



August 30, 2011

Donald Berwick, MD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**RE: Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2012**

Dear Dr. Berwick:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the proposed rule entitled, “Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012,” released on July 1, 2011. We look forward to continuing to collaborate with the Centers for Medicare and Medicaid Services (CMS) on the issues in this proposed rule, those associated with the Affordable Care Act (ACA), and other administrative simplification issues that will increase practice efficiencies while improving patient care.

MGMA, founded in 1926, is the nation’s principal voice for medical group practice. MGMA’s nearly 22,500 members manage and lead 13,700 organizations, in which 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States. MGMA’s core purpose is to improve the effectiveness of medical group practices and the knowledge and skills of the individuals who manage and lead them. Individual members, including practice managers, clinic administrators and physician executives, work on a daily basis to ensure that the financial and administrative mechanisms within group practices operate efficiently so that patient care remains the focus of physicians’ time and resources.

MGMA offers detailed critiques and recommendations related to this rule on behalf of our members. Key points include:

- MGMA urges CMS to use its regulatory authority to deem all physicians that meet meaningful use requirements (and therefore electronically prescribe and report clinical quality measures under that program) as also successfully meeting all electronic prescribing and Physician Quality Reporting System (PQRS) requirements in each corresponding performance year. Eligible professionals that successfully meet the meaningful use requirements should automatically earn the bonus for PQRS and avoid penalties for both electronic prescribing and PQRS.
- MGMA is extremely concerned with CMS’s use of quality related payment reductions to adjust Medicare allowables (such as the e-prescribing adjustment effective Jan.1, 2012). This will lead to significant administrative problems for group practices as well as CMS and its contractors as they attempt to administer what would amount to thousands of individual physician level Medicare fee

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schedules.

- MGMA opposes CMS's proposal to assign 2015 PQRS penalties and the 2015 value-based modifier based on a provider's activity in 2013. While MGMA opposes any financial penalties related to quality, if they are to be used they should only be levied retrospectively so as to account for a physician's performance during the relevant program year, rather than prior years.
- MGMA opposes proposed changes to the definition of a group practice under the PQRS and electronic prescribing reporting options. We urge CMS to maintain the current definition of two eligible professionals (EPs) or more. Under the proposed definition of a group practice (25 or more EPs), a significant percentage of EPs will no longer be able to utilize the group practice reporting option.
- MGMA opposes CMS's proposal to expand the multiple procedure payment reduction to apply to the payment for the professional component of imaging services performed during the same session. MGMA is concerned that these cuts are arbitrary and not based on any actual reduction in physician work.
- MGMA opposes CMS's proposal to transition from the Department of Housing and Urban Development (HUD) data to American Community Survey (ACS) data for two bedroom rental as a proxy for physician office rent. Commercial data, rather than residential data, should be used as the source for pricing medical office space when determining Geographic Practice Cost Indices (GPCIs) updates.
- MGMA is concerned with the highly prescriptive nature of the proposed health risk assessment (HRA), which would be a required part of initial and subsequent Annual Wellness Visits. If this burdensome HRA is finalized, MGMA urges CMS to increase the payment for the Annual Wellness Visits to reflect the additional work and resources necessary to provide the HRA.
- CMS's proposed changes to services performed in practices that are owned or operated by a hospital during the three days before an inpatient stay are unworkable. MGMA opposes the proposal, which would require such practices to adopt new and complex billing procedures, reduce reimbursement and increase the risk that such practices would inadvertently bill Medicare improperly.

### **Medicare Physician Reimbursement**

CMS proposes a negative 29.5 percent payment update for services in 2012, based on the application of the sustainable growth rate (SGR) formula, which is required by statute. This massive cut will have catastrophic consequences on medical group practices and the patients they serve. Although Congress has repeatedly taken action to override most of the SGR's prescribed fee schedule reductions, these temporary "fixes" have increased both the size of future cuts and the cost of repealing the flawed payment system. As a consequence, the frequent need to override increasingly steeper cuts is undermining confidence in the Medicare program and jeopardizing the financial stability of medical practices. The current environment is forcing group practices to make operational changes that severely challenge their ability to provide quality care to Medicare beneficiaries.

The severe consequences of insufficient Medicare payments alone do not reflect the extent of the program's impact on the American healthcare system. Most of the nation's private health insurance companies use the Medicare physician fee schedule as a benchmark for their fee schedules. Thus, the failure of Medicare payments to reflect increasing costs to provide care is magnified throughout the delivery system and affects access to healthcare for both the Medicare and non-Medicare populations.

For more than 50 years, MGMA has conducted annual surveys that focus on revenues/expenses, provider compensation and production, management compensation and group performance for medical and academic practices. MGMA data resulting from our medical practice cost surveys clearly demonstrate that operational costs continue to rise. According to our data, total operating cost per full-time equivalent physician has increased by 51 percent since 2001, while Medicare physician payments have remained relatively stagnant during that same time period, with a sharp decrease forecasted for 2012. This widening gap is becoming insurmountable for many physician practices.

In 2010, MGMA conducted a member survey focused on the potential impact future reductions in Medicare physician payment would have on practices and the patients they serve. The study found that many medical practices were likely to limit the number of new Medicare patients they accept unless Congress takes action to eliminate pending Medicare reimbursement cuts. In addition to reducing the number of Medicare patients they see, practices stated they would take other steps to cope with decreased reimbursement, such as delaying the purchase of electronic health records.

Given the importance of this issue, MGMA will conduct extensive member research in the fall to determine the steps medical practices have already taken to address payment uncertainty, as well as the actions they plan to take in light of the uncertain future of Medicare payments. We look forward to sharing the data with CMS and with Congress, so all parties understand the ramifications of continued failure to repeal the current SGR. MGMA will continue to work with Congressional leaders, urging them to permanently address the broken Medicare physician payment system and replace it with a more stable and predictable update mechanism that takes into account the actual cost of providing care to Medicare beneficiaries.

### **Multiple Procedure Payment Reduction**

CMS proposes to expand the multiple procedure payment reduction (MPPR) to the professional component (PC) of the same diagnostic imaging codes subject to the current MPPR for the technical component (TC). Under the proposed policy, CMS would pay the full amount for the procedure with the highest PC payment and reduce each additional procedure by 50 percent when additional procedures are performed on the same patient in the same imaging session.

MGMA strongly objects to this proposal, which comes after years of imaging payment reductions that have cut several services by over 50 percent since 2006. We do not believe CMS provides adequate rationale for this additional cut or for setting it at 50 percent across the board. CMS refers to the current MPPRs applied to surgeries and the TC of imaging procedures in its justification for its proposal. It is important to note, however, that at the time CMS proposed the 50 percent reduction to the TC of multiple imaging procedures, it solicited data from providers of diagnostic imaging so it could evaluate the duplication of effort and determine the proper percentage. Rather than use that approach in this instance, CMS has instead relied on the analysis of three new codes created by the American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee (RUC) that combine CT of the abdomen and pelvis.

Because the AMA RUC found a 50 percent reduction in work values in this one instance, CMS claims that a 50 percent reduction is appropriate for all imaging performed in the same session, regardless of modality or body part. CMS does not, however, address the fact that in its process of combining codes frequently performed together, the AMA RUC has not consistently found a 50 percent reduction in physician work when services are performed together. Rather, the reductions have ranged anywhere from 0 to 100 percent. To isolate this single code combination of services performed with the same equipment on contiguous body parts and extrapolate a uniform payment cut for all imaging based on that analysis is not accurate or equitable.

The current reduction to the TC of imaging services is based on the fact that certain tasks do not need to be performed twice when two imaging services are performed together (e.g., greet the patient, clean the exam room, etc.). In proposing to apply the same percentage payment cut to the PC of imaging services, CMS gives no indication what specific aspects of the physician's work it expects a physician to skip on the second service – saying only that efficiencies would come “primarily in the pre-and post- service periods.” Professional responsibility requires a physician to perform a full and complete review of each scan, and potential liability for missing an important result does not diminish when two scans are performed together. Further, CMS's proposal leaves several questions unanswered. Will the 50 percent reduction apply when a physician does not read both scans together – for example, in emergency situations – even though both scans were performed in the same session? Will it apply if two physicians with different specialties each read a separate scan of a patient, though both scans were taken during the same session? While that result seems illogical, CMS's proposal leaves this question open as a possibility. We urge CMS not to implement this proposal or any further cuts to imaging, especially without careful study of the issue with input from stakeholders to develop a reasoned proposal.

### **Geographic Practice Cost Indices**

MGMA is pleased to see that CMS expanded the number of occupations included in the employee wage index that were historically excluded from the employee wage calculation. However, as noted in previous comments, MGMA remains concerned about the appropriateness of data used to calculate adjustments and the lack of transparency of the methods for making the adjustments.

While we appreciate the difficulty CMS has had in identifying alternative sources for pricing medical office space, we do not believe the proposed transition from the Department of Housing and Urban Development (HUD) data to American Community Survey (ACS) data for two bedroom rental as a proxy for physician office rent is sufficient. MGMA remains opposed to the use of residential and not commercial data for this purpose.

CMS proposes to determine the cost share weights for the 2012 Geographic Practice Cost Indices (GPCIs) on the 2006-based medical economic index (MEI). The MEI was rebased and revised in the 2011 final rule. As noted last year, MGMA believes it was premature to rebase and revise the MEI prior to the MEI technical advisory panel convening. It is critical that physicians have input into future revisions of methodology, sources of data, inputs, input weights and price-measurement.

In the 2011 Medicare physician fee schedule final rule, CMS stated it would review the findings of the Secretary's Medicare Geographic Payment Summit and the MEI technical advisory panel during future rulemaking (75 FR 73256). However, the MEI technical advisory panel has not yet

convened. Modifications to GPCIs should not be imposed until CMS convenes the MEI technical advisory panel in a formal and fully transparent manner.

### **Part B Drug Payment**

MGMA is concerned with CMS's proposal to substitute 103 percent of the Average Manufacturer's Price (AMP) for certain drugs currently paid at 106 percent of the manufacturer's average sales price (ASP). Reducing reimbursement by using this price substitution policy may jeopardize beneficiary access to critical drugs, including oncology treatments. By implementing this proposal CMS will exacerbate the difficulties of certain practices and physicians to recoup the cost of acquiring these therapies, subsequently threatening their ability to continue to provide these services in physician offices. MGMA urges CMS to remove this price substitution proposal.

### **Annual Wellness Visit**

As required by the Affordable Care Act (ACA), CMS proposes to modify the initial and subsequent Medicare Annual Wellness Visits (AWV) by including a Health Risk Assessment (HRA) as a required component of AWVs beginning in 2012. The HRA serves as an evaluation tool to provide a systematic approach to obtaining information about the patient's health status, injury risks, modifiable risk factors and urgent health needs. ACA requires an HRA to be part of the AWVs, but the Secretary of the Department of Health and Human Services (HHS) has flexibility in developing the guidelines of the HRA. While MGMA supports gathering information to help practitioners provide useful health advice and appropriate referrals, MGMA opposes the highly prescriptive nature of the proposed HRA. The AWV is a new benefit, and CMS should not implement such an onerous HRA, which may serve as a disincentive to providers and beneficiaries from administering or receiving an AWV.

The proposed HRA includes numerous categories with multiple detailed pieces of information that providers must collect. CMS proposes to modify the definitions of initial and subsequent AWVs to require reviewing the results of an HRA and establishing a written screening schedule for the individual. CMS intends to have the beneficiary leave the AWV with personalized health advice, appropriate referrals and a written individualized screening schedule, such as a check list. The ability to give a written individualized screening schedule to a beneficiary will greatly depend on whether the beneficiary is willing and able to complete the HRA prior to the AWV, or if this information is gathered during the visit.

Despite the additional work from the HRA, CMS fails to modify the payment for either the initial or subsequent AWV. These are currently paid at an amount equivalent to level 4 E/M new or established patient visits, respectively. The significant additional work required by the HRA warrants a higher payment for both the initial and subsequent AWVs.

In addition, the Secretary of HHS is required by Section 4103(b) of ACA to establish standards for interactive web-based programs to furnish HRAs. To date, this task has not been accomplished and no publicly available HRAs have been identified. This creates an additional burden on practices performing AWVs because they will have to create and/or implement HRAs, necessitating more time and resources from the practice. Overall, the proposed HRA is too prescriptive and onerous and places unnecessary burdens on providers and beneficiaries. CMS should modify this proposal to allow more flexibility, make it less burdensome and provide a publicly available HRA as required by ACA.

## **Physician Quality Reporting System**

MGMA continues to support quality improvement initiatives that improve patient care and clinical outcomes. However, we have strong concerns and extensive recommendations regarding specific physician quality reporting system (PQRS) provisions in this proposed rule.

### Proposed Definition of Group Practice

CMS proposes to change the definition of a group practice as part of its consolidation of the existing group practice reporting option (GPRO) I (200 or more EPs) and GPRO II (2-199 EPs) options. Under the current proposal, the group practice definition would be limited to practices with 25 or more EPs. More than two-thirds of MGMA members manage practices with 25 or fewer physicians. The proportion of smaller practices is even higher in the overall Medicare physician population. Under the proposed definition of a group practice, a significant percentage of EPs will no longer be able to utilize the GPRO as they participate in PQRS and other incentive programs. This is a step backward. CMS should seek ways to simplify physician participation in PQRS, not limit options to participate in this and other incentive programs.

We urge CMS to revise its proposed group practice definition and continue offering this option to groups of two EPs and larger. While we recognize there was only modest initial reporting through GPRO II, the option should remain open for 2012 and beyond. In addition, we encourage the agency to amplify its physician education efforts regarding GPRO as this may also increase participation.

### Proposed Criteria for Satisfactory Reporting of Individual Quality Measures for Individual Eligible Professionals via Claims

In this rule, CMS proposes that physicians in family practice, general practice, internal medicine and cardiology report on at least one of seven core measures of cardiovascular care. While we typically welcome new opportunities to simplify reporting, we have concerns with the precedent this sets of the agency limiting measure selection choice and narrowly defining what is clinically relevant to physicians participating in the program. Physicians should have full discretion over which measures they report based on the actual care they deliver. If CMS elects to expand “core” measures to other specialty groups in the future MGMA would be concerned, for example, that there may be subspecialties that may not fit into narrow, CMS-dictated measure sets. We oppose CMS imposing further reporting mandates within PQRS. Physicians should have full discretion to choose which measures are most clinically relevant to the care they provide.

### Informal Review

CMS proposes to provide an EP with a response to a request for an informal review within 90 days of receiving the original request. Currently, CMS provides an EP with a response to a request for an informal review within 60 days. We recognize that CMS anticipates a higher volume of informal review requests due to potential growth in participation; however, we strongly feel that 90 days is far too long a timeframe to receive a response to an informal review request. CMS should maintain the informal review within 60 days. Further, we have strong concerns with the current structure of the Quality Net Help Desk used for the informal review process. Practices have had numerous difficulties in accessing and obtaining reliable information from the Help Desk. We urge CMS to ensure that the Quality Net Help Desk is adequately resourced to handle additional requests for informal reviews and to assure that professionals that may have been incorrectly deemed as unsuccessfully participating in PQRS receive responses to

their reviews in an appropriate timeframe. Further, we request that CMS offer a more comprehensive process that allows for more than one type of appeal. The appeals process is more important than ever now that PQRS information is posted on a public Website and moving into a penalty phase in 2015.

### Reporting Periods

CMS proposes eliminating the six-month reporting period for reporting individual measures via claims and registry while retaining the six-month reporting period for measures groups via registry. We appreciate the agency's efforts to align the PQRS reporting periods with other CMS quality reporting programs; however, we have concerns that this may prohibit new providers from participating in the program. We request that the agency maintain the six-month reporting option to benefit new providers.

### Public Reporting

CMS proposes taking an initial step toward publicly reporting physician performance information by posting performance rates specific to quality measures that group practices submit under the 2012 PQRS GPRO option. CMS also proposes publicly reporting, as early as 2013, quality measure performance rates for group practices participating in the GPRO. The measures would be reported for the group as whole, not individual providers. As part of their self nomination letters, group practices participating in the 2012 GRPO would be required to agree in advance to have their performance results publicly reported. MGMA believes group practices should not have to agree to have their information be made publicly available as a condition of participation in GPRO.

### Payment Adjustments

CMS proposes using the 2013 program year as the reporting period for purposes of the 2015 PQRS negative payment adjustment of 1.5 percent. MGMA opposes CMS's proposal to assign penalties based on any year other than the year in which the penalty is applied. For instance, the 2015 penalty should be based on what an EP does in 2015 and not on what he or she does in 2013. In general, MGMA opposes penalties for physicians who choose to not participate in incentive programs. If penalties are used, they should reflect the EP's actions in the applicable year rather than be based on any previous years. Under the current structure of the program, we strongly believe that financial penalties should only be levied retrospectively. As with the CMS electronic prescribing program, we are extremely concerned that the prospective application of penalties will lead to significant administrative problems for group practices as well as CMS and its contractors. The application of different Medicare allowables for individual physicians within a group practice will be an administrative nightmare. MGMA predicts significant problems with Medicare contractors attempting to administer what will amount to customized individual Medicare fee schedules.

CMS's proposal in no way conforms to Congressional intent. Under this proposal, Medicare patients may pay different amounts depending on the physicians they see and whether or not the physician participates in PQRS or e-prescribes. Congress did not intend to create quality incentive programs under which beneficiaries get discounts for being treated by Medicare participating physicians that do not report quality measures or e-prescribe. With lower physician payments and consequently, lower beneficiary co-insurance amounts, CMS's proposal to apply prospective penalties will skew beneficiary financial incentives against its very own quality initiatives.

### Alignment of Various CMS Initiatives

We urge CMS to synchronize the various, overlapping Medicare incentive programs so that, for example, eligible physicians who receive Medicare EHR incentives will have also met the requirement for successful participation in PQRS and e-prescribing. CMS has this authority and should use it. For instance, under the Medicare Shared Savings Program proposed rule, CMS would deem Accountable Care Organizations to have qualified for incentive payments under the PQRS if they meet the quality performance standards under the Shared Savings Program for the first performance year. CMS should use this same regulatory authority to deem all physicians that meet meaningful use requirements (and therefore report quality measures and e-prescribe under that program) as also successfully meeting all PQRS and e-prescribing requirements in each corresponding performance year.

### **E-prescribing Incentive Program**

MGMA strongly supports e-prescribing (eRx) and other health information technology initiatives that will improve clinical care and reduce administrative costs. ERx offers a number of important opportunities to prescribers and pharmacists. From the clinical perspective, eRx can permit the clinician and pharmacist to review allergies, drug-drug interactions and contraindications that, if not identified, could have a dangerous impact on the patient. ERx can also facilitate administrative functions such as accessing information related to formulary and benefit management. Additionally, fully integrated eRx systems have the potential to reduce the time prescribers and pharmacists spend on formulary management issues, create efficiencies in the delivery of healthcare, and provide enhanced access to electronic patient health information. We have concerns, however, with the redundant nature of CMS reporting programs and the agency's reliance on claims-based clinical data collection. We strongly urge CMS to collect e-prescribing data directly from the Part D program, thus eliminating the necessity for eligible professionals (EPs) to separately collect and report this information.

### Eligibility

CMS proposes continuing to require the current criteria for determining an EP's success as an e-prescriber. For the 2012 incentive program, CMS proposes that each eligible professional report the G-code indicating that he/she electronically generated at least one prescription during a Medicare patient encounter for at least 25 patient encounters during the reporting period. MGMA supports this continued streamlined eligibility requirement as an alternative to CMS's original approach. This simplified method, requiring qualified professionals to report 25 or more instances of electronic prescribing during a reporting period, is reasonable when coupled with appropriate exclusion criteria and should continue to facilitate increased adoption of this important technology.

### Reporting Options

CMS proposes three reporting mechanisms for individual EPs. The agency would permit:

- Claims-based reporting
- Registry-based reporting
- Direct from the EHR-based reporting

MGMA supports offering physicians multiple methods for reporting eRx data. Under this proposal, only 2012 PQRS-qualified registries could submit measure results and numerator and denominator data on the eRx measure. We also support the ability of physicians to report both

PQRS measures and the eRx incentive code using the same registry if he or she uses the registry reporting option. While MGMA concurs with the CMS commentary regarding the limitations of claims-based reporting, MGMA encourages CMS to continue offering a claims-based reporting system for reporting eRx measures until the transition to reporting via registries and EHRs is complete.

#### Intersection with the Medicare EHR Incentive Program

It is clear that significant overlap exists between the 2012 Medicare eRx initiative and Stage 1 of the Medicare EHR incentive program. As CMS has historically been unable to provide feedback to physicians until the year following their participation in the program, it will be extremely challenging for physicians to determine if they have qualified for one or both of these incentive programs in a timely manner. Thus, it is expected that many EPs will apply for both the eRx and EHR incentive programs in 2012. As EPs are not eligible to receive payments from both programs in 2012, it is critical that CMS accurately and quickly ascertains if an EP has successfully completed all requirements for either program, and expediently report the results to the EP. CMS should use its regulatory authority to deem all physicians that meet meaningful use requirements (and therefore e-prescribe under that program) as also successfully meeting all eRx requirements in each corresponding performance year.

#### 2012 Payment Adjustments Based on 2011 Reporting

CMS has developed a two-tiered reporting period for purposes of the 2012 and 2013 payment adjustments. EPs were required to submit a minimum of 10 qualifying e-prescribing events, on claims, from Jan. 1, 2011 to June 30, 2011 to avoid the 2012 payment adjustment and are required to submit evidence of 25 qualified e-prescribing events from Jan. 1, 2011 to Dec. 31, 2011 using any of the three approved methods (claims-based, registry or direct from an EHR): We strongly recommend not imposing payment adjustments in 2012 and 2013 for 2011 e-prescribing activity. We assert that payment adjustments should be made in 2012 and 2013 based strictly on the EPs and group practice's e-prescribing activity in 2012 and 2013 respectively. For the 2012 incentive program and payment adjustment, this could be done either by developing a Jan. 1, 2012 to Dec. 31, 2012 reporting period, or alternatively, a Jan. 1, 2012 to Oct. 31, 2012 reporting period. For purposes of the 2013 incentive program and payment adjustment, the reporting period could be Jan. 1, 2013 to Dec. 31, 2013, or alternatively, Jan. 1, 2013 to Oct. 31, 2013. The payment adjustments, like the incentive program payments, can be assigned retroactively. Modifying the reporting periods will provide additional time for CMS, trade associations and professional societies to educate EPs on the eRx program requirements.

#### Reporting Periods for 2012, 2013 and 2014

We do not believe that Congress intended for CMS to establish an incentive program that would both reward and penalize an EP for their e-prescribing activity in the same year. We assert that Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 grants the Secretary considerable latitude in determining the appropriate reporting period for payment adjustment purposes. We urge CMS to exercise this statutory discretion and modify its current policy regarding the incentive program reporting periods and the assignment of payment adjustments. Medicare pays the eRx incentive program payments retrospectively, the assignment of payment adjustments should be conducted in a similar manner.

### Claims-Based Reporting and the 2012 Payment Adjustment

CMS required EPs to report a minimum of 10 e-prescribing events to Medicare patients using the claims-based reporting approach between Jan. 1, 2011 and June 30, 2011 in order to avoid the 2012 payment adjustment. Use of registries or direct submission from an EHR is not permitted. Requiring submission of the G codes on claims runs contrary to the expressed goal of Congress and the Administration in developing this and other health information technology (HIT) incentive programs.

We urge CMS to revise its policy regarding the 2012 payment adjustment reporting period and recognize that in order to harmonize the various HIT incentive programs, it must permit EPs and group practices to submit the appropriate G codes using claims, registries or directly from an EHR. MGMA again asserts that CMS should exempt all physicians meeting meaningful use requirements in 2012 and beyond from any e-prescribing penalties.

### Certification and Qualifying Systems

CMS proposes expanding the definition of a qualifying eRx system so that EHR technology under the Medicare/Medicaid EHR incentive program can be recognized as a qualifying system under the eRx program. For the purposes of reporting the current eRx quality measure during 2011 for incentives and for avoiding the 2012 eRx penalty, CMS has indicated that nothing precludes eligible professionals (or a group practice) who already have certified EHR technology that meets the four functionalities described above from using that technology for the eRx Medicare incentive program. CMS further indicates that if it finalizes the proposed rule later this year, certified EHR technology will be acceptable for eRx in future reporting years even if the certified EHR does not meet the four specific functionalities.

We strongly support CMS's proposal to recognize EHR technology certified under the Medicare/Medicaid EHR incentive program as a qualifying system under the eRx incentive and penalty programs. This recognition is an example of the importance of synchronizing the overlapping eRx and EHR incentive programs so that EPs do not have to purchase an eRx system just to avoid penalties, and can invest in certified EHR technology that does more than just enable eRx. However, we strongly encourage the expansion of this provision to include the purchase in 2012 of EHR technology certified under the Medicare/Medicaid EHR incentive program to either qualify for the eRx incentive program bonus in 2012 and/or avoid the 2012 payment adjustment.

### Proposed Exemption Categories

We support the exemption and significant hardship categories outlined in the proposed rule, including:

- An EP who is not an MD, DO, podiatrist, nurse practitioner or physician assistant by June 30, 2012
- An EP whose Medicare Part B allowed charges for covered professional services to which the eRx quality measure applies are less than 10 percent of the total Medicare Part B allowed charges furnished by the EP during the reporting period
- An EP who does not have at least 100 cases containing the encounter code that falls within the denominator of the eRx measure
- EP or GPRO practices in a rural area with limited high-speed internet access

- EP or GPRO practices in an area with limited available pharmacies for electronic prescribing

We agree with the agency when it proposes to include the following significant hardship exemptions:

- Inability of the EP to electronically prescribe due to local, state, or federal law or regulation
- EPs who prescribe fewer than 100 prescriptions during a 6-month payment adjustment reporting period

These are both outlined in the proposed rule entitled “Proposed Changes to the Electronic Prescribing (eRx) Incentive” (76 FR 31547). In that proposed rule, the agency also identified additional hardship exemption categories for the 2012 payment adjustment that we strongly believe should be incorporated into the 2013 and 2014 programs. These are:

- **An EP that has registered to participate in the Medicare or Medicaid EHR incentive program and has adopted certified EHR technology** – EPs who have registered to participate in the EHR incentive program in 2012 and have adopted certified EHR technology should not be subject to a 2012 or 2013 payment adjustment. This would help in further harmonizing the two incentive programs. In addition, EPs should be permitted to provide the serial number or certification number of the certified EHR technology or any other appropriate information to verify that the specific EHR product has been purchased in 2011 or 2012 for participation in the Medicare or Medicaid EHR incentive program.
- **An EP that has insufficient opportunities to report the eRx measure due to program limitations** – We believe it is imperative that CMS permit an EP that e-prescribes to a patient on a different day than the day of the encounter with the patient to be eligible to apply for this eRx exemption. This exemption should also include but not be limited to situations such as when global billing is utilized and when claims are submitted for outpatient or office visits to Medicare that do not normally have any prescriptions associated with those visits.

Further, an EP who attests to being a meaningful user under the CMS Medicare or Medicaid EHR incentive program should be exempt from any payment adjustment in any year under the eRx incentive program. Finally, those EPs who have attested to being a meaningful user for purposes of the Medicare or Medicaid EHR incentive program should not be required to submit a hardship exemption form. As CMS is clearly requiring the interoperability of provider systems, the agency itself should develop the capability to harmonize the capturing and processing of provider information to and from multiple CMS-administered incentive programs.

In addition, no penalties should be assigned in 2012, 2013 or 2014 to:

- **EPs who indicate that they intend to retire in 2012, 2013 or 2014** – It is unreasonable to expect EPs to transition to a complicated and expensive stand-alone eRx system for a short period of time prior to retirement.
- **EPs who prescribe a large percentage of controlled substances** – As the Drug Enforcement Administration has not yet released a final rule on the e-prescribing of controlled substances, few vendors have produced the required software. As a result, EPs

may be forced to utilize paper prescriptions until the final rule is published and the appropriate software is widely available.

#### Submission of Hardship Requests

CMS proposes to permit EPs or group practices to submit a 2013 hardship request via a Web-portal by June 30, 2012 and by June 30, 2013 for the 2014 hardship request. Should CMS not adopt the more reasonable approach of utilizing 2012 e-prescribing activity to determine the 2012 payment adjustment and 2013 e-prescribing activity to determine the 2013 payment adjustment, we strongly encourage the agency to extend the time period in which EPs can submit hardship requests to Dec. 31, 2012 and Dec. 31, 2013 respectively.

Further, as many EPs who cannot meet the eRx program requirements may not have access to the Internet, CMS should permit EPs to submit their hardship requests by phone or in writing, in addition to offering EPs the ability to submit this request directly via a Web-portal. We also encourage the agency to limit the amount of information that an EP or group practice would be required to include in an exemption application. It appears reasonable to require identifying information (e.g., TIN, NPI, name, mailing address and e-mail address of all affected eligible professionals), one or more of the significant hardship exemption categories that apply, a brief justification statement and an attestation of the accuracy of the information provided. We also recommend that once CMS has completed its review of the EPs request for an exemption, it notify the EP or group practice within two weeks.

#### Third Party Designation and Batch Submissions

We strongly encourage CMS to develop a process that permits EPs and group practices to designate an individual responsible for submission of an EP's exemption application. Further, the agency should develop the ability for a group practice with multiple EPs to complete a single hardship exemption application for multiple EPs at once. Implementing these two recommendations will significantly streamline the application process.

#### Establishment of an Appeals Process

In its proposal, CMS states they it will not offer any appeals process for EPs and group practices it deems to not to have met the eRx incentive program requirements and/or a hardship exemption. We encourage the agency to reevaluate this approach and consider establishing a process that would permit EPs and group practices to appeal their e-prescriber designation or their rejected hardship request. This appeals process should be automated and streamlined to the greatest degree possible, permitting EPs and group practices to submit appeal requests by phone, in writing and via a Web portal.

#### Good Faith Incentive Program Participation

EPs and group practices who participated in the eRx Incentive Program in good faith, but encountered problems in their use or submission of G codes should be provided an opportunity to correct the problems. It is important to note that CMS prohibits the resubmission of claims for the purpose of correcting an improper G code. Prior to incurring a payment adjustment, however, EPs and group practices should be provided the opportunity to explain that they participated in the incentive program in good faith but were unable to meet the program requirements due to data submission errors. These EPs and group practices should be permitted additional time to submit the appropriate G codes to qualify for the incentive and/or be exempt from the payment adjustment.

### Feedback Reports and Payments

We strongly encourage the agency to expedite payments as quickly as possible for the 2012, 2013 and 2014 programs and take all appropriate steps to ensure that feedback reports for each year's program are issued to EPs in a timely manner. Payments and reports issued soon (i.e., 30 days) after completing the program requirements would act as an additional incentive for EPs to transition to eRx. This more rapid reporting process would also permit EPs that failed to meet the program requirements in the first part of a year the opportunity to correct the problem and qualify for the incentive payments later that same year.

### Public Reporting

CMS intends to post the names of eligible professionals who are successful e-prescribers on [www.medicare.gov](http://www.medicare.gov). MGMA urges CMS to carefully review all data for accuracy and recommends that CMS incorporate an appeals process prior to any public reporting for those EPs and groups deemed to have failed to meet program requirements.

### Increased Incentive Program Harmonization

EPs are increasing their adoption of EHRs into their practices. The harmonization of federal HIT incentive programs will be critical to their overall success. This sentiment was clearly articulated in the Government Accountability Office's (GAO) February 2011 report, "Electronic Prescribing: CMS Should Address Inconsistencies in Its Two Incentive Programs That Encourage the Use of Health Information Technology." In that report, the GAO concluded that CMS must encourage physicians and other providers in the eRx incentive program to adopt certified technology and that CMS should expedite efforts to remove the overlap in reporting requirements for EPs who may be eligible for incentive payments or subject to penalties under both programs. As stated previously, we strongly encourage CMS to develop the capability to harmonize the capturing and processing of provider information to and from multiple CMS-administered incentive programs. To further streamline these incentive programs, we urge the agency to automatically deem those EPs who are meaningful users to have fulfilled both the eRx and PQRS requirements.

We believe it is critical for CMS to adopt the GAO's recommendations and pursue reasonable, achievable requirements aligned with those for the various incentive programs currently underway to simplify the process for all EPs, and coordinate educational outreach efforts.

### **E-prescribing: Group Practice Reporting Option**

#### Proposed Definition of Group Practice

CMS proposes to change the definition of a group practice as part of a consolidation of the existing GPRO I (200 or more EPs) and GPRO II (2-199 EPs) options. Under the current proposal, the group practice definition would be limited to those with 25 or more EPs. MGMA has concerns about this proposal as more than two-thirds of our members are in practices of 25 physicians or fewer. This proportion is likely even higher in the overall Medicare physician population. Under the proposed definition of a group practice, a significant percentage of EPs will no longer be able to utilize the GPRO as they participate in eRx and other incentive programs. This is a step backward. CMS should seek ways to simplify physician participation in eRx, not limit options to participate in this and other incentive programs.

We urge CMS to revise this proposed group practice definition and continue offering this option to groups of two EPs or more. While we recognize there was only modest initial reporting through GPRO II, the option should remain open for 2012 and beyond. In addition, we encourage the agency to amplify its physician education efforts regarding GPRO as this may also increase participation.

For reporting periods that occur during 2012 and 2013, CMS also proposes that a group practice that wants to participate in the eRx Incentive Program as an eRx GPRO for a particular calendar year will have to indicate which reporting mechanism the group practice intends to use to report the electronic prescribing measure. That is, the group practice will need to indicate at the time it self-nominates which reporting mechanism (claims, qualified registry, or qualified EHR) the group practice intends to use for purposes of participating in the eRx GPRO. At the time of self-nomination, groups may be planning on utilizing one reporting mechanism, but later find that another one is more appropriate. We urge CMS to add some flexibility to this requirement and permit groups to change their reporting mechanism after they have self-nominated.

### **Medicare EHR Incentive Program for Eligible Professionals for the 2012 Payment Year**

In the 2010 final rule for the Medicare and Medicaid EHR Incentive Program, CMS stated that certified EHR technology would be required to calculate the clinical quality measures (CQM) results and transmit under the PQRI Registry Extensible Markup Language (XML) specification standards. CMS has now determined that it is not feasible to receive electronically the information necessary for clinical quality measure reporting based solely on the use of PQRI 2009 Registry XML specification content exchange standards as is required for certified EHR technology. It proposes to modify the requirement that CQM reporting be done electronically. We agree with the agency's assessment of the reporting standards issue and support the proposal that for the 2012 payment year, EPs continue to be permitted to report CQM results as calculated by certified EHR technology by attestation.

### **The Proposed Physician Quality Reporting System-Medicare EHR Incentive Pilot**

We are pleased to see CMS exploring options for reducing the administrative burden on EPs seeking to participate in the agency's incentive programs. The Physician Quality Reporting System-Medicare EHR Incentive pilot offers an EP with a certified EHR the opportunity to submit clinical quality measures required for both incentive programs in one step. While we are very supportive of streamlining this type of administrative requirement, we urge the agency to consider approaches that will eliminate the necessity for EPs to report the same CQM data for multiple incentive programs. We believe that should the EP achieve meaningful use, with its more robust CQM requirements, they should be automatically eligible for the PQRS incentive and exempt from any PQRS payment adjustment. This reporting modification will serve to increase EP participation in the incentive programs.

In addition, we are concerned that CMS proposes to hold the meaningful use payment until at least two months after the PQRS data reporting period has ended on Feb. 29, 2013. The reporting period for EPs attesting to meaningful use for the first time in 2012 is 90 days. Thus, for those EPs participating in this pilot, they would have to wait approximately one year for their first payment under the EHR incentive program. This could prove to be an unacceptably long delay for many EPs who financed their EHR with the understanding of receiving their first year payment in a timely manner. We urge CMS to issue the payment expeditiously to these first year

EHR incentive program participants who elect to participate in this pilot and not wait until after the PQRS reporting period has ended.

### **Resource Use Reports and the Value-Based Modifier Program**

In January 2009, CMS implemented resource use reports for the purpose of providing physicians with confidential feedback and to allow them to compare their Medicare resource use with that of their peers. CMS states in the proposed rule that in 2012 the agency expects to expand dissemination of reports to cover 100,000 physicians nationally. Additionally, during 2012 CMS will test and plan how to use an “episode grouper” that could be used to compare resource use and quality among physicians in the application of a value-based modifier. In 2013, performance as measured in the feedback reports would become the basis for determination of the value-based modifier that will be phased in Jan. 1, 2015 through Jan. 1, 2017. CMS will apply a separate, budget-neutral quality and cost payment modifier to the physician fee schedule payment formula.

While MGMA supports efforts to improve the efficiency and the quality of care physicians provide to their patients, we have significant concerns with the value-based modifier program and question if it can be practically implemented. We are well aware of the unintended negative consequences programs like the value-based modifier can have when developed too quickly and rely on resources and measures that have not been appropriately tested. It is also important to note that the ACA requires a number of new reporting programs associated with financial incentives and/or penalties. MGMA does not believe that the methodology currently exists to implement the value-based modifier in coordination with these programs.

MGMA also has concerns with “episode groupers” and their accuracy of measurements, appropriateness of risk adjustment methodologies and data difficulties. Currently, no single risk adjustment methodology is appropriate across a spectrum of conditions or episodes of care. As a result, a risk adjustment model should be condition-specific. The risk adjustment methodology should also adequately address the complexities which arise from the multiple chronic conditions of the population of Medicare beneficiaries.

We are pleased CMS focuses on distributing meaningful and reliable resource use reports to providers; however, the recent GAO report entitled “CMS Faces Challenges with Methodology and Distribution of Physician Reports” identified several challenges the agency faces with incorporating resource use and quality measures for feedback reports that are meaningful, actionable and reliable. According to the report, CMS had difficulty measuring resources used to treat specific episodes of an illness and the quality measures used in the program’s most recent phase applied to a limited number of physicians. Additionally, the report identified challenges CMS faced distributing feedback reports to physicians. In the most recent phase of the program, 82 percent of physicians in CMS’s sample were not eligible to receive a report after CMS’s methodological decisions were applied. The report also notes that there were many challenges with distribution of the reports as CMS had difficulty obtaining physicians’ contact information, and methods of electronic distribution were burdensome for providers.

Finally, as with the PQRS program, we have significant concerns about basing a 2015 modifier on what a provider does in 2013. Financial penalties should only be levied retrospectively so they take into account what a provider does during the relevant year, rather than be based on previous years. This is especially true given CMS’s indication in the proposal that it will not finalize program requirements until Nov. 1, 2013 as part of the 2014 final physician fee schedule rule.

Under this “cart before the horse” approach, physicians will be measured in 2013 before the program rules are finalized later that year.

We understand the desire to measure and improve both the quality and efficiency of healthcare; however, we strongly believe more time is needed to test valid measures of cost and quality, as well as mechanisms that accurately adjust for risk, before moving forward with a program that modifies physicians’ payment based on CMS’s definition of value.

### **Payments for Services Provided During the Three-Day Window**

CMS proposes to pay for physician services using the facility (vs. non-facility) rate for the physician component of diagnostic services and for nondiagnostic services that: 1) are performed in the three days prior to an inpatient admission; 2) are related to the admission; and 3) are performed in a physician practice that is wholly owned or operated by the hospital. While CMS has stated that it is not sure how many physicians or groups will be affected by this proposal, those that are affected could face huge logistical and administrative burdens.

As proposed, CMS expects a hospital to notify a wholly owned or operated physician practice when a patient seen at the practice is subsequently admitted for an inpatient stay within three days of the office visit. Upon notification from the hospital, the physician practice would include a Healthcare Common Procedure Coding System (or HCPCS) modifier on its claim for the office visit, notifying CMS that this claim should be paid at the lower facility rate. The problem arises when the hospital and physician practice do not have a seamless line of communication that can immediately convey information about hospital inpatient admissions. If a practice submits a claim without receiving word from the hospital that its patient was subsequently admitted as an inpatient, the practice will not have had the opportunity to attach a modifier to its claim and will be paid at the higher, non-facility rate. If the practice does not learn of this omission immediately, it is in danger of keeping an overpayment from Medicare which, after 60 days, becomes a false claim subject to all the penalties of the False Claims Act as a result of Section 6402 of the Affordable Care Act. If the practice does become aware of the error, it will need to resubmit its claims and return the difference between the facility and non-facility rate to the government, a process that is not addressed in the proposed rule.

As relationships between hospitals and physician practices continue to evolve, there are countless forms that they can take. While a practice may be wholly owned and operated by a hospital, it may not share the same electronic infrastructure as or be geographically close to the hospital. Moreover, the business operations may not be structured so that hospital payments subsidize the supplies, equipment or staff of the practice, which is CMS’s justification for paying physicians at the lower facility rate. We urge CMS to reconsider this proposal due to the administrative burden it places on practices and potential False Claims liability they could face.

### **Hospital Discharge Care Coordination**

MGMA supports CMS’s efforts to ensure that payment for care coordination, particularly for a beneficiary transitioning from a hospital to the community, is adequately reflected in the value of codes used by physicians discharging patients from the hospital and those serving as the beneficiary’s primary physician in the community. Care coordination is an essential part of preventing adverse events. MGMA has pledged to support HHS’s Partnership for Patients and encourages CMS’s efforts to reflect those goals in its payment policies.

Donald Berwick  
August 30, 2011  
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MGMA appreciates your consideration of these comments and looks forward to collaborating with CMS to educate medical group practices on the numerous Medicare program changes. If you have any questions, please contact Anders Gilberg, senior vice-president for government affairs at (202) 293-3450.

Sincerely,

A handwritten signature in black ink, appearing to read "William F. Jessee". The signature is fluid and cursive, with a long horizontal stroke at the end.

William F. Jessee, MD, FACMPE  
President and Chief Executive Officer