, oversight entities, private payers, and other interested parties.

**Chronic care management services**

The rule seeks comment on a code established in the CY 2014 Part B final rule with comment period that allows separate payment, beginning CY 2015, for care management services furnished to Medicare beneficiaries with two or more chronic conditions. At least 20 minutes of chronic care management services must be furnished during a 30-day billing period, and only one claim per beneficiary will be paid per 30-day period. The practitioner must obtain the patient's consent to have these services provided, and the patient is subject to cost-sharing. The rule also proposes that CCM services must be furnished with the use of an electronic health record or other health IT or health information exchange platform that includes an electronic care plan that is accessible to all providers within the practice, including being accessible to those who are furnishing care outside of normal business hours, and that is available to be shared electronically with care team members outside of the practice.

*Comment*

The Commission supports the establishment of the new billing code for chronic care management. However, to mitigate the risk of duplicate 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 code.

According to CMS policy, physicians or nurse practitioners employed by or under arrangement with hospice or a home health agency cannot bill for care plan oversight because CMS considers care plan oversight to be a part of the hospice or home health agency payment. CMS also believes there is significant overlap in the resources required to provide care plan oversight and chronic care management, and as such, care plan oversight cannot be billed separately during the time period when the chronic care management services are billed.

It follows that chronic care management functions which overlap with care plan oversight functions are also a part of the hospice or home health agency payment, and as such, practitioners employed or under arrangement with hospice or home health agencies should not be eligible to bill for the new chronic care management code just as they are not eligible to bill for care plan oversight.

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<sup>11</sup> Medicare Payment Advisory Commission. 2009. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

### Physician quality reporting system and value-based payment modifier

Current law requires CMS to develop and apply a value-based payment modifier (“value modifier”) to all physicians and other professionals billing under the fee schedule. The value modifier must adjust fee schedule payments to clinicians based on the quality of care furnished to beneficiaries compared to the cost of that care. Under the statute, CMS is required to apply the value modifier to all clinicians by 2017.

CMS has, in the past two years, proposed and finalized plans for the 2015 and 2016 value modifier, and in the current rule, proposes rules for the 2017 value modifier. CMS must calculate individual-level modifiers (or group-level, if the clinician bills at the group level) for all clinicians billing under the fee schedule. CMS proposes to use 2015 as the measurement year for the 2017 value modifier, hence its inclusion in this year’s proposed rule.

CMS proposes three main policies:

- Clinicians must successfully report on a minimum number of quality measures through the Physician Quality Reporting System (PQRS). If they do not, then, in addition to a PQRS non-participation penalty of -2.0 percent in 2017, they also would receive an automatic -4.0 percent penalty through the value modifier in 2017.
- Groups of clinicians with less than 10 eligible practitioners would be eligible only for a neutral or upward adjustment, and would not be subject to a negative adjustment in 2017.
- Groups of clinicians with 10 or more eligible practitioners would be eligible for an upward, neutral, or downward adjustment based on the group’s quality relative to cost. The proposed adjustment in 2017 for each cost/quality combination is shown in Table 2:

**Table 2. Proposed 2017 value modifier adjustment amounts**

	<b>Low quality</b>	<b>Average quality</b>	<b>High quality</b>
<b>Low cost</b>	+0.0%	+2.0x*	+4.0x*
<b>Average cost</b>	-2.0%	+0.0%	+2.0x*
<b>High cost</b>	-4.0%	-2.0%	+0.0%

Note: \*The upward payment adjustment factor (“x”) will be determined after the performance period has ended based on the aggregate amount of downward payment adjustments. Eligible practitioners may qualify for an additional bonus of +1.0x if they report clinical data for quality measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

The quality measures used in calculating the value modifier may include:

- the PQRS measures that a clinician elects to report (at least 9 measures);
- patient experience assessed with the CAHPS-Clinician/Group survey instrument (with mandatory reporting for groups with at least 100 clinicians); and

- three claims-based outcome measures: an all-cause readmission measure; a composite measure of potentially preventable hospitalizations for patients with certain acute conditions (dehydration, urinary tract infections, and bacterial pneumonia); and a composite measure of potentially preventable hospitalizations for patients with certain chronic conditions (heart failure, chronic obstructive pulmonary disease, and diabetes).

The cost measures that CMS uses in calculating the value modifier include: total per capita cost, total per capita costs for four conditions, and the Medicare spending per beneficiary measure that was created for use in the IPPS value-based purchasing program.

CMS also has proposed an attribution method for assigning patients to clinicians for the claims-based quality measures and the cost measures.

### *Comments*

The Commission appreciates the effort that CMS has gone through to establish a system for tracking and assessing the quality and cost of care provided by physicians and other health professionals, and the difficulty that Congress faced in establishing a statutory provision to measure and adjust payments to clinicians based on the quality and cost of care they provide. All stakeholders, including the Commission, are seeking ways to improve the delivery of integrated, coordinated, and reliably high-quality care for beneficiaries.

However, the complexity of the PQRS and the value modifier are clear signals of the many challenges in assessing performance at the individual clinician level. First, there is a trade-off between the type of quality measures Medicare can deploy (outcome measures versus process measures) and the statistical accuracy (i.e., reliability) of the different kinds of measures at the clinician level. Process measures may be less meaningful to patients as quality indicators, but they are more reliable to measure at the individual clinician level; whereas more meaningful outcome measures, such as potentially preventable admissions/readmissions and mortality, are less reliable when measured at the individual clinician level. This means that the measures that can be most important and meaningful to patients—a provider's performance on the outcomes of care—often are not statistically reliable when measured at the individual clinician level.

Second, while CMS and physician specialties have worked to increase the number of PQRS measures, it may be difficult to define clinically meaningful and statistically reliable quality measures for some specialties, such as certain surgical subspecialties and hospital-based specialties such as radiologists, pathologists, and anesthesiologists. In the absence of reliable measures, the default assumption Medicare will make is that the quality of each clinician's performance is no different than average. But this assumption renders moot a policy to adjust or redistribute some portion of payments on the basis of variations in quality across providers. For the foreseeable future, it is likely that gaps will persist in Medicare's ability to measure quality for some physician specialties.

Third, a payment signal that is not transparent or understandable by clinicians is unlikely to improve care in the way it is designed. The value modifier, despite CMS's effort to be transparent

and clearly implement the statute, is highly complex. The complexity derives from the inherent difficulty in measuring individual clinician performance. If clinicians do not know what to do to improve their value modifier result, they are unlikely to devote resources effectively to improving the quality and increasing the efficiency of the care they provide.

Fourth, the value modifier joins two other clinician-level payment adjustments under current law (PQRS and the EHR “meaningful use” program), each with different participation requirements and potential payment adjustments (see Table 3). CMS has tried to unify the administrative requirements across the three programs so that clinicians do not face overly complex reporting in order to successfully participate, but the three programs still operate separately.

**Table 3. Medicare quality-based payment incentives for physicians and other eligible professionals, 2015-2017**

<b>Policy</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>
Value-based payment modifier	Bonus maximum +1.0x* Penalty maximum -1.0%	Bonus maximum +2.0x* Penalty maximum -2.0%	Bonus maximum +4.0x* Penalty maximum -4.0%
PQRS (penalty only)	-1.5%	-2.0%	-2.0%
EHR “meaningful use” (penalty only)	Maximum -1.0%	Maximum -2.0%	Maximum -3.0%
<b>Total maximum possible payment penalty</b>	<b>-3.5%</b>	<b>-6.0%</b>	<b>-9.0%</b>

Note: \*The upward payment adjustment factor (“x”) will be determined after the performance period has ended based on the aggregate amount of downward payment adjustments. Eligible practitioners may qualify for an additional bonus of +1.0x if they meet PQRS requirements for successful reporting and their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores.

Given these fundamental challenges, the Commission’s view is that quality measurement for clinicians in FFS Medicare at the individual level may not be worth the resources required. While it is not impossible for a medical group to assess performance of its clinicians, it may in fact be impossible for the Medicare program to transparently and reliably establish, collect, benchmark, assess and adjust payments based on quality measures for individual clinicians. Furthermore, under the current value modifier or any conceivable alternatives, clinicians are unlikely to understand why their payments are changing, and what they need to do to improve their performance and thereby increase their quality based-payments from Medicare.

A more promising avenue would be to encourage clinicians to organize into or join groups that take clinical and financial accountability for their patients, and have their performance assessed on the basis of a few key outcome measures as discussed in our June 2014 Report to the Congress. These groups could take the form of ACOs that are subject to two-sided risk, or MA plans.

If clinicians do not organize themselves into formal groups, the alternative would be to measure their performance as if they were organized, for example by grouping them according to specialty, practice within a local geographic area, or other natural group to improve the statistical reliability of the deployed outcome measures. Clinicians may resist approaches to create such “virtual groups” since, they could argue, there would be no actual organization or administrative entity through which they could act to improve their performance on the measures.

### **Quality measurement for accountable care organizations (ACOs) under the Medicare Shared Savings Program**

CMS proposes several changes to how the agency determines the quality of care delivered by each accountable care organization (ACO) that participates in the Medicare Shared Savings Program. CMS uses each ACO’s quality performance to decide whether and, if so, to what extent an ACO will share in any savings it has generated.

The current set of ACO quality measures includes 33 measures spanning four “domains,” such as patient/caregiver experience of care, preventive health services (e.g., screenings), and some condition-specific clinical care processes (e.g., performing foot examinations of patients diagnosed with diabetes). Some of the current quality measures are calculated by CMS from Medicare claims data (such as a risk-standardized, all-condition 30-day readmission rate) or from patients’ responses to the Clinician/Group version of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, but two-thirds of them require ACOs to extract data from samples of attributed beneficiaries’ medical charts and then report the extracted data through a customized Web interface maintained by a CMS contractor. This resource-intensive reporting system is unique to the Medicare program, i.e., it is not used by or for any other payer.

CMS proposes to add twelve measures to the current list of ACO quality measures: one CAHPS patient experience measure; one measure that uses claims data to estimate a risk-standardized rate of all-cause, unplanned readmissions to a hospital for patients who were admitted to a SNF within 30 days of a prior hospital discharge; three claims-based measures of all-cause, unplanned hospital admission rates for patients with diabetes, heart failure, or multiple chronic conditions; and seven new process of care measures that would use data extracted from patient medical charts. CMS also proposes to drop eight outdated process of care measures that use medical chart data. Altogether under the proposal, CMS would use 37 measures to assess ACOs’ quality of care in the next three-year contracting cycle, compared to 33 measures in the current contracting period.

CMS also proposes to modify the formula it uses to calculate an ACO’s overall quality performance, and therefore its shared savings, to include a calculation of how much improvement there was in an ACO’s quality scores relative to its scores in the previous year. Under current policy, an ACO’s quality performance is assessed solely on the basis of its attaining or surpassing a national benchmark for the measure. Lastly, CMS proposes to change how it handles scoring ACOs performance on “topped out” measures, which are measures where almost all ACOs achieve near-perfect performance and therefore the measure is no longer useful for distinguishing meaningful performance differences among ACOs.



*Comments*

The Commission commends CMS for proposing to eliminate eight process measures that use data extracted from patient medical charts. We do not support essentially replacing the deleted measures, and the associated administrative burden of extracting and reporting data from a sample of patient medical records, by adding seven new chart-based process measures. As described in chapter 3 of our June 2014 Report to the Congress, the Commission would move quality measurement for ACOs, MA plans, and FFS Medicare in the direction of a small set of population-based outcome measures, such as potentially preventable inpatient hospital admissions, emergency department visits, and readmissions.<sup>12</sup> To further reduce the number of measures in the current program, we encourage CMS to drop process measures from the measure set as they become “topped out.”

The Commission supports adding a measure of readmissions for skilled nursing facilities (SNF) to the ACO measure set. Managing post-acute care (PAC) and transitions between settings are key strategies for ACOs to undertake to improve the care furnished to beneficiaries. Our discussions with ACOs indicate that some ACOs partner with PAC providers with low readmission rates as one way to provide high quality PAC. The hospital readmission reduction policy under FFS Medicare has focused the attention of many hospitals and SNFs to lower their rates. Beginning in 2018, a FFS Medicare readmission policy for SNFs will tie a portion of their payments to their readmission rates. The proposed readmission measure for ACOs will align the incentives of ACOs and SNFs to lower their readmission rates.

However, the Commission encourages CMS to reconsider the specific measure it proposes to use, which is a 30-day all-cause readmission measure. The Commission supports outcome measures that reflect the care within the control of the providers. To that end, the Commission has for several years reported a risk-adjusted measure of potentially avoidable readmissions for SNFs, and over time has refined the measure to make it broader in scope and more targeted at potentially avoidable readmissions. We also have revised the risk-adjustment method to better control for differences across providers in the mix of patients they treat.

The potentially avoidable readmission measure used by the Commission counts the readmissions that can reasonably be expected to be managed by a SNF or that result from poor care management. The measure meets several of the principles the Commission laid out in discussing pay-for-performance programs: it is an outcome measure (not a process measure), is broad in scope (the 13 conditions considered potentially avoidable account for almost half of all SNF readmissions), does not require additional data submissions from providers, and is a measure many SNFs can improve on. Our work found considerable variation in rates across SNFs (with rates ranging from zero percent to 43 percent), indicating substantial room for improvement. Because the measure is readily available and does not require additional data, we believe a measure of potentially avoidable readmission is a better measure of readmissions that are typically within the control of providers, compared to the all-cause readmission measure CMS proposes here.

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<sup>12</sup> Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

On the three proposed measures of all-cause, unplanned, condition-specific admissions, we suggest collapsing them into one measure of potentially avoidable hospitalizations, because we are concerned that the proposed condition-specific measures will be statistically unreliable and subject to random variation that will limit their usefulness in distinguishing ACOs' actual performance. This technical limitation of the condition-specific measures will be particularly evident for ACOs with small attributed populations.

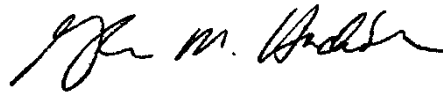
Lastly, it is the Commission's view that the quality performance benchmarks against which an ACO's performance should be compared is the quality of FFS Medicare in the local area. We discuss this approach in greater detail in chapter 3 of our June 2014 Report to the Congress.

### **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,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with a large initial "G" and "H".

Glenn M. Hackbarth, J.D.  
Chairman