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*Via Electronic Submission* ([www.regulations.gov](http://www.regulations.gov))

September 8, 2015

Mr. Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
ATTN: CMS-1631-P  
7500 Security Blvd.  
Baltimore, MD 21244-8013

Dear Mr. Slavitt:

**Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, File Code CMS-1631-P**

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) proposed rule, *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016*, 80 Fed. Reg. 41686 (July 15, 2015). The AAMC is a not-for-profit association representing all 144 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, and 93 academic and professional societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The calendar year (CY) 2016 Physician Fee Schedule (PFS) rule proposes several policy changes including the Advanced Care Planning (ACP) code. The AAMC appreciates that CMS has chosen to propose minimal changes for the upcoming year as the move toward the new physician payment system established by the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) will be sufficiently challenging in subsequent rulemakings. Among the areas addressed by this letter are feedback on MACRA implementation, quality reporting programs, Physician Compare Website, payment for care coordination, and the request for information on changes to the physician self-referral regulations.

**SUMMARY OF THE AAMC'S MAJOR COMMENTS**

**Feedback on MACRA Implementation**

In April 2015, Congress passed MACRA which significantly changes the way in which physicians will be paid and evaluated for quality. The law repeals the sustainable growth rate (SGR), the statutory formula

that did not perform as a control on the growth in aggregate Medicare expenditures for physicians' services as was intended by Congress, replacing it with a several years of predictable updates, followed by several years with no updates. Starting in 2019, physician payment will be driven by either transitioning to alternative payment models (APM) or participating in the Merit-based Incentive Payment System (MIPS), a consolidated pay-for-performance program. The CY 2016 PFS rule is the first since the passage of MACRA and comes at a time when physician payment is in a period of transition. The AAMC provides comments on two important issues for the future of MACRA: defining a group for MIPS participation and defining APMs.

The AAMC strongly urges CMS that, as it works to define the framework for MIPS pay-for-performance program, it create a group reporting option. Both the Value Modifier (VM) and the Physician Quality Reporting System (PQRS), which represent two of the three programs that will be incorporated into MIPS, provide an option for group measurement. Several academic practices have adopted this reporting option as it allows the organization to focus on a shared set of goals and build the infrastructure necessary to improve care.

The implementation of the APM criteria requires broad policies that reflect the numerous contracting arrangements that exist between physician practices and other partners in the health system. The physician group not only is an integral part of the care redesign, but often leads the effort. However, depending on the structure of the academic medical center or health system, the physician group may not be the organization signing the contract. The AAMC recommends that CMS ensure that its policies do not undercount physicians' APM activities by failing to give credit to partner physician groups for their involvement in care redesign and the provision of quality care.

### **Value Modifier (VM) and Physician Quality Reporting System (PQRS) Recommendations**

The proposed rule outlines the final rules and requirements for the VM and PQRS payment adjustments, which will be paid in 2018 based on a 2016 reporting and performance period. Given that both programs will transition to MIPS starting in 2019, CMS continues many of the policies from 2015. Generally, the AAMC is pleased to have stable policies. One outstanding concern, however, is that the VM scoring methodology appears to be biased against those providers who care for complex patients. In the 2015 VM, no groups with high risk patients received an upward adjustment in quality tiering, and 30 percent received a negative adjustment. As will be discussed in more detail later, the AAMC asks that CMS immediately implement changes to create a more accurate and fair comparison. Last, CMS uses AHRQ developed indicators to assess group performance that have not been adjusted for clinical variation. The Agency should ensure that these indicators are appropriately adjusted, as described below.

### **Physician Compare Website**

The AAMC believes it is premature for CMS to finalize the proposed Achievable Benchmark of Care (ABC) benchmarking methodology for Physician Compare. The AAMC supports public reporting that has a clear purpose, is transparent, and is valid,<sup>1</sup> and supports CMS's continued efforts to improve Physician Compare. However, the proposed benchmarking methodology is not well understood by

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<sup>1</sup> <https://www.aamc.org/download/370236/data/guidingprinciplesforpublicreporting.pdf>

physicians, nor has it been sufficiently tested in a national program with a wide range of reporting options. CMS should conduct more thorough analyses to ensure that this methodology addresses factors such as risk adjustments, variation in reporting mechanisms and programs, and patient complexities. Lastly, the Agency should not develop a single 5-star rating system for physicians, as it is impossible to distill the variety of healthcare services offered into a valid and comparable single composite score.

CMS requests feedback on whether to stratify measures by certain variables in the future. As the AAMC has previously commented, we believe CMS should stratify certain outcome measures by socio-demographic status (SDS). CMS should use feedback from the IMPACT Act (which requires a study on SDS), as well as feedback from the National Quality Forum (NQF) trial period on SDS to inform the Agency which variables should be used. CMS should implement a similar methodology for Hospital Compare.

### **Alternative Payment Models**

CMS proposes several changes related to the Medicare Shared Savings Program (MSSP). The AAMC has provided comments on the exclusion of skilled nursing facility (SNF) visits and the statin and quality measures. Additionally, CMS is proposing to not expand the Comprehensive Primary Care Initiative (CPCI) at this time but seeks public comments to obtain information about specific issues (i.e. practice readiness) related to this potential expansion. The AAMC believes this model holds potential but further analysis and stakeholder engagement should be done to evaluate the feasibility and benefits of this model.

### **Care Coordination**

CMS seeks feedback on ways the Agency can more accurately improve payment for primary care and care management services that occur outside of an evaluation and management (E/M) visit. The AAMC appreciates that CMS's current codes recognize that care coordination can occur in multiple settings, including hospital outpatient departments, by multiple specialists. Reducing the administrative hurdles that must be overcome to bill for these codes will improve the accessibility to these services, and ensure that more providers are paid for services that they provide. The Agency can also improve care collaboration by recognizing the time and efforts of both parties involved in the coordination discussion – the care coordinator as well as the other practices. The AAMC believes the e-consult model, which is being implemented and evaluated with funding through its Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Awards, is a potential model to recognize this type of collaborative effort.

### **Physician Self-Referral**

CMS should exercise its regulatory authority to provide more flexibility regarding waivers to the physician self-referral laws and work with the Office of Inspector General (OIG) to ensure that waivers are available for other fraud and abuse laws that are impediments to coordination and transformation of medical care. The current regulations are an impediment to hospitals and physicians working together to provide coordinated care and do not take into account the many quality programs that ensure that there is no risk of program abuse.

## **Comments on Other Proposals**

- The AAMC supports the new advanced care planning (ACP) codes.
- The AAMC supports the Agency's efforts in expanding telehealth services.
- CMS should minimize the impact of the target for relative value adjustments.

## **FEEDBACK ON MACRA (80 *Fed. Reg.* at 41879-41880)**

MACRA is a landmark piece of legislation for physician payment. In addition to repealing the SGR formula, it also transforms Medicare into a program that uses quality components as a driver of reimbursement rates. Starting in 2019, tracks for practices will be available to determine payment:

- The MIPS consolidates the payment adjustments from the Medicare Electronic Health Record (EHR) Incentive Program, the VM, and PQRS into a large pay-for-performance program. Providers will be measured on quality, resource use, clinical practice improvement activities, and meaningful use of an EHR.
- The APM track provides "qualifying APM participants" incentives for significantly participating in selected alternative payment models. Eventually the qualifying APM participants will also receive a higher annual update.

At this time CMS is seeking public input on the implementation of MIPS and the APM provisions.

## **CMS Must Implement a Group Reporting Option in MIPS**

One key challenge in developing the MIPS framework is reconciling the unit measure differences among the three existing physician reporting and performance programs. The Medicare EHR Incentive Program requires all measures to be reported by individual (as defined by national provider identifier (NPI)). In contrast, the VM primarily evaluates performance at the group level (as defined by tax identification numbers (TIN)). Finally, PQRS provides practices the option to report either as a group (as defined by TIN) or as individuals within a group (as defined by TIN/NPI combination). MIPS provides CMS with the opportunity to create better alignment across these programs.

As a strong proponent of group reporting, the AAMC recognizes the need for a flexible definition of what constitutes a group. The current PQRS and VM policies recognize groups only by TIN. TIN is a reasonable definition, but is too limiting as the only option. As described below, the AAMC encourages CMS to identify ways to allow: a) related TINs to combine and report as a single group and b) a subset of physicians within a large TIN to report separately as a group.

While CMS must create a group option for the quality reporting portion of MIPS, the MACRA legislation says the Agency "may establish" a group reporting option for the other MIPS components. The AAMC strongly encourages CMS to exercise this option and create a group reporting option. There are numerous benefits to group reporting, including that it:

- Focuses an organization's attention on a set of common goals and encourages investment in the infrastructure needed to develop systems.

- Encourages teamwork. As medicine moves increasingly to inter-disciplinary care, team-based care it becomes more challenging to attribute particular activities to a single provider.
- Reduces administrative burden. Specifically for academic centers that have hundreds or thousands of physicians, tracking individual performance is challenging, particularly when providers may work for different groups throughout the year.
- Improves sample size. Most measures, particularly those that require outcomes, need sufficient sample size to be reliable and group reporting can help increase the sample size.

For all of these reasons, the AAMC supports group reporting as an important option. The Association also recognizes that creating a MIPS group reporting option means the Medicare EHR data must be measured differently for groups than for individuals. Ideally, the Medicare EHR requirements would be reconfigured to allow measurement at the practice or site level, similar to the way hospitals are measured for the program. The Association welcomes the opportunity to work with CMS to develop this type of adjustment.

### **Group Reporting Option Requires Flexibility in Defining MIPS Groups**

In the VM and PQRS programs, CMS defines groups by TIN. The AAMC continues to believe this is a reasonable definition but is too restrictive to be the ONLY definition.

As physician practices continue to evolve their employment and billing models, it is important for the practice to have the option to say “this group of providers should be measured differently than others.” Similarly, some faculty practices have multiple TINs for business or legal reasons entirely unrelated to defining a group within the Medicare program. Changing these designations is not an easy process. Nonetheless, for all other purposes these physicians are all part of the same group: they have either shared systems, shared branding, shared resources, or all three. These TINs should be able to attest that they are a group and have the option to be measured as one practice.

CMS can find a precedent for linking multiple TINs for quality and cost reporting in the MSSP ACO. Each ACO defines the “parent TIN” which provides a main contact for quality reporting coordination and payments. However, the data for the other TINs in the ACO (i.e., the “children TINs”) are used for population attribution assignment, and the “children TINs” receive credit for the cost and quality of care for the ACO population. The AAMC believes this format could easily be used for the MIPS.

For groups that want to break a large TIN into smaller components, CMS can use data elements that currently exist in claims data, such as the group identification number. During the group registration process, the single TIN would be able to document that it wants to be measured at the smaller unit level. For additional details on these options, please see the AAMC’s CY 2013 comments on the Physician Fee Schedule proposed rule.<sup>2</sup>

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<sup>2</sup> <https://www.aamc.org/download/302946/data/aamccommentletteroncy2013pfsproposedrule.pdf>

### **Create a Broad Definition of Clinical Practice Improvement Activities**

MIPS creates a new category of measurement, Clinical Practice Improvement Activities (CPIA), which comprises 15 percent of the composite score. MACRA outlines the types of activities that fall in this category, including expanded practice access, population management, care coordination, beneficiary engagement, patient safety/practice assessment, and participation in an APM. The AAMC believes that CMS should broadly interpret the CPIA requirements both in terms of activities that are recognized as CPIAs and in giving credit to providers who participate significantly in the improvement activity, with recognition that such activities often are engaged in by physicians as partners with hospitals or other providers.

CMS should recognize the variety of innovations that are occurring within practices. Some activities, such as APM participation and accredited patient-centered medical homes (PCMH), are easy to document because the practice, or an affiliated partner of the practice, is either participating in a formal program or has received certification from a national organization. The AAMC believes that other activities, such as participation in a CMMI innovation grant or contracting to collect patient experience data, also should be recognized as practice improvement. Further, the Agency should allow practices to apply for credit through applications that describe and document the types of innovative work that are occurring in their practices. For example, faculty practices have developed innovative initiatives on telehealth, referral loops, and resident training that should be credited as innovations. Creating an application process will also allow CMS to understand, track, and disseminate information about the variety of improvement activities occurring in medicine.

When assessing what counts as CPIA credit, the Agency also needs to consider the different contractual arrangements that exist to support practice improvement. Population management, data analytics, and care coordination activities are very expensive, and the cost is typically shared among many participants. The Agency's policy needs to reward practices that are actively involved with care improvement, rather than the organization that is paying for that improvement activity. For example, a hospital or health system, not the physician practice, might own the PCMH, but the physicians care for the patients who are enrolled. Similarly, a teaching hospital might be the awardee in a BPCI contract, but the faculty practice physicians are leading the effort to redesign care.

One option is for CMS to create a "collaborator" category for CPIAs, similar to the proposal in the proposed rule on Comprehensive Care for Joint Replacement (CCJR) which defines a collaborator as "directly furnishing related items or services to a CCJR beneficiary during the episode and/or specifically participate in CCJR model LEJR episode care redesign activities (80 Fed Reg at 41262). For CCJR CMS recognizes "physician group practices" among the entities that qualify as collaborators. CMS could establish a similar option for APMs.

### **Financial Risks Should Include APM Start-Up Costs; CMS Should Recognize Diverse Practice Arrangements that Encourage Care Coordination**

MACRA creates financial incentives for physicians to transition into APMs. Qualifying APM participants can achieve a 5 percent bonus for five years. Starting in 2026, qualifying APM participants will have a higher annual update than non-qualifying APM participants. Not all providers working in an

APM will be able to achieve these benefits, however. MACRA stipulates the provider must be in an *eligible* APM, meaning the APM requires the use of certified EHR technology, provides payment for covered services based on quality measures comparable to MIPS, and either (a) bears financial risk for losses that are in excess of “a nominal amount” or (b) is a medical home expanded under CMMI. In addition to qualify for these incentives, the qualifying APM participant must meet or exceed certain volume thresholds. In the proposed rule, CMS asks for early input on how to implement the various APM terms.

The AAMC suggests that CMS must consider several primary issues when implementing APM: identifying which APMs meet the criteria identified in legislation, determining which providers have participated, and establishing a methodology to calculate the thresholds. CMS should develop a policy that provides sufficient flexibility so that physicians are broadly encouraged to participate in APMs. The policy should be structured with the view that care must be coordinated and that appropriate credit should be given when physicians work toward that end.

In addition, as CMS determines how to implement the MACRA provision that APM participants have “more than nominal financial risk,” the Agency should acknowledge that physician organizations that invest in APM infrastructure costs are at considerable financial risk already as they have no guarantee that they will receive a positive return from their investment. When assessing whether the APM model meets the financial risk criteria, the AAMC encourages CMS to consider the cost of infrastructure investments to qualify as bearing financial risk for losses. For example, many MSSP accountable care organizations (ACOs) are in Model 1, which is upside only savings. But CMS estimates the first year costs for ACOs to be \$1.8 million. The National Association of ACOs estimates the ongoing operating costs to be \$1.5 million. By investing money which may never be recaptured, these organizations are at “more than nominal risk.”

When assessing provider participation, CMS should consider the many types of contractual obligations that exist in healthcare today and implement policies that reflect that diversity. As noted earlier, many teaching hospitals and their physicians have engaged in BPCI, a model which could meet the APM eligibility criteria under MACRA. The AAMC believes that physicians working with their partner teaching hospital should receive credit for APM participation, even without a formal gain sharing arrangement. The physician practices are still at risk because the finances of academic center entities are interdependent, with the success of one being closely tied to the success of the whole. To recognize these relationships, the AAMC recommends the creation of a “collaborator” category, similar to the CCJR, as discussed above.

A failure to recognize partner relationships could create a system whereby physicians would have to engage in a separate APM from the hospital to achieve savings. This phenomenon has occurred in BPCI, as some group practices and hospitals compete over ownership of the episode and care redesign process. The AAMC encourages CMS to identify policies that encourage collaboration across settings for the benefit of beneficiaries.

Finally, when determining how to calculate the Qualifying APM participant calculations, CMS should develop a group-level policy that is consistent with MIPS. These new MACRA policies are intertwined and the associated policies should provide a seamless transition from one path to the other.

## **VALUE MODIFIER (80 Fed. Reg. at 41892-41909)**

CY 2016 is the last performance period for the VM program before the payment adjustment moves into the MIPS. Given the impending transition, CMS proposes minor tweaks to previously finalized VM policies. While the AAMC supports stability in the VM program, the Association remains concerned that groups caring for complex patients are more likely to have a downward adjustment. The 2015 Value Modifier Experience Report documented that of the 106 groups that went through quality tiering, **none** of the groups with the highest quartile of risky patients received an upward adjustment, and a little over 30 percent had a downward adjustment. This finding is similar to the 2012 QRUR experience report. While we provide detailed comments on several of the VM proposals below, the AAMC urges CMS to address this disparity by immediately adopting the following policies:

- Risk adjust the outcome measures to reflect clinical differences in underlying attributed patients;
- Exclude nursing visits with a SNF place of service from the total per-capita attribution methodology; and
- Hold harmless any provider who shifts from “average cost” to “high cost” under quality tiering when the shift is caused by changes in attribution methodology.

### **VM Quality Measure Policies Need Modifications**

CMS does not propose to add new measures to the VM quality composite. Rather, the composite will continue to include all PQRS measures and three outcome measures (two admission measures and one readmission measure). Groups that report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS (and are not part of the MSSP program) will have an option to elect whether or not to include the patient experience survey results in their composite score.

#### Acute and Chronic Outcome Measures Need Clinical and SES Risk Adjustment to Ensure Fair Comparisons

CMS continues to use composites of the ARHQ-developed prevention quality indicators (PQIs) to assess group performance without adjusting for clinical variation. This adjustment is applied to virtually all other outcome measures. A lack of an adjustment is inappropriate for numerous reasons.

First the PQIs were originally designed to measure ambulatory sensitive conditions at a community level and the rate calculated per 100,000 population. Such a large sample size allows communities to evaluate their primary care system at a macro level. CMS is using these composite measures to compare providers who only need to have a minimum of 20 attributed patients. These measures have not been tested for such a small population or endorsed by the National Quality Forum for the purpose of provider-level comparisons and should not be used in this way.

Second, the characteristics of the attributed Medicare patients can vary widely by physician group practice. In the 2015 Value Modifier Experience Report, groups in the low-quality and/or high-cost categories had worse performance on these measures. These cohorts tended to have patients with a higher risk score. Not accounting for the clinical variation in the underlying population is extremely misleading and disproportionately affects the physicians who care for the most complex patients.



The Measure Applications Partnership (MAP) previously noted concerns with the PQI measures. In the most recent 2015 report<sup>3</sup> the MAP recommended that CMS test these measures on an ACO population. Such testing needs to include an appropriate clinical risk adjustment. In addition, as admissions and readmissions are often connected to the broader community, CMS should consider adding an adjustment or stratification to account for socio-demographic factors.

#### Align Quality Measure Policies in VM with the MSSP Program

The VM and MSSP ACO quality reporting policies are not aligned. New MSSP ACOs have two years of “pay-for-reporting” before their quality performance affects their savings rate. The MSSP program also phases in new measures by making them pay-for-reporting for the first few years. This policy provides ACOs time to understand the measures and develop systems to better collect data before their quality performance affects their payments.

The policies in the VM program are not consistent with those in MSSP. New ACOs that are still in the pay-for-reporting period under the MSSP program are considered to be in pay-for-performance under the 2017 VM. The AAMC believes that CMS should revise the VM program to allow MSSP ACOs that are in their pay-for-reporting period to have their GPRO Web Interface measures excluded in the VM quality composite. Additionally, because of the large number of GPRO Web measures that must be reported, group practices that are reporting GPRO Web for the first time should have a year of pay-for-reporting. Similarly, any new GPRO Web measures that are considered pay-for-reporting under MSSP should be excluded from the VM quality composite. These changes should be implemented as soon as possible.

#### The AAMC Supports the Creation of Separate Benchmarks for E-Measures; Model Impact for Additional Stratification

CMS proposes to create separate quality benchmarks for e-specified measures. The AAMC supports this proposal as e-measures often have very different specifications than the same measure using a different reporting mechanism. The AAMC also recommends that CMS model the performance rates by other reporting options, and by individual versus group reporting. Some reporting options allow providers to check the chart for incomplete information. While this performance data is likely the most accurate, it may look very different than other reporting mechanisms in which providers are not allowed to correct inaccurate information. CMS should work to understand the impact the different reporting mechanisms may have on the final quality composite score and determine if further revisions are needed. Finally, we ask that the Agency take additional steps to standardize electronic health systems to allow for the capture of EHR-derived core clinical data elements. Such elements may be used to enhance the risk adjustment of quality measures moving forward.

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<sup>3</sup> [https://www.qualityforum.org/Publications/2015/03/Cross-Cutting\\_Challenges\\_Facing\\_Measurement\\_-\\_MAP\\_2015\\_Guidance.aspx](https://www.qualityforum.org/Publications/2015/03/Cross-Cutting_Challenges_Facing_Measurement_-_MAP_2015_Guidance.aspx)

## **CMS Should Make Changes to the Attribution Methodology and Hold Providers Harmless if Performance Changes Due to Attribution Changes**

In the proposed rule, CMS acknowledges concerns from stakeholders about the cost performance for providers who work in post-acute, home health, and long-term care settings. CMS seeks feedback on whether or not to stratify costs by risk profile.

As noted earlier, the AAMC is very concerned that providers with complex patients seem to be disproportionately affected by the Value Modifier. The Association believes the current CMS Hierarchical Condition Categories (CMS-HCC) risk adjustment model is beneficial in adjusting the total-per-capita measure, but the risk adjustment is not sufficiently refined to address the concerns described above and should not be used.

Rather than stratify by risk score, CMS should exclude SNF visits, similar to the proposal for the MSSP program. The total-per-capita costs methodology should be applied to a cohort of primary care patients with which the physician has a standing relationship. This attribution is not only used for the total-per-capita measures, it is also used to measure admission and readmission outcome measures, as well as GPRO Web Interface. None of these measures make sense if the patient does not have a long-standing relationship with their attributed provider. As CMS notes in the MSSP section, patients in SNFs are often being treated for rehabilitation or post-acute care, where the relationship with the provider ends when the patient leaves the facility. Including these services in the attribution methodology would be inaccurate.

In addition to excluding the SNF visits from the attribution, CMS should consider whether special adjustments are needed to measure the quality and cost of patients who reside in long-term care facilities or who have long-term home health needs. These patients tend to be frailer and more complex. For example, it may be less important to measure a patient with multiple complex comorbidities, including dementia, who resides in a nursing, for colorectal cancer screening and more important to monitor the patient's fall risk. The AAMC urges CMS to consider removing these patients from the total per-capita measures and perhaps measure them separately, particularly as the Agency moves toward MIPS.

Finally, it is possible that changes to the attribution methodology may appropriately remove the high cost label from some physicians, while causing other providers to suddenly be labeled "high cost." The AAMC urges CMS to hold harmless any provider who moves from "average cost" to "high cost" solely as a result of attribution changes. Holding this group harmless during the first year of the new methodology is consistent with other VM policies which do not have downward adjustments for providers new to the program. In this case, the change in the attribution algorithm would be new to the provider and should be considered comparable to a provider being new to the program.

## **AAMC Supports a Number of VM Proposals**

While the AAMC has outlined some concerns about the performance scoring in the VM program, the Association also supports the following proposals:

- **Applying the VM to all practitioners who would be eligible for MIPS in 2019.** The VM currently covers physicians. Last year, CMS proposed to expand the program in 2018 to all the PQRS eligible professionals. Refining this proposal to match MIPS eligibility instead of PQRS is

a logical adjustment. However, sufficient time should be provided to non-physician EPs to allow them to learn how to work with the VM before they are included in MIPS; otherwise, they are at a significant disadvantage due to their lack of VM experience.

- **Not increasing the amount at risk in quality tiering for groups with physicians and 10 or more EPs.** The Association remains concerned that providers caring for complex patients are more likely to see a decreased payment, but unlike previous years, CMS is not increasing the amount at risk. The AAMC also requests that CMS **consider lowering** the amount at risk for quality tiering given the scoring concerns outlined above.
- **Increasing the number of MSPB Cases from 20 to 100.** The AAMC agrees that 100 cases will provide a more reliable number. The Association also ask CMS to consider the minimum case size of the other outcome variables.

### **PHYSICIAN QUALITY REPORTING SYSTEM (80 Fed. Reg. at 41815-41878)**

In this rule, CMS proposes to satisfy the 2016 PQRS reporting requirements to avoid a 2 percent payment adjustment in 2018. Given that the payment adjustment will transition into MIPS starting the following year, CMS kept most of the reporting requirements consistent with previous years. The biggest changes are allowing groups to report via a qualified clinical data registry (QCDR); modifying the CAHPS for PQRS reporting requirements; and adding a new measure for GPRO Web Interface measure set. The AAMC appreciates the stability of the PQRS reporting requirements and supports the addition of a QCDR group practice reporting option. As described below, the AAMC is concerned about the new statin measure for GPRO Web.

#### **New Statin Measure Should Not Be Included in the 2016 GPRO Web Interface Measure Set**

CMS proposes to add a new measure to the GPRO Web Interface reporting option which focuses on statin usage. The AAMC agrees conceptually that statin therapy is an important measure, but opposes its inclusion in the 2016 PQRS GPRO Web Interface module. Unlike the other PQRS reporting options, reporters in GPRO Web are required to report on ALL measures in the data set. This means that every measure must be thoroughly tested and have clear specifications and clinical interpretation. The AAMC does not believe this measure meets that criteria at this time. Members who currently report via GPRO Web Interface note the following concerns with the measure:

- The multiple patient denominators makes performance evaluation confusing;
- Groups believe it will be difficult to confirm the group with atherosclerotic cardiovascular disease (ACVD) without doing chart review. Some patients will meet the clinical criteria, while others may have a diagnosis without supporting diagnostic testing.
- Using chart review and interpreting clinical findings introduces both reporting bias and increases the data burden. The value of the measures is limited as it only records whether or not a statin was prescribed but does not record whether the dose was appropriate to the abnormal lipid finding.
- Finally, two new cholesterol lowering drugs, PCSK9 inhibitors have just received FDA approval and could revolutionize statin guidelines and medication selection.

The MAP noted that this measure needs further development. The AAMC strongly agrees. If CMS wants to include this measure in future years, additional development and testing must occur, including an

evaluation of whether there are alternative tested statin therapy measures which could be used in the future.

### **CMS Should Extend the Registration Deadline**

CMS needs to provide groups with the certainty that they can report the CAHPS for PQRS survey in a statically valid manner before requiring them to expend resources to potentially meet this requirement. CMS is requiring practices to register for GPRO by June 30, but may not know whether they have enough attributed beneficiaries until after that date. Therefore, CMS needs to extend the registration deadline to accommodate practices that need more time and are unable to meet the proposed deadline.

### **PHYSICIAN COMPARE WEBSITE (80 *Fed. Reg.* at 41807-41815)**

#### **Pending Further Analysis CMS Should Not Finalize the ABC Benchmarking Methodology**

CMS proposes to use the Achievable Benchmark of Care (ABC) methodology for Physician Compare. A measure benchmark is created by calculating a performance score among the subset of top performers that account for at least 10 percent of the patient population for Physician Compare. The AAMC has serious reservations about how the ABC methodology will work in a national Medicare program and believes it is premature to finalize this methodology. Instead, CMS needs to conduct further analysis to better understand how the methodology will function with the variety of PQRS reporting mechanisms and measures.

AAMC supports the goal of having high-quality publicly reported performance data to assist consumers in making informed decisions, but the ABC methodology needs more analysis and clinician education before being finalized. Although CMS contends that the methodology is simple for physicians to understand, several AAMC members report that they have not seen this methodology used in other reporting systems and believe their physician practices will find it challenging to explain how the score was calculated.

Another concern is how the 10 percent patient threshold logic will work in the PQRS program, as different providers may have dramatically different sample sizes, depending on practice size and reporting mechanism. CMS needs to test the potential effect of data that may be skewed by reporting mechanism and/or a large provider group.

Finally, the AAMC is unsure that this methodology can be accurately applied to both process measures and outcome measures. A study referenced by CMS focused only on process measures.<sup>4</sup> It is unclear how the same methodology could be applied for measures that require risk adjustment. CMS needs to clarify how the low volume adjustment works and the implications of using it when evaluating PQRS data.

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<sup>4</sup> <http://intqhc.oxfordjournals.org.proxy.lib.umich.edu/content/intqhc/10/5/443.full.pdf>

CMS also proposes to use the benchmark to systematically assign stars for the Physician Compare 5-star rating. It is too premature to apply this methodology for this objective. Moving to a star rating system before having a well-tested benchmarking methodology could have unintended consequences. The ratings may be misinterpreted and provide misleading information to consumers.

### **CMS Should Continue to Engage Stakeholders**

Despite the concerns about the proposed benchmarking methodology, the AAMC commends CMS for gathering stakeholder feedback on Physician Compare this past year and recommends continuing the conversations with stakeholders in the upcoming year. To make the feedback sessions more productive, CMS should model the potential benchmarks by practice characteristics and provide the data in advance to stakeholders.

In the proposed rule, CMS did not state whether Physician Compare would create separate benchmarks for different reporting mechanisms. As was noted in VM section, the AAMC supports establishing separate benchmarks for e-measures and other reporting systems. Further analysis should be done to assess whether benchmarks should be generated for group reporting and individual reporting.

### **CMS Needs to Establish an Efficient Process for Group Practices to Validate and Correct Information**

As part of its improvement efforts, CMS needs to develop a process that effectively and efficiently allows group practice managers to review and correct information concerning the group practice on Physician Compare. The AAMC continues to hear of circumstances in which either the group information is incorrect or the wrong providers are affiliated with the group. Currently, correcting information is an awkward process and it may take weeks before the information is refreshed on the website. The AAMC would be happy to work with CMS to develop a more streamlined process.

### **Other Data on Physician Compare**

The Agency seeks comments on what information should be provided on Physician Compare and in the accompanying downloadable database for publication in 2017. The AAMC provides comments regarding possible elements to be incorporated into the Physician Compare initiative below.

#### Additions to the Downloadable Data Base

*The AAMC Opposes Adding VM Quality Tiering and Payment Adjustments to the Downloadable Database.*

As discussed above, the AAMC believes the VM scoring disadvantages physician group practices that care for complex patients. With the VM transitioning to MIPS and the concern about the scoring disparities, the AAMC does not recommend adding this quality tiering result and payment adjustment to the downloadable database.

### Possible Future Data Elements

#### *The AAMC supports adding Medicare Advantage Information to Physician Compare*

CMS proposes to add Medicare Advantage information to Physician Compare individual EP and group practice profile page on the Physician Compare website. It will be highly beneficial for consumers to be informed about which specific Medicare Advantage health plans the EP or group accepts.

#### *CMS Should Not Include VM Cost and Quality Data*

CMS seeks comments on including additional VM cost and quality data. Specific cost and quality information include: indicator for downward and neutral VM adjustment, VM quality composite or other VM quality performance data and measure data all to be displayed on group practice and individual EP profile pages. As noted above, the AAMC is concerned that the VM cost and quality composites will be of limited utility due to the movement towards MIPS which will have its own evaluation system.

#### *Data Should be Stratified by Various Factors*

CMS seeks comments on including individual EPs and group practice-level quality measure data stratified by race, ethnicity, and gender on Physician Compare. The AAMC supports stratifying certain measures by socioeconomic status using the findings from the pending IMPACT analysis, and the results from the NQF trial period. CMS should ensure that the provider performance accounts for both the patient's complexity and factors for which the physicians cannot reasonably control.

#### *Open Payments Data Should Not be Displayed*

The AAMC does not recommend that open payments data be displayed on individual profile pages. These two databases serve different purposes and conflating the two would be confusing to users of the systems. The AAMC is concerned that linking an individual's profile on Physician Compare to the listing of payments reported by industry will suggest erroneously that there is a correlation between the amount, number, or nature of payments that manufacturers have reported to CMS about a physician and the quality of care that physician will provide. CMS has worked diligently with stakeholders to increase the context and background on Open Payments.

Given the complexity of the information Open Payments is collecting, it would be unfortunate if the progress CMS has made in explaining the Open Payments data is undermined by connecting it to quality or other metrics on Physician Compare. Both transparency initiatives serve important purposes, and providing information about the uses of each database in a central location on the CMS website would allow consumers to access information without sacrificing the specific context that each database provides.

## **ALTERNATIVE PAYMENT MODELS**

### **Medicare Shared Saving Program Proposals (80 *Fed. Reg.* at 41884-41892)**

#### CMS Should Finalize the Proposal to Remove SNF Visits from Attribution Methodology and Extend This Methodology to the VM Total-Per-Capita Measures

CMS is proposing to refine the definition of primary care services to exclude visits in a SNF. Specifically, the Agency proposes to exclude from the primary care definition claims billed with a nursing facility CPT code between 99304-99318 and with a place of service (POS) code = “31” (SNF). The AAMC agrees that patients in these settings typically are short stay patients who are “generally receiving continued acute medical care and rehabilitative services.” (80 *Fed. Reg.* at 41891) and generally receive primary care elsewhere. This logic change should be applied to the VM as well.

#### Statin Measure Should Not Be in 2016 GPRO Web Measure Set

As detailed in the PQRS section above, the AAMC believes the statin measure needs more testing before being incorporated into a mandatory reporting program.

#### CMS Should Remove or Update Quality Measures If Guidelines Change

When clinical guidelines change outside the rulemaking process, some quality measures become out-of-date. For the MSSP program, CMS proposes to revert the measures from pay-for-performance to pay-for-reporting. The AAMC agrees that measures used for performance should match current clinical guidelines, but the AAMC disagrees with the CMS proposal to revert the measures to pay-for-reporting. The AAMC encourages CMS to either drop the measure completely from the MSSP measure set or update the measure to current guidelines, if possible. To keep a measure, even for pay-for-reporting credit, requires ACOs to track data that is not clinically appropriate. That increases the data collection burden without adding value and calls to question the clinical integrity of the reporting effort.

### **Potential Expansion of the Comprehensive Primary Care Initiative (80 *Fed. Reg.* at 41881-41884)**

CMS is seeking comment on issues related to a possible expansion CPCI. CPCI is a CMMI medical home model which coordinates payments across multiple payers and requires participants to provide comprehensive primary care in five functions: risk stratified care management, access and continuity, planned care for chronic conditions and preventive care, patient and caregiver engagement, and coordination of care across a medical neighborhood. The AAMC believes CPCI holds potential, but most practices will need significant infrastructure support to succeed.

Conversations with members who participated in CPCI identified the following challenges: having to develop tools to help with population management; working with payers to have consistent and timely payments and explanation of benefits; and delays from EHR vendors that had limited capacity to develop new workflows.

The AAMC encourages CMS to work with the CPCI participants and assess their feedback to identify program success and ways to improve the program.

## **CARE COORDINATION** (80 *Fed. Reg.* at 41708-41711)

### **Chronic Care Management Services**

#### AAMC Continues to Support Care Management Services Codes (99495-99496, 99490) Despite Continuing Concerns about the Administrative Burden

In CY 2013, CMS provided for a payment for transitional care management (TCM) when a patient transitions from an institutional setting. In the CY 2014 and CY 2015 Physician Fee Schedule (PFS) Final Rules, CMS finalized policies for a new care coordination code that would pay providers a separate fee starting in 2015 for providing chronic care management (CCM) services. The AAMC supports these new codes and appreciates that a variety of providers, in a variety of settings, have the option to bill for the services. The AAMC appreciates that CMS has not proposed any major changes to these codes, but concerns remain that the administrative complexity required to bill the TCM and CCM codes could prevent these services from being billed. Common issues include:

- EHR has to be able to track all the requirements (patient's qualification for CCM code and 20 minutes).
- Proper documentation of patient's authorization and knowing that the patient isn't seeking CCM services with another provider.
- The cost associated with submission of the bill, coder review, and auditing will equal or exceed the revenue generated.
- Changes in patient enrollment could negate eligibility.
- Logistics to comply with patient requests to be unenrolled from the program

Allowing only one provider to bill the services affects the appropriate billing of the services and the operational feasibility. Simplifying the documentation and reporting requirements for these codes would be a significant improvement. The AAMC recommends convening stakeholders to consider how to reduce the administrative burden while not creating incentives for fraudulent behavior.

### **Care Collaboration**

#### AAMC applauds CMS's Acknowledgement of Consultative Services that Are Occurring between a Primary Care Provider and a Specialist.

Fragmentation in the health care system often means that patients with multiple chronic illnesses are cared for by providers across many specialists. Particularly for this population, maintaining a single locus for as much care as is appropriate is an important goal. Incentives aligned across providers are key to achieving this end. It is important to design a system that avoids redundant care, conflicting management advice, high costs and inconvenience. To that end, the AAMC strongly supports a model that will capture consultative services that occur between two parties working to best coordinate a patient's care. The AAMC believes that the eConsult model described below could be a model for this type of system.



### eConsult Model

The AAMC is working with 5 academic medical centers (AMCs) to implement a new model of care delivery and technology that allows primary care providers to receive timely, electronic consultations from specialist colleagues through the CMMI Health Care Innovation Award's grant. Through this project, a payment model has been introduced for asynchronous eConsults where specialists and primary care physicians both get credit for the time they spend on the consult, but only after the consult is complete and not converted to a referral for a specialty visit. The purpose is not to double the reimbursement amount by paying two people, but rather to acknowledge the joint responsibility for high quality care in the most appropriate setting and to divide a payment between those accountable for the care.

In the model, a primary care physician (PCP) asks a specialist a targeted clinical question, using a standardized template. No one receives credit unless the eConsult is completed (that is, the specialist responds, enabling the PCP to manage the patient's problem or needs), at which point both providers split the allocated relative value unit (RVU) credits. The reimbursement recognizes the time it takes for the specialist to complete the eConsult, and the follow-up activities that the primary care physician will manage as a result of the averted referral. Without this shared payment, specialists have little financial incentive to provide electronic support instead of insisting on seeing the patient in person for a separately billed appointment. This model of collaborative care, or similar models, may offer new tools for enhancing care coordination between providers, thereby creating sustainable reductions in unnecessary care. Through the AAMC's Health Care Innovation Award, an evaluation will be completed to understand the impact of the eConsult model on costs, utilization, access and quality across 5 AMCs, and recommendations will also be made for a future sustainable payment model.

### **PHYSICIAN SELF-REFERRAL**

CMS is "soliciting comments regarding the impact of the physician self-referral law on health care delivery payment and reform." The agency notes that it is particularly interested in barriers to achieving clinical and financial integration. The AAMC appreciates that CMS recognizes the challenges imposed by the physician self-referral law. Members report that the physician self-referral law imposes many impediments to much they are trying to accomplish as they work in a health care system that is rapidly moving from volume-based reimbursement systems to value-based systems. Much of the impetus for the self-referral regulation came from a health care system in which payment for volume was the rule, and there were limited controls in place to ensure that patients received the appropriate care and were not denied care. That does not represent the health care system of today.

In January of this year Health and Human Services Secretary Sylvia Burwell announced that by 2018 the Medicare program will move 50% of fee for service payments to alternative payment models, which rely on coordinated care and include significant quality components. The passage of the Medicare Access and Chip Authorization Act (MACRA) ensured that Medicare payments to physicians will move aggressively in that direction. Numerous programs in which hospitals and physicians must participate already exist that put hospitals and physicians at financial risk for meeting quality measures which ensure that patients receive appropriate care. For example:

- Hospital Acquired Conditions (HAC) Reduction Program: 25 percent of all hospitals will be penalized 1 percent of all Medicare payments for poor performance on safety and infection measures.
- Hospital Value Based Purchasing (VBP) Program: Hospitals with poor performance on quality and cost measures will have up to 1.75 percent of base DRG payments at risk.
- Hospital Readmissions Reduction Program (HRRP): Hospitals with excess readmissions will have up to 3 percent of base DRG payments at risk.
- Physician VM: Group practices of 10 or more physicians with poor performance on quality and cost measures will have up to 2 percent of Medicare payments at risk
- EHR Incentive Programs (also known as meaningful use) contains significant quality components. If physicians and hospitals do not meet all parts of the program as specified by CMS, they face adjustment in 2015 if they fail to meet meaningful use requirements.
- Replacement of SGR beginning in 2019: physician must meet quality programs or participate in APMs in which they have financial risk

Section 1877(b)(4) of the Social Security Act provides for a permissible exception to the prohibition on referrals “in the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.” The AAMC believes that the time has come for CMS to exercise its authority under the statute to facilitate the financial and clinical integration required under alternative payment models through a new, broad exception. If the Agency waits for the passage of legislation and the rulemaking that will be required to implement the statutory changes, years will go by during which providers will continue to struggle to comply with requirements that do not fit the way that providers are now paid for the services they provide. Providers should not be put in the untenable position of being penalized under the physician self-referral or other fraud and abuse laws for attempting to comply with the requirements of these new payment models, especially in light of potential penalties under the various enforcement mechanisms.

It is critical that CMS, the Office of Inspector General (OIG), and other associated agencies coordinate their efforts to allow waivers not only of the physician self-referral law, but also of the civil monetary penalties and anti-kickback laws, as appropriate to support the needed clinical and financial integration that providers are being pushed to by CMS. The highly regulated nature of these alternative payment models guard against the possibility that patients will be denied care or will be given poor quality care.

Programs such as BPCI and the proposed rule on CCJR, 80 *Fed Reg.* 41198) address gain-sharing and provide waivers. Given the increasing prevalence of payment programs that focus on meeting quality standards, and the need to, at a minimum, allow for gain-sharing with physicians and others, it is time for CMS and the OIG to consider the many changes that should be made to various fraud and abuse laws. Given the ample protections against program and patient abuse that are now, and increasingly will be, part of the Medicare program, the focus should be on simplifying the criteria for the waivers and making them broadly available rather than only being available on a program-by-program or case-by-case basis.

## **OTHER PROPOSALS IN THE PHYSICIAN FEE SCHEDULE**

### **AAMC Supports CMS's Proposed Advanced Care Planning Code (80 Fed. Reg. at 41773)**

The AAMC commends CMS for the proposal of two new CPT codes to make separate payments for ACP services. These services include the explanation and discussion of advance directives along with completion of standard forms. The proposed rule will provide payment for the time that physicians now spend with patients and their families and/or caregivers, conversations that are essential to providing patient-centered care. .

### **Telehealth Services (80 Fed. Reg. 41781-41784)**

CMS proposes to add prolonged service codes in the inpatient and observation setting (CPT codes 99356 and 99357) and ESRD-related services (CPT codes 90933-90936) to the list of telehealth services for CY 2015. The AAMC appreciates CMS's efforts to expand access to telehealth services by acknowledging that many of these at-home services are performed from an authorized originating site regarding ESRD related services. The Association also supports the authorization of certified registered nurse anesthetist to the list of distant site practitioners who can furnish Medicare telehealth services. The AAMC encourage CMS to continue to expand the list of eligible telehealth services in future rulemaking.

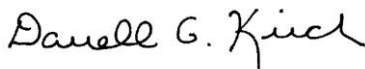
### **Missed RVU Targets Could Reduce Conversion Factor (80 Fed. Reg. 41937-41943)**

CMS is required to meet a 1 percent reduction in expenditures for 2016. If the target is missed, then the PFS will be reduced by the difference between the actual adjustment and the target. The AAMC encourages CMS to work with the physician community to identify ways to reduce or eliminate this potential reduction. It would be disappointing if the first payment update after the SGR repeal was decreased or negative due to missing the relative value target.

## **Conclusion**

The AAMC appreciates your consideration of the above comments. Should you have any questions, please contact Tanvi Mehta at [tmehta@aamc.org](mailto:tmehta@aamc.org) or Ivy Baer at [ibaer@aamc.org](mailto:ibaer@aamc.org).

Sincerely,



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