September 4, 2012

Marilyn Tavenner  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
P. O. Box 8013  
Baltimore, MD 21244-8013

RE: CMS-1590-P Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face to Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013

Dear Acting Administrator Tavenner:

The American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE) appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services’ (CMS) proposed rule (CMS-1590-P), published on July 30, 2012 in the Federal Register, regarding the proposed policy revisions to the 2013 Medicare physician fee schedule (PFS). Our three societies represent virtually all practicing gastroenterologists in the United States.

There are a number of provisions in the proposed rule that impact practicing gastroenterologists and the Medicare beneficiaries they treat. Our comments focus on proposals related to the following issues:

Payment Policy
- Potentially Misvalued Codes
- Primary Care and Care Coordination
- Technical Correction: Waiver of Deductible for Surgical Services Furnished on the Same Date as a Planned Screening Colorectal Cancer (CRC) Test and CRC Screening Test Definition
- Medical Device Tax
Quality Improvement

- Physician Quality Reporting System (PQRS)
- Electronic Prescribing (e-Rx) Incentive Program
- Physician Compare Website
- Value-Based Payment (VBP) Modifier

PAYMENT POLICY

Potentially Misvalued Codes/ Review of High Physician Fee Schedule Expenditure

Procedural Codes

We understand that CMS is required by the Affordable Care Act (ACA) to periodically identify and review potentially misvalued codes and to make appropriate adjustments to the relative values of those services. Under this proposed rule, CMS identified 16 potentially misvalued codes, nine of which are scheduled or have been referred for American Medical Association (AMA) Relative Value Scale Update Committee (RUC) review. CMS has identified these codes as potentially misvalued on the basis that they are Harvard-valued services with annual Medicare allowed charges of $10 million or more. The AMA RUC intends to review these codes in 2013.

Our societies are committed to working within the AMA RUC process to ensure gastroenterology endoscopy codes are accurately and fairly valued. Our societies are preparing for a coding change submission to the CPT Editorial Panel for codes 43260-43272, including code 43264; Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts, which is on CMS’ proposed list of potentially misvalued procedural codes with annual Medicare Part B charges of $10 million or more. Pending the recommendations of the CPT Editorial Panel, we expect to survey this code and submit our recommendations to the AMA RUC during 2013.

Primary Care and Care Coordination

CMS is proposing to create a HCPCS G-code to describe care management involving the transition of a beneficiary from care furnished by a treating physician during a hospital stay (inpatient, outpatient observation services, or outpatient partial hospitalization), SNF stay, or community mental health center partial hospitalization program to care furnished by the beneficiary’s primary physician in the community.

The budget impact of this proposal assumes that every transitional care management service will be reported for every hospital discharge. While our societies appreciate the value of improved patient care coordination, a $1 billion offset to the Medicare conversion factor is proposed to redistribute from other physician services the cost of paying for post-discharge transitional care management services. We agree with the AMA analysis that the cost impact is overstated. We believe CMS should review data from the primary care community and the RUC regarding expected utilization when it is submitted in early October. In addition, CMS should first determine savings from readmissions prior to applying redistributions within the RBRVS or physician payment. CMS should propose a methodology to track success of the new
transitional care management services and to then apply a readmission savings offset to the Medicare PFS.

**Technical Correction: Waiver of Deductible for Surgical Services Furnished on the Same Date as a Planned Screening CRC Test and CRC Screening Test Definition**

As CMS correctly notes in the proposed rule, when a colorectal cancer screening test becomes a diagnostic service, practitioners are to append a modifier to the diagnostic procedure code that is reported instead of the HCPCS code for screening colonoscopy or screening flexible sigmoidoscopy or as a result of the barium enema. By use of this modifier, practitioners signal that the procedure meets the criteria for the deductible to be waived, as required under the ACA. To reflect this policy in its regulations, CMS proposes to amend §410.160 Part B annual deductible to include colorectal screening tests that become diagnostic services in the list of services for which the deductible does not apply.

We appreciate that CMS is making this technical correction. Our societies have found that there is still much confusion among patients and providers about Medicare beneficiary cost-sharing obligations for colorectal cancer screenings that become diagnostic services. The confusion has resulted in inaccurate coding that could result in Medicare beneficiaries being inappropriately held liable for a deductible.

We would also like to take this opportunity to thank CMS for making efforts to correct confusing or inaccurate information about colorectal cancer screening cost sharing obligations on its website and hope the efforts will continue.

**Medical Device Tax**

Our societies remain concerned about the forthcoming federal excise tax on medical devices as required by the ACA. Many services in gastroenterology are device-intensive and require the widespread use of products and supplies currently considered a “taxable medical device” under the proposed regulation published by the Department of Treasury.

Section 4191 of the ACA imposes a 2.3 percent excise tax beginning 2013 on the sale of medical devices as defined in the Federal Food, Drug, and Cosmetic Act (FFDCA). According to the FFDCA, this definition is broad and encompasses many products used in routine care. The term “device” means any instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, or any supplement to them; intended for the use in the diagnosis of disease or other conditions, or in the cure mitigation, treatment, or prevention of disease.

We are quite concerned that medical device and other suppliers will pass this cost on to purchasers of these products, which include health care facilities and physicians. Our societies intend to closely monitor any significant changes in prices for devices, equipment, and supplies necessary to provide gastrointestinal specialty care and, if necessary, will use CMS’ established process for making requests for changes to PE database price inputs for supplies and equipment used in existing codes, especially in the non-facility setting.
QUALITY IMPROVEMENT

We are pleased that CMS is making efforts to minimize reporting burdens and encourage participation in its quality improvement programs. CMS’ goals to align program requirements across the PQRS, e-Rx Incentive Program, Electronic Health Record (EHR) Incentive Program, Medicare Shared Savings Program, and VBP modifier program are a step in the right direction. We applaud CMS for these efforts.

Physician Quality Reporting System

The ACA authorizes CMS to provide incentive payments to eligible professionals who successfully participate in PQRS for 2011-2014. However, beginning in 2015, ACA imposes payment penalties to eligible professionals who do not meet PQRS reporting requirements. Additionally, PQRS performance data will soon be made available to the public, which makes successful PQRS participation crucial to our members. It is important that CMS encourage and facilitate participation in PQRS. We believe that CMS has made a number of positive improvements to the program over the years and we look forward to continuing our collaboration with CMS to improve the PQRS program, including its relevance to and ease of participation by gastroenterologists. Our societies share the objective of increasing the number of gastroenterologists participating in the program. The following comments and suggestions are offered in the spirit of collaboration with CMS and continual quality improvement.

Reporting Options to Avoid the 2015 and 2016 Payment Penalties

Our organizations support CMS’ proposal to provide individual eligible professionals and group practices the option to elect an administrative claims-based reporting mechanism to avoid the 2015 and 2016 payment adjustments. We recognize that the administrative claims-based mechanism is simply a temporary low-burden reporting option that is geared toward physicians and group practices that have yet to successfully participate in PQRS. CMS has proposed 19 measures for the administrative claims-based reporting option. CMS proposes to analyze Medicare claims to determine whether an eligible professional or group practice performed any of the clinical quality actions specified in the 19 measures. We understand that the administrative claims-based option is available to all eligible professionals and group practices regardless of specialty and regardless of past PQRS reporting history. We believe that it would be helpful for CMS to provide a clarifying statement in the final rule that a physician or group practice would be considered a successful reporter under the administrative claims-based option even if CMS’ analysis of an eligible professional’s or group practice’s claims found that the physician or group did not perform clinical quality actions for some or all of the measures because of their lack of applicability.

Additionally, CMS is proposing that an eligible professional or group practice may report one measure or measures group using claims, registry, or EHR-based reporting mechanisms during the 12-month reporting period for the 2015 and 2016 payment adjustments. We understand that these less stringent criteria would only be an option to eligible professionals and group practices
that have not previously participated in PQRS and would allow them to ease into reporting. **We support this option because, unlike the administrative claims-based option, this option will allow eligible professionals and group practices to familiarize themselves with more meaningful PQRS reporting options.**

CMS is also proposing that if an eligible professional participates in PQRS using the claims, registry, or EHR reporting mechanisms and is shy of meeting the reporting criteria for the 2013 or 2014 incentive, CMS would analyze the claims of the eligible professional during the respective 2015 and 2016 payment adjustment reporting periods under the administrative claims-based reporting option so the eligible professional could meet satisfactory criteria for reporting and avoid the payment penalty. **Our organizations also support this fallback option, but ask CMS to clarify whether this proposal also applies to group practices.**

**Group Practice Reporting Option (GPRO)**

**Definition of Group Practice**
We offer comments regarding CMS’ proposed definition of a group practice as “a single Tax Identification Number (TIN) with two or more eligible professionals, as identified by their individual National Provider (NPI), who have reassigned their Medicare billing rights to the TIN.” Our societies support and appreciate CMS’ efforts to increase PQRS participation by allowing smaller group practices to report quality measures through the GPRO. The majority of gastroenterology practices do not meet the current group practice size requirement of 25 or more eligible professionals, so the new proposal for two or more will allow additional opportunities for gastroenterology practices to report measures through the GPRO.

As we have commented to CMS previously, we believe the requirement that physicians reassign their billing rights to a single TIN for purposes of participating in the GPRO is unnecessarily limiting. It is not uncommon for physicians who work in a group practice setting to continue billing Medicare on their own behalf rather than reassigning their billing rights to a group practice TIN. Because these physicians function as a group and use the same data systems, they should be allowed to exercise the GPRO reporting option. For PQRS and the e-Rx Program, as well as for other reporting programs, **we propose that CMS create a unique group identifier for the purpose of identifying a group practice in instances where billing reassignment by individual physicians to a single TIN is not practical.**

Physicians who wish to be identified as a group practice could then be recognized accordingly by either: 1) reassigning their billing rights to the group practice TIN; or 2) by having their NPI associated with a unique group identifier. For physicians who associate their NPI with a unique group identifier, incentive payments or penalties would still be applied at the individual physician level, but success or failure of participation in PQRS would be determined at the aggregate group level, as would public reporting of participation and performance.

**GPRO Reporting Mechanisms and Measures for the 2013 and 2014 Performance Years**
We support the CMS proposal to allow, beginning with the 2013 reporting year, physicians groups participating in PQRS GPRO to report data on quality measures using the claims,
registry, and EHR-based reporting mechanisms for the 2013 and 2014 PQRS incentives and to avoid the 2015 and 2016 downward payment adjustments. Additionally, CMS proposes a new proposed administrative claims reporting option, which could also be utilized by group practices for reporting. We strongly support CMS’ proposal to enhance the reporting mechanisms for group practices reporting through the GPRO.

**PQRS Quality Measures for 2013 and Beyond**

For 2013 and beyond, CMS proposes a new gastroenterology PQRS measure, “Endoscopy and Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients,” for claims and registry reporting. This measure will capture the percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report. Historically, many gastroenterologists have been reluctant to participate in PQRS because of the lack of measures related to digestive conditions and diseases. Our organizations advocated for this measure and we thank CMS for its inclusion, thus improving the relevancy of PQRS measures for gastroenterologists.

CMS also proposes to add the “Participation by a Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality” measure to the PQRS for 2013 and beyond. This structural measure recognizes a physician’s participation in a clinical registry. We believe this measure is consistent with CMS’ previously stated desire to increase the frequency of registry-based reporting, rather than claims-based reporting. This measure is an important bridge to increased registry-based PQRS reporting. By including it in PQRS, CMS sends a message to physician organizations about the importance of establishing and maintaining clinical data registries. We applaud CMS’ decision to recognize the value of clinical data registries. Our organizations maintain specialized registries that provide valuable tools to gastroenterologists, which help to improve patient health outcomes and cost effectiveness of digestive care. We expect that gastroenterologists who participate in our registries will be able to report on this measure.

**Colonoscopy Measures Group**

Our societies also wish to use this comment letter opportunity to request that CMS accept our joint-developed “colorectal cancer screening” measures group for PQRS beginning in 2014. Colonoscopy is widely performed by our members and is most likely the highest volume among services performed by gastroenterologists in Medicare Part B according to CMS claims-data. As part of the CMS “call for 2014 PQRS measures,” our organizations recommended that CMS create a colorectal cancer screening measures group consisting of the following measures:

- Endoscopy and Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (PQRS Measure #185; NQF Measure #659)

- Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients (PQRS Measure TBD; NQF Measure #658)
• Screening Colonoscopy Adenoma Detection Rate (Recently developed by the AGA, ASGE, and ACG Quality Improvement Task Force)

• Colonoscopy Quality Composite (Recently developed by the AGA, ASGE, and ACG Quality Improvement Task Force)

Proposed Reporting Periods for the PQRS Payment Adjustments for 2015 and Beyond

We continue to oppose CMS’ back-dating proposals for quality programs. The two-year delay in payment adjustments makes it very difficult for physicians to adjust their fiscal obligations, thus impacting a practice’s bottom line. CMS continues to maintain that it is not technically feasible for the agency to calculate payment adjustments in less than two years.

We are pleased that CMS is proposing to retain the six-month reporting option for physicians who use the registry-based reporting option for submitting data on measure groups. CMS, however, is proposing to eliminate all six-month reporting options and move toward using only 12-month reporting periods once the reporting periods for the 2013 and 2014 incentives conclude. Therefore, for the 2017 payment adjustment and beyond, CMS would use a 12-month reporting period that falls two years prior to the respective payment adjustment (e.g., January 1, 2015 – December 31, 2015 for the 2017 payment adjustment). Our societies believe that CMS should consider retaining the six-month reporting option for registry reporting and consider adding the six-month option for EHRs in the future. We believe that by providing a six-month reporting option (July 1-December 31), it gives physicians, particularly new PQRS participants, an additional six months to incorporate and test the technology and infrastructure needed for registry and EHR reporting. This flexibility could be especially important to a physician practice that is experiencing EHR software upgrades.

Proposed Audits of Registries

CMS proposes a new process to audit PQRS qualified registries. If CMS finds during an audit that a qualified registry has submitted grossly inaccurate data, the agency will disqualify the registry from reporting the subsequent year. While we appreciate CMS’ concern with data integrity, our societies feel this proposal is overly strict and could have a negative impact on participating physicians, as many enter into multi-year contracts with registry providers. If the registry is disqualified, the physician is ultimately punished through no fault of his/her own. We propose that CMS should give the PQRS qualified registry an opportunity to present a plan of corrective action if inaccurate data has been found, which could be followed by reassessment of the registry by CMS at a later date.

CH-CAHPS Clinician/Group Survey Measure

For 2013 and beyond, CMS is proposing the following measure be available for reporting – Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS): Getting timely care, appointments and information; How well your doctors communicate;
Our societies support and appreciate CMS’ efforts to align the quality programs by proposing a consistent group definition across the PQRS and e-Rx programs. For the e-Rx GPRO, CMS proposes changing the minimum practice size from 25 to two, and will add this to the criterion for being a successful electronic prescriber for the program. Since CMS proposes to change the definition, the agency also proposes to lower the reporting thresholds for group practices participating in the e-Rx GPRO. As stated above, most gastroenterology practices do not meet the current group practice size requirement of 25 or more eligible professionals, so the new proposal for two or more will allow additional opportunities for gastroenterology practices to report.

Additional Hardship Exemptions

CMS acknowledges that stakeholders participating in the EHR Incentive Program, which requires a certain level of electronic prescribing, are also beholden to the e-Rx payment adjustments. For this reason, CMS proposes including additional hardship exemptions for the 2013 and 2014 e-Rx payment adjustment periods, which would exempt the following providers from the e-Rx penalties:

- Eligible professionals or group practices that achieve meaningful use during certain e-Rx payment adjustment reporting periods.

- Eligible professionals or group practices that demonstrate intent to participate in the EHR incentive program and adoption of certified EHR technology.

We appreciate CMS’ recognition that even once certified EHR technology is adopted, significant changes and workflow redesign are required to facilitate adoption and information exchange, and that it may be difficult for an individual or group practice to begin electronic prescribing on day one. We support CMS’ proposal to include these new hardship exemptions for future reporting periods along with the existing hardship exemptions.
Informal Review Process

CMS is proposing to establish an informal review process for the e-Rx Incentive Program. While our members have successfully reported e-Rx measures, they have encountered difficulty with CMS applying payment adjustments. We support CMS’ proposal to allow an eligible professional or group practice to request an informal review within 90 days of the release of his or her feedback report.

Physician Compare Website

Our societies are encouraged with CMS’ statement in the proposed rule that it would “only post data on Physician Compare if it is technically feasible; the data is available; the system is set up/adjusted to post information; and the data is useful, sufficiently reliable, and accurate.” We offer the following recommendations below to help ensure these goals.

Basic Demographic Data

Our societies provided comment on the PFS 2012 proposed rule regarding the accuracy of the demographic data on Physician Compare. This included basic information, such as provider name, address, practice location, and specialty designation. These data have been found to be wholly or partially inaccurate. Some physicians have found they are missing from the directory entirely. These errors have drawn concern by our members about CMS’ plans for future updates, as well as the quality and validity of information that will be made available to consumers. Our societies are deeply concerned with CMS’ plan to expand the information on Physician Compare because, unfortunately, our members have found that problems with basic physician information persist.

Furthermore, our findings of inaccurate practice locations for physicians on Physician Compare have led us to question whether Physician Compare is being used by health systems to drive patient choice of providers in select markets, thereby intentionally misleading Medicare beneficiaries. We believe that CMS should address in the final rule the efforts it is taking to correct inaccuracies on the Physician Compare website. CMS should also develop a mechanism by which physicians and other health care professionals can report to Physician Compare any inaccuracies identified outside their own profiles. Gastroenterologists have reported that they have been unsuccessful in getting inaccurate information corrected through the Provider Enrollment, Chain, and Ownership System (PECOS), and, consequently, are left feeling they have little recourse and fear that the posting of performance information will also be fraught with inaccuracies.

Our societies recommend that CMS ensure the accuracy of the basic demographic information before proceeding with plans to include other physician-related information, such as patient satisfaction and other information that is not reviewed by the physician before posting on her/his profile.
Review of Patient Experience Measures for All Providers

As discussed in the proposed rule, CMS has plans to implement a major Physician Compare redesign in 2013. Our societies hope that the accuracy of the information is also verified during this overhaul. Our societies also urge CMS to take advantage of the planned website design to implement a system that notifies providers before any patient experience data is posted on the provider's profile. CMS should also afford the opportunity for the provider to confidentially review and challenge any patient-experience data before CMS displays the information on the website.

As is being proposed for patient experience data relating to 2013 PQRS GPRO and ACOs, we suggest that for group practices for which patient experience data is collected in 2013, those group practices should have an opportunity to confidentially review their data and be allowed to make practice changes based on the patient survey results. Therefore, we recommend that patient experience data collected in 2014 would potentially be the first data made available on Physician Compare no earlier than 2015.

As stated above, we ask CMS to offer more detailed guidance in the final regulation on how the agency intends to collect this sample of patient experience data in order for us to better educate our members. Our societies have fielded questions from our memberships on this proposal, yet we lack information to provide adequate responses.

Inclusion of Specialty Measures

Our societies commend CMS’ interest in reporting measures developed and collected by approved and vetted specialty societies. We believe that by adding this data, it will provide Medicare beneficiaries with more useful data when using Physician Compare in seeking specialty care providers for a specific condition/service. For example, Medicare beneficiaries should be able to use Physician Compare to compare performance of a certain procedure or service such as screening colonoscopy. Many of our members participate in quality improvement registries that measure physician performance on specific procedures/services in their specialty at their own expense. These evidence-based measures were created by various task forces established by our societies. Many have been endorsed by independent quality improvement organizations, such as the National Quality Forum (NQF). Our societies also ask CMS to list on Physician Compare successful completion of other quality improvement and accreditation programs sponsored by physician professional societies.

While the gastroenterology community supports the overarching goals of fostering improved quality of care and enhanced transparency for consumers, we are concerned that the agency has not taken the appropriate steps to ensure that data posted is reliable. Absent such steps, it will be difficult for consumers to make the kind of informed choices about their health care that CMS is hoping for and that patients deserve. To that end, we urge CMS to work with the physician community to develop actionable solutions that will ensure the integrity of the Physician Compare site.
We would be pleased to meet with the appropriate CMS staff to outline other suggestions that would ensure the site is a trustworthy resource for consumers in the future. Additionally, we believe that Physician Compare represents a unique opportunity for CMS to include information about physician participation in established, medical society-driven educational and voluntary quality of care initiatives. We believe that adding this type of information as a feature on Physician Compare will add additional value to the website.

**Value-Based Payment Modifier**

Our societies recognize and appreciate that the proposed rule represents a significant milestone in transforming Medicare from a passive payer to an active purchaser of higher quality, more efficient health care. We understand that CMS is under a mandate to transition to a VBP modifier for all physicians by January 1, 2017. Given the short transition period, we expect that CMS will need to continue, beyond the 2015 payment determination, the cautious approach it has appropriately taken with implementation of the VBP modifier in this proposed rule as quality measurement and VBP methodologies continue to evolve. We appreciate the thoughtful consideration CMS has given to VBP implementation at a time when physicians are faced with Medicare payment uncertainty due to the sustainable growth rate formula, sequestration, and the risk of payment penalties as a result of unsuccessful participation in CMS’ quality reporting programs. We offer our comments on the following areas and look forward to working with CMS on this important issue:

- Application of the VBP Modifier in 2015
- Selecting the Quality-Tiering Approach
- VBP Quality Measures and Alignment with PQRS
- Cost Measures and Patient Risk Adjustment
- Patient Attribution of Quality and Cost Measures
- Composite Scores for the VBP Modifier
- VBP Modifier Scoring Methodology for Quality-Tiering Model
- Applying the VBP to Individual Physicians

**Application of the VBP Modifier in 2015**

**Application of VBP to Physician Groups**

We understand that CMS has the authority to apply the VBP modifier to specific physicians and groups of physicians as deemed appropriate. **We support CMS’ decision to begin implementation with large physician groups rather than individual physicians based on specialty because of the challenges of applying the VBP modifier to individual physicians.**

We support CMS’ decision to apply the VBP modifier to physician groups comprised of 25 or more eligible professionals, including single-specialty groups, in 2015 so long as CMS does not limit physician groups to a subset of PQRS measures for GPRO reporting because PQRS quality data comprises the VBP quality composite. It is important that the VBP quality composite be based upon measures that are highly relevant to the patients and conditions experienced by a physician group.
Definition of Group Practice

We support CMS’ proposal to initially define a group practice for the purpose of the VBP modifier as a single TIN with 25 or more eligible professionals, as identified by their NPI, who have reassigned their Medicare billing rights to the TIN. We recognize that CMS chose to apply the VBP to groups of 25 or more eligible professionals to align with the PQRS definitions and reporting requirements for group practices. Furthermore, CMS allowed group practices of 25 or more eligible professionals to participate in the 2012 PQRS GPRO, thus giving these groups added time to make decisions regarding the submission of quality data. Our organizations considered, for purposes of the VBP modifier, whether a group practice should be defined by the number of its physicians or, as proposed, the number of its eligible professionals as defined in Sec. 1848(k)(3)(B) of the Social Security Act. Because the VBP modifier only applies to the services billed by physicians under a group’s TIN, we considered that the group be defined only by the number of its physicians. We support CMS’ proposal to apply the VBP modifier in 2015 to group practices with 25 or more eligible professionals so long as CMS finalizes its proposals to allow physician groups to elect how the modifier should apply and that the risk for penalty remains low. Our support for the 25 or more threshold is also based upon CMS being able to fulfill its proposal to provide Physician Feedback reports at the TIN level to all physician groups with 25 or more eligible professionals by fall 2013. As discussed below, we believe that providing group practices timely access to feedback reports is critical. Given the resources needed to compile and disseminate feedback reports, we suggest that CMS consider from an agency resource perspective whether the VBP modifier should initially apply to fewer group practices (e.g., group practices with 100 or more eligible professionals).

In the proposed rule, CMS states that it proposes to assess whether a physician group has 25 or more eligible professionals at the time the group of physicians is selected to participate under the PQRS GPRO. We suggest that CMS clarify in the final rule how it will identify and apply the VBP modifier to groups of 25 or more eligible professionals that do not self-nominate for the PQRS GPRO. Additionally, we believe in the final rule CMS should outline a process by which a group can appeal if CMS inaccurately determines that a group is comprised of 25 or more eligible professionals.

As stated above, we encourage CMS to look into creating a unique group identifier for the purpose of identifying a group practice in instances where billing reassignment by individual physicians to a single TIN is not practical.

VBP Modifier Flexibility

Our societies strongly support CMS’ proposal to allow physician practices to elect how the VBP modifier should apply to their payment in 2015. We support CMS’ proposal to set the VBP modifier at zero for physician groups that satisfactorily report data on PQRS quality measures for the 2013 incentive or meet the criteria for satisfactory reporting using the administrative claims-based reporting mechanism to avoid the 2015 payment adjustment. We also support setting the modifier at -1.0 percent for physician groups that do not meet PQRS GPRO reporting requirements. We believe that -1.0 is a fair adjustment because CMS has proposed to expand the measures and reporting mechanisms for the PQRS GPRO. Therefore, our
support of the -1.0 adjustment is contingent upon CMS finalizing its proposal to allow group practices that participate in 2013 PQRS GPRO to report quality data using the Web interface, claims, registries, and EHRs, as well as to select the administrative claims option.

Physician participation in the quality-tiering approach is necessary to designing and improving the VBP program. We support CMS’ decision to allow physician groups to choose whether to have their VBP modifier calculated using a quality-tiering approach. We believe that limiting the risk of poor performing group practices is critical to encouraging group practices to select the quality-tiering approach. We suggest that CMS consider whether a payment adjustment floor of -0.5 percent would make the quality-tiering approach attractive to more group practices. We understand, however, the challenge of limiting the downside risk as much as possible to incentivize participation, while creating the opportunity for an upward payment adjustment for high-quality/low-cost practices. We support CMS’ proposal to limit the downside risk of group practices that choose the quality-tiering approach to -1.0 percent.

**Selecting the Quality-Tiering Approach**

CMS seeks comment on how best to ascertain whether a group of physicians with 25 or more eligible professionals request the option that their VBP modifier be calculated using the quality-tiering approach. We feel strongly that physician groups should have the entire reporting year (e.g., all of 2013 for the 2015 payment year) to indicate to CMS whether they want their VBP modifier calculated using the quality-tiering approach. Therefore, we encourage CMS to establish a Web-based registration system (separate from the PQRS self-nomination process) for physician groups to register for the quality-tiering approach. We believe that by giving physician groups the entire year to register, it should provide groups an opportunity to review their feedback reports, which should be issued during the fall of the reporting year, before making their decision.

**VBP Quality Measures and Alignment with PQRS**

**PQRS GPRO**

We commend CMS for taking significant steps in the proposed rule to align reporting requirements and measures across its quality improvement programs. We are particularly pleased that CMS has proposed to incorporate performance on more quality measures than the subset of measures that were finalized in the CY 2012 PFS final rule for calculation of the VBP modifier. As CMS states in the proposed rule, allowing group practices to report on the full complement of PQRS measures recognizes the diversity of services provided among physicians and physician groups, and, thus, allows for more appropriate assessments of quality. We strongly support CMS’ proposal to allow performance rates for physician groups to be calculated using any of the PQRS GPRO reporting mechanisms.

Physician group practices are required to self nominate for the PQRS GPRO by January 31, 2013. Therefore, we believe it is very important that CMS undertake aggressive outreach prior to the January 31 deadline to those physician group practices to which the VBP will likely apply for
the 2015 payment determination so they are aware that they must self nominate for the PQRS GRPO in order to avoid a negative VBP modifier in 2015.

Administrative Claims Default
CMS requests comment on whether it should assess a group practice’s performance for the purposes of the VBP modifier, if it has chosen the quality-tiering approach, on the proposed PQRS administrative claims-based measures as a default if the group attempts to participate in one of the PQRS GPRO reporting mechanisms and is unsuccessful. Because we believe that compelling physicians to participate in the quality-tiering approach is linked to the future success or failure of the program, having the administrative claims default may encourage group practices that are still new to PQRS to choose the quality-tiering approach. CMS may need to consider at some point depending upon future proposals whether group practices should have the option to elect, rather than an automatic default, to have their performance based on the administrative claims if they fail to successfully participate in PQRS GRPO using one of the other reporting mechanisms. Because the current administrative claims measures are not highly relevant to many specialty practice groups, practices may not want to have their performance assessed on these measures and subsequently made public on Physician Compare.

Outcome Measures
In addition to the PQRS measures, CMS has proposed to calculate the VBP quality composite also using four proposed outcome measures (acute condition composite, chronic care composite, all-cause readmission, and 30-day post discharge visit). While we believe that patients will benefit from better care coordination across providers, it will be difficult to measure physician practices on these measures since they were developed to be applied at the community level. Our objective is a VBP modifier that is calculated using outcome measures that are specific to physicians and their scope of practice. We agree with the comments provided by the AMA that CMS should consider the substitution of its four proposed outcome measures with physician-level care transition measures recently endorsed by the NQF.

Cost Measures and Patient Risk Adjustment

In the CY 2012 PFS final rule, CMS finalized for the VBP modifier its use of total per capita cost measures and per capita cost measures for beneficiaries with chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes. We believe that ultimately episode-based cost measures will allow for a better evaluation of costs. However, we agree with CMS that episode-based cost measures should be included in the Physician Feedback reports before they are proposed for the VBP modifier.

We believe that the risk adjustment approach used for the 2010 Physician Feedback reports is the best available approach to risk adjustment for the VBP modifier at this time and that CMS is using the best identified proxies for health status and socioeconomic status.

Patient Attribution of Quality and Cost Measures
For the 2015 VBP adjustment year, we believe that CMS should attribute beneficiaries to groups of physicians using either the plurality of care method or the Medicare Shared Savings Program attribution methodology. We believe that CMS should use one of these two methods for the following reasons: the plurality of care method was used to attribute beneficiaries in the 2010 Physician Feedback reports provided to group practices; and we believe that further analysis of the “degree of involvement” methodology, based on the 2010 individual Physician Feedback reports, is needed before it is used for purposes of VBP payment determination.

We believe that attribution methodology alignment of the PQRS GPRO Web-interface reporting mechanism and the VBP quality and cost measures is important. We are concerned, as CMS acknowledges, that the plurality of care methodology may be too restrictive, particularly for a gastroenterology practice that primarily performs endoscopic services. However, a patient that sees a specialist for the management of chronic conditions and receives the plurality of their primary care services from that specialist would be appropriately attributed to that specialist under the Shared Savings Program attribution methodology. Besides more accurate attribution, using the Shared Savings Program attribution methodology would also have the added benefit of attribution alignment between the Shared Savings and VBP programs.

We suggest that, as part of the Physician Feedback program, CMS run, for a subset of physicians or physician groups, at least two attribution programs simultaneously in order to ascertain attribution accuracy, and, consequently, the best attribution method moving forward.

Composite Scores for the VBP Modifier

Quality Domains
For the quality measures, CMS proposes to classify each of the quality measures that it has proposed for the VBP modifier into one of six domains and to weight each domain equally to form the quality of care composite. Within each domain, CMS proposes to weight each measure equally. Should CMS decide to retain the four proposed outcomes measures (acute condition composite, chronic care composite, all cause readmission, and 30-day post discharge visit), we suggest that initially CMS consider weighting them lower than the PQRS measures. We believe the PQRS measures selected by physicians should be weighted more heavily because they are likely to be more direct indicators of a physician’s performance, particularly for specialty physicians.

Benchmarks
We believe that fair quality and cost comparisons among physicians or physician groups will be facilitated through the availability and reporting of measure groups. For example, if the vast majority of gastroenterologists report on the same measure groups, it will allow more accurate comparisons and better benchmarking. Gastroenterologists currently have the option to report on a Hepatitis C measure group and an IBD measure group, and our societies have recommended that CMS include a colonoscopy measure group beginning with the 2014 reporting year.

Reliability Standard
We support CMS’ proposal to require a minimum case size for both quality and cost measures to ensure high statistical reliability, but we believe that the minimum case size should be 30 rather than 20. We agree with CMS’ statement in the proposed rule that if it cannot develop either a reliable quality of care composite or cost composite because it does not have reliable domain information, it would not calculate a VBP modifier and payment would not be affected. This is particularly important for group practices that choose the quality-tiering method and unsuccessfully participate in PQRS GPRO using the claims, registry, EHR or Web-interface reporting mechanisms. In this case, if CMS chooses to allow the administrative claims measures as a default for those group practices, it is possible a physician group may meet the minimum case threshold on only a few, or possibly none, of the 19 administrative measures. As a result, reliable domain information may not be obtainable.

VBP Modifier Scoring Methodology for Quality-Tiering Model

Assessing Meaningful Differences
Under the quality-tiering model, CMS proposes to assess meaningful differences as those performance scores that are at least one standard deviation from the mean. At one standard deviation from the mean, the result will be a greater number of outliers. **We suggest that using two standard deviations is a more recognized way to determine whether something is a true outlier.** However, we understand that by using a standard deviation of greater than one, there will be fewer outliers, and, therefore, fewer group practices that receive a downward payment adjustment. Because the VBP modifier must be applied in a budget-neutral manner, we realize that the fewer group practices that receive a downward adjustment, the less money there is to redistribute to group practices that qualify for an upward adjustment. We are sympathetic to the delicate balance that CMS is trying to achieve. **We suggest that if one standard deviation be used for the initial VBP year that CMS reconsider using a standard deviation of at least two if and when the risk for downward adjustment increases (e.g., if CMS removes the downward payment adjustment floor).**

We assume that by proposing that the mean be used to assess differences in performance scores that CMS has information that shows that the data will be normally distributed. Otherwise, we suggest that CMS use the median and not mean to assess whether a score is an outlier at specified percentiles.

CMS also seeks comment on whether to define the high and low categories of the quality composites as a fixed percentage of number of groups of physicians or of the amount of payments under the PFS. CMS notes that the latter approach would minimize the number of physician groups subject to payment adjustments. As stated above, we acknowledge the balance CMS is trying to achieve in a budget-neutral system to provide adequate incentive for physician groups to opt for the quality-tiering approach. We believe that initially, so long as there is a payment adjustment floor, there is less risk to having the high and low categories defined as a fixed percentage of number of physician groups.

Incentive for Furnishing Care to High-Risk Beneficiaries
CMS proposes an additional payment incentive for physician groups that furnish care to high-risk Medicare beneficiaries. Under the proposal, the additional upward payment adjustment would apply to the following categories: high quality/low cost; average quality/low cost; and high quality/average cost. We recognize that the added payment reward serves to deter group practices from avoiding high-risk beneficiaries. We understand that there has been some discussion about whether to apply an additional upward payment adjustment to the other quality tier categories. Again, in a budget-neutral system, it is difficult to justify added incentives for the other categories (low quality/low cost; average quality/average cost; low quality/average cost; average quality/high cost; and low quality/high cost).

**Payment Adjustments**

*Our societies believe that at this time CMS should apply the same upward payment adjustment to groups of physicians classified as high quality/medium cost and medium quality/low cost.* Under this scenario, on one hand (high quality/medium cost), beneficiaries gain on quality without the program incurring significant additional costs. On the other (medium quality/low cost), beneficiaries are receiving adequate quality of care (average) with programmatic cost savings.

CMS seeks comment on whether it should not provide as great an upward payment adjustment for those groups of physicians that select to report under the PQRS via the administrative claims-based reporting option so as to encourage greater PQRS participation. While we believe that PQRS measures are preferable for assessing performance and quality, we believe that initially the upward adjustment should not vary based on PQRS reporting method. However, as mentioned above, we support CMS’ position that that if it cannot develop either a quality of care composite or cost composite because it does not have reliable domain information, it would not calculate a VBP modifier and payment would not be affected. As a result, for those group practices that choose the PQRS administrative claims-based reporting option and also choose the quality-tiering approach, if data collection does not lead to reliable domain information, the physician group would not have a VBP modifier calculated.

**Applying the VBP to Individual Physicians**

We recognize that CMS is seeking comment on the application of a VBP modifier to individual physicians, and we understand that CMS is under statutory obligation to apply a VBP modifier to all physicians by January 2017. Our organizations look forward to working with CMS as it considers the next phase of VBP modifier implementation. We believe that the 2011 and 2012 Physician Feedback reports will be highly instructive in designing a program that captures small and solo practices. Our societies have and will continue working through the working group convened by the AMA to provide suggestions on how to improve the Physician Feedback reports and support the recommendations included as attachments in the AMA’s comment letter that covers the reports’ distribution, format and methodology, as well as suggestions for additional analysis. We appreciate CMS’ desire for input from the physician community and its receptivity to our suggestions.
CONCLUSION

The ACG, AGA, and ASGE appreciate the opportunity to provide comments on the 2013 physician fee schedule proposed rule. If we may provide any additional information, please contact Brad Conway, Vice President of Public Policy, ACG, at 301-263-9000 or bconway@acg.gi.org; Elizabeth Wolf, Director of Regulatory Affairs, AGA, at 240-482-3223 or ewolf@gastro.org; or Camille Bonta, consultant to ASGE, at 202-320-3658 or cbonta@summithealthconsulting.com.

Sincerely,

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