MEDPAC Medicare Payment Advisory Commission

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August 31, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1590–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: File code CMS-1590-P

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission welcomes the opportunity to comment on the Center for Medicare and Medicaid Services (CMS) proposed rule entitled "Medicare Program; 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," published in the *Federal Register*, vol. 77, no. 146, pages 44722 to 45061. We appreciate your staff's ongoing efforts to administer and improve payment systems for physician and other services, particularly considering the competing demands on the agency.

Our comments address the following provisions in the proposed rule:

- Resource-based practice expense relative value units (RVUs)
- Potentially misvalued services under the physician fee schedule
- Therapy services
- Primary care and care coordination
- Physician value-based payment modifier and the physician feedback reporting program

Resource-based practice expense relative value units

Part of Medicare's payments for physician services reflect the costs incurred by physicians in running a practice. These costs—also known as practice expenses—include nonphysician staff, medical supplies, medical equipment, rent, utilities, and other overhead costs. In estimating the per service cost of medical equipment, CMS makes assumptions about how frequently the equipment is operated, its purchase price, the interest rate paid by practices when borrowing money to buy the equipment, and other factors. Since 1998, CMS has assumed that practices pay an interest rate

of 11 percent, despite changes in market conditions. This assumption is based on data from 1997 and 2007 from the Small Business Administration (SBA).

CMS proposes to change the interest rate assumption for 2013. The agency would use a sliding scale approach based on the current maximum SBA interest rate for different categories of loan size and maturity. Rather than a uniform interest rate of 11 percent for all types of equipment, CMS proposes to use interest rates that range from 5.5 percent to 8 percent, depending on the price and useful life of each type of equipment. For example, CMS would assume an interest rate of 5.5 percent for a piece of equipment that costs $50,000 and has a useful life of less than 7 years based on the SBA maximum rate for fixed rate loans of $50,000 or more with a maturity of less than 7 years. CMS also proposes to update the interest rate assumption annually based on newer data.

This proposal would reduce the estimated per service cost of medical equipment, which would reduce practice expense RVUs for services that use expensive equipment, such as computed tomography (CT) machines. For example, the estimated per service cost of a CT machine for CT of the abdomen and pelvis, with and without contrast (CPT code 74178), would be 12 percent lower in 2013 than 2012 ($189 in 2013 compared with $214 in 2012).

Comment

We support CMS's proposal to use more accurate interest rate information because this will improve the accuracy of practice expense payment rates and redistribute dollars from overvalued codes to undervalued codes.

Potentially misvalued services under the physician fee schedule

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

Identifying, reviewing, and validating RVUs of potentially misvalued services

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

To meet these requirements, CMS has established a process that includes input from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) and others. As discussed in the proposed rule, CMS identifies potentially misvalued services for review and requests recommendations from the RUC and other public commenters on revised work RVUs and practice expense inputs. In addition, the RUC identifies potentially misvalued services through its own processes, and other individuals and stakeholder groups nominate services for review. CMS states in the proposed rule that since 2009 it has used this process to review over 1,000 services.

As a next step, CMS is considering review of more services, selected in response to specific concerns about payment accuracy. For example, the agency is seeking comments on methods for obtaining accurate and current data on evaluation and management (E&M) services furnished as part of global surgical services. This request responds to findings of the Office of the Inspector General (OIG) that the RVUs for certain global surgical services they examined (eye and musculoskeletal procedures) are too high. According to the OIG, the RVUs include the work of E&M services that are not typically furnished within the global periods for the reviewed procedures.

As another example of review of selected services, CMS is proposing to adjust the procedure time assumptions for two radiation therapy services: intensity modulated radiation therapy and stereotactic body radiation therapy. These adjustments would make the services' assumed procedure times consistent with information available to the general public—from the American Society for Radiation Oncology, the American College of Radiology, and others—on the typical duration of each procedure. (The Commission's comments on this proposal are discussed later in this letter.)

The proposed rule is almost silent, however, on the statutory requirement that the Secretary validate the fee schedule's work RVUs. The rule notes that CMS intends to enter into a contract for assistance in validating the RVUs of potentially misvalued services. No details are provided except for mention of a model to validate work RVUs of both new and existing services. CMS plans to discuss this model further in future rulemaking.

Comment

While the Commission supports CMS's continuing efforts to identify and review potentially misvalued services, we are concerned about the pace of the agency's progress toward validating the fee schedule's work RVUs. As discussed in our June 2011 report to the Congress, it is particularly important to validate the fee schedule's estimates of the time that physicians and other health professionals spend when furnishing services. Even though the estimates explain most of the variation in the work RVUs, the process for developing the estimates relies on surveys conducted by physician specialty societies. Those societies and their members have a financial stake in the process.

After working with two contractors to consider alternatives, we believe that CMS could establish time estimates with data collected from a cohort of physician offices and other settings where physicians and other health professionals provide care. The data will not be collected easily,

however, if the decision is made to collect data on the time practitioners spend on each discrete billable service. Nonetheless, as discussed below, there may be approaches to collecting data that reduce the burden for CMS and practitioners and that make the effort feasible.

The data collection activity we have considered could also be used to ensure the accuracy of the fee schedule's practice expense RVUs. There are two data problems in developing and updating these RVUs. First, the practice expense RVUs rely in part on information about the prices practitioners pay for equipment and supplies, and CMS does not have a data source that allows for regular updating of these prices. Second, the practice expense RVUs also rely on data obtained from a survey on total practice costs incurred by practitioners, and CMS has not articulated a strategy for keeping the survey data up to date. Our conclusion is that it is feasible to collect practice expense data while collecting data to replace the time estimates for the work RVUs.

In the Commission's October 2011 letter on moving forward from the sustainable growth rate (SGR), we recommended that the Congress direct the Secretary to regularly collect data for the fee schedule—including service volume and work time—to establish more accurate relative value units (RVUs) for the work of physicians and other health professionals and for practice expense. One option for collecting the data is to do so service by service, a bottom-up approach. For example, in the case of data to validate the fee schedule's time estimates, the data would represent time in three segments typical of most services: pre-service (e.g., review of patient's medical history before seeing the patient), intra-service (e.g., perform physical examination), and post-service (e.g., complete medical record documentation). The difficulty with this approach is that it may require direct observation, or time-and-motion studies. Alternatively, detailed data from electronic systems such as electronic health records (EHRs) may be needed.

Based on the work of a Commission contractor, it would be very difficult to collect time and other data service by service ("bottom-up").[1] Direct observation does not seem to be a viable national strategy due to cost, time to develop the necessary methods, and the potential for bias due to the Hawthorne effect. Electronic systems may have potential, but collection of time data has not been a major focus of developers of these systems. Our conclusion is that a bottom-up approach would be burdensome for providers and CMS, potentially biased, and very costly. Because of the burden and cost, it is unlikely that the approach could be implemented with any frequency.

The other option is more "top-down," with the physician or other health professional as the unit of analysis. Practices would submit two types of data:

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

[1] Braun, P. and N. McCall. 2011. *Improving the accuracy of time in the Medicare physician fee schedule: feasibility of using extant data and of collecting primary data*. A white paper prepared for the Medicare Payment Advisory Commission by RTI International. Research Triangle Park, NC: MedPAC; and Braun, P. and N. McCall. 2011. *Methodological concerns with the Medicare RBRVS payment system and recommendations for additional study*. A white paper for the Medicare Payment Advisory Commission by RTI International. Research Triangle Park, NC: MedPAC. Reports available at http://www.medpac.gov.

In addition, a top-down approach would give the Secretary sufficient data to assess the validity of the current RVUs and possibly to change RVUs. Based on the work of a contractor to develop this approach, we believe it has advantages over the bottom-up alternative.[2] Compared to bottom-up, a top-down approach has advantages that outweigh the alternative: it would be less burdensome, it would not be subject to bias from the Hawthorne effect, and it would be less costly, thereby permitting its more frequent use. If issues of methodology or data accuracy arise, information can be provided to the RUC for a more detailed assessment.

The Commission is aware that collection of data to establish more accurate RVUs would require additional resources and made the point in our June 2011 report to the Congress. We urge CMS to support the recommendation and to seek the necessary resources from the Congress.

Review of services with stand-alone practice expense procedure time

For codes that do not have physician work, such as many radiation therapy and imaging services, the amount of time assigned to the code is based on the estimated time that it takes clinical staff to perform the service. These time estimates are used to determine the clinical staff and equipment resources for each service, which are then used to calculate practice expense RVUs. CMS calls services that do not have physician work "codes with stand-alone practice expense procedure time." CMS states that these codes have not been examined with the same level of scrutiny by the RUC and CMS as codes that have physician work but recognizes that they should be.

For the proposed rule, CMS has reviewed and proposed changes to the amount of time allocated for clinical labor and equipment for two radiation treatment services: intensity modulated radiation therapy (IMRT) delivery services (CPT code 77418) and stereotactic body radiation therapy (SBRT) delivery services (CPT code 77373). These services are considered stand-alone practice expense procedure time codes because they do not have physician work (other codes are used to bill for the physician work involved in planning and managing radiation treatment). The practice expense RVUs for these codes are primarily based on the time allocated for clinical labor and equipment.

The current time estimate for IMRT is 60 minutes, which is based on recommendations from the RUC about the typical treatment time. However, CMS has identified public information indicating that the IMRT sessions are typically 10 to 30 minutes. According to a patient fact sheet published by the American Society for Radiation Oncology, each session of external beam radiation therapy, including IMRT, takes about 15 minutes. In addition, a patient website cosponsored by the American College of Radiology (ACR) and the Radiological Society of North America (RSNA) states that IMRT sessions usually take between 10 and 30 minutes. Based on this information, CMS proposes to reduce procedure time for IMRT from 60 minutes to 30 minutes, which is the high end of the range of estimates from the professional societies. We estimate that this change, along with the proposed change to the interest rate assumption for equipment discussed earlier and

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

the proposed new discharge transitional care management code would reduce RVUs for IMRT by 34 percent.

Similarly, CMS found information indicating that the current time estimate for SBRT is too high. The current time estimate for SBRT is 90 minutes, which is based on recommendations from the RUC about the typical treatment time. However, public information indicates that SBRT sessions are typically no longer than 60 minutes. For example, the ACR and RSNA website states that SBRT sessions can take up to one hour. Based on this information, CMS proposes to reduce procedure time for SBRT from 90 minutes to 60 minutes. We estimate that this change, along with the proposed change to the interest rate assumption for equipment discussed earlier and the proposed new discharge transitional care management code would reduce RVUs for SBRT by 26 percent.

In proposing these changes to radiation treatment services, CMS recognizes the importance of using more accurate information to correct large overestimates of procedure time. CMS also cites a Commission report that states that the payment rates for rapidly-growing services that use newer technologies, such as IMRT, may need to be reexamined.[3] Further, CMS notes that articles in the *Wall Street Journal* and *Washington Post* have drawn attention to the possibility that inappropriate payment rates for IMRT create financial incentives to increase use.

CMS believes that other services with stand-alone practice expense procedure time may also be overvalued, and proposes to review these codes in the future. CMS would prioritize for review codes that have annual allowed charges of $100,000 or more, include equipment inputs of $100 or more, and have procedure time greater than 5 minutes. Several radiation treatment delivery codes (such as CPT code 77280, set radiation therapy field) meet these criteria. However, CMS would exclude from review diagnostic imaging services that meet these criteria if the physician fee schedule (PFS) payment rates for the technical component of these services are capped at the amount paid under the hospital outpatient prospective payment system (OPPS). Several MRI, nuclear medicine, and CT services meet CMS's criteria but are subject to the OPPS cap and therefore would not be reviewed.

Comment

Medicare has a responsibility to pay accurately for physician services. This responsibility includes identifying misvalued codes and making appropriate adjustments to such codes. CMS has identified credible evidence that the current procedure time estimates for IMRT and SBRT services are too high. CMS should implement its proposal to reduce the time estimates for these codes on the basis of this new evidence. If the RUC and other stakeholders object to these changes, they should provide objective, valid evidence to CMS that the agency's proposed time estimates are too low. The physician surveys that the RUC generally uses to develop time estimates are conducted by physician specialty societies, which have a financial stake in the process. Therefore, the RUC should seek evidence other than the surveys conducted by specialty societies. As long as FFS remains an important mechanism for Medicare payment to providers, CMS may need to regularly

[3] Medicare Payment Advisory Commission. 2010. *Report to the Congress: Aligning incentives in Medicare* .

collect data on service time and other variables to establish more accurate RVUs for practice expense and physician work.

In addition to recommending that CMS identify overpriced services, the Commission has also recommended that CMS and the RUC accelerate efforts to combine into a single payment rate multiple discrete services often furnished together during the same encounter.[4] IMRT and image guided radiation therapy (IGRT) are typically used together.[5] The position of the radiation beam is adjusted with IGRT prior to every treatment, and the intensity of the beam is modulated with IMRT once the treatment begins. IGRT is growing rapidly. While units of service for IMRT went up by 4 percent from 2009 to 2010, during the same period units of service for stereoscopic x-ray IGRT (CPT 77421) went up by 18 percent and units of service for CT IGRT (CPT 77014) went up by 30 percent. IGRT services account for a substantial amount of Medicare spending: $211 million in 2010. Given the growing importance of IGRT as an integral part of IMRT, CMS should request that the CPT Editorial Panel create a bundled code for these services and that the RUC recommend a value for the new bundled code. The value for the bundled code should reflect efficiencies that occur when the two services are performed together.

Because services with stand-alone practice expense procedure time other than IMRT and SBRT may be overvalued, we support CMS's proposal to review other services with stand-alone procedure time in the future. Given Medicare's high spending on diagnostic imaging services, we encourage CMS to include imaging services that are subject to the OPPS cap in this review. However, CMS proposes, without explanation, to exclude these services from its review. The time estimates of several high-priced and high-expenditure imaging codes have not been reviewed by the RUC since 2002 or 2003 and may be too high. The Commission has noted that recent advances in CT and MRI machines have made it possible to scan patients faster.[6] Even providers who are using older equipment could be performing studies in less time as they become more familiar with the procedures and equipment.

Expanding the multiple procedure payment reduction policy

When outpatient therapy or surgical services are furnished to the same patient on the same day, Medicare reduces payments for the second and subsequent procedure to account for efficiencies in practice expense and physician work. Similarly, Medicare reduces payments for the professional component and technical component of multiple imaging studies that are performed in the same session (the technical component includes the cost of the nonphysician staff who perform the test, medical equipment, medical supplies, and overhead expenses; the professional component includes the physician's work involved in interpreting the study's results and writing a report). This policy

[4] Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the Health Care Delivery System*.
[5] Ip, S., T. Dvorak, W. W. Yu, et al. 2010. *Technology assessment: comparative evaluation of radiation treatments for clinically localized prostate cancer: an update.* A report prepared for the Agency For Healthcare Research and Quality by the Tufts Evidence-based Practice Center. Rockville, MD: AHRQ.
[6] Medicare Payment Advisory Commission. 2009. *Report to the Congress: Medicare Payment Policy.*

applies to CT, MRI, certain ultrasound, and nuclear medicine studies but not other types of imaging.

CMS proposes to expand this policy—called the multiple procedure payment reduction (MPPR)—to cardiovascular and ophthalmology diagnostic procedures that are not currently subject to the MPPR. CMS found that these tests are frequently furnished to the same patient on the same day. For example, a type of nuclear medicine study (heart muscle image (SPECT), multiple) is frequently billed with cardiovascular stress tests. When these diagnostic tests are performed together, most of the clinical labor activities—such as greeting and gowning the patient, preparing the room and equipment, taking the patient's history and vitals, and cleaning the room— are not furnished twice. However, the clinical labor time estimates for these tests assume that each test is furnished independently and do not consider efficiencies related to performing tests in the same session.

Therefore, when multiple cardiovascular or ophthalmology tests are provided by the same physician (or physicians in the same group practice) to the same patient on the same day, CMS is proposing to pay the full amount for the technical component of the higher-priced test but reduce the payment amount for the technical component of the lower-priced test by 25 percent. This proposed reduction is based on CMS's analysis of the efficiencies in practice expense that occur when these diagnostic tests are furnished in the same session. The savings from this policy would be redistributed to other physician fee schedule services. CMS does not propose to reduce the payment amount for the professional component of cardiovascular and ophthalmology tests that are performed together.

Comment

We support CMS's proposal to expand the MPPR to cardiovascular and ophthalmology diagnostic services that are not currently subject to the MPPR. The Commission recommended expanding the MPPR to both the technical component and professional component of all imaging services to account for efficiencies in practice expense and physician work that occur when multiple studies are performed in the same session.[7] If other types of diagnostic tests have efficiencies when they are provided together, Medicare's payments should be reduced to account for efficiencies in practice expense and physician work. CMS proposes to apply the MPPR to the technical component—but not the professional component—of cardiovascular and ophthalmology diagnostic tests. We encourage CMS to examine whether there are efficiencies in physician work that occur when multiple tests are provided in the same session that would justify applying the MPPR to the professional component of these services. For example, when multiple tests are performed together, certain physician activities (such as reviewing the patient's medical records and discussing the findings with the referring physician) are likely to occur only once.

In last year's proposed rule, CMS asked for comment on whether it should apply the MPPR to the technical component and professional component of *all* imaging services based on expected

[7] Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the Health Care Delivery System*; Medicare Payment Advisory Commission. 2005. *Report to the Congress: Medicare Payment Policy.*

efficiencies in practice expense and physician work (the MPPR currently applies to CT, MRI, certain ultrasound, and nuclear medicine studies). As we stated in our comment letter on last year's proposed rule, the Commission supports expanding the MPPR to both the technical and professional components of *all* imaging services to account for efficiencies in practice expense and work that occur when multiple studies are performed in the same session. Our recommendations to apply the MPPR to imaging services performed in the same session were not limited to specific imaging codes. Given that there are efficiencies when CT, MRI, certain ultrasound, and nuclear medicine studies are provided together, it is reasonable to expect that similar efficiencies occur when other imaging services (e.g., other ultrasound, X-rays, and fluoroscopy) are furnished in the same session. CMS should expand the MPPR to additional imaging services and should apply this policy to both the technical and professional components to maintain consistency between the two portions of an imaging study.

CMS also asked for comment in last year's proposed rule on whether it should apply the MPPR to the technical component of all diagnostic tests (beyond imaging services). To address CMS's request for comment, we examined Part B claims data from 2010 to look for diagnostic tests that are frequently performed more than once on the same date for the same patient by the same physician; such tests could be included in the MPPR policy or combined into a bundled code. We found that several surgical pathology codes are frequently billed with more than one unit of service on the same date. For example, one-third of the claims for CPT code 88305 (Level IV, surgical pathology, gross and microscopic examination) contained more than one unit of service for that code. In addition, 57 percent of the claims for CPT code 88342 (immunohistochemistry, each antibody) contained more than one unit of service for that code. In these cases, it appears that multiple specimens from the same patient were examined at the same time by the same pathologist. CMS should analyze whether there are efficiencies in practice expense or physician work that occur when multiple units of the same test are performed at the same time. If so, CMS should consider applying the MPPR policy to these services or creating bundled codes that include multiple units of the same test. These services account for a substantial and growing amount of Medicare spending: in 2010, Medicare spent $1.3 billion on CPT code 88305 and $241 million on CPT code 88342.

Medicare outpatient therapy services

CMS has requested comments on the proposed collection of data on functional limitations on outpatient therapy claims. This policy is in response to a statutory requirement in the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRAJCA). Currently, CMS does not collect information on patients' functional levels or the severity of their illness at any point during the course of therapy. The proposal aims to address this limitation by collecting functional status at three separate points using non-payable G-codes: at the outset of the episode, at a specified point during the episode, and at discharge. CMS also proposed a 12-point scale of modifiers to indicate the level of impairment. For example, one modifier code would indicate 0 percent impairment; the next would indicate 1 percent to 9 percent impairment; then 10 percent to 19 percent impairment and so on. By tracking functional limitations during an episode, CMS believes, there would be information on outcomes that when combined with clinical diagnoses would facilitate payment reform for outpatient therapy services. CMS is mandated to implement this data collection effort

by January 1, 2013, and has proposed a testing period that will last through June 30, 2013. From July 1, 2013, claims without newly proposed G-codes will not be paid.

Comment

The Commission has not made formal recommendations on the collection of functional status data. During this fall, the Commission will evaluate—as part of our mandate in MCTRAJCA—approaches to improve the outpatient therapy benefit to better reflect the condition and therapy needs of the patient, and we anticipate addressing the collection of functional status data as part of that work.

While the collection of functional status data is a positive step in principle, it is important to start this process with a standardized approach to clinical assessment of function and improvement on the same patient over time. We have several concerns with the proposed approach to measuring functional limitations.

The collection of generic G-codes to assess function—without a standardized tool— would generate large amounts of data, and not provide clear information on patients' limitations or functional status. The lack of a standard measurement tool could introduce heterogeneity in how patients are assessed and classified. It is conceivable that a physical therapy patient deemed to perform walking and moving activities with 40 percent impairment using one tool by a particular therapist, could be judged as 60 percent impaired using another tool by another therapist. This variation would potentially impede the utility of such data for policymakers. Further, the multi-step approach CMS outlined to convert patients' scores using multiple assessment tools to CMS's proposed scale seems burdensome and unrealistic. As discussed in our June 2006 report to the Congress, standardized measurement of function would help CMS design a payment system that encourages efficient use of resources while achieving good outcomes.

CMS should consider developing an instrument that collects the necessary information that would allow Medicare to categorize beneficiaries by condition and severity in order to pay appropriately. Currently, there are various tools with which to measure functional status among outpatient therapy beneficiaries, but a lack of consensus around a specific tool. In addition, CMS believes it is constrained in endorsing a specific tool since many are proprietary. Most existing tools collect similar information about affected body functions (e.g., mental, hearing, gait), relevant body structures (e.g., lumbar region, hip, tongue), and the specific limitations in activities and participation (e.g., communication, carrying/lifting objects, walking/moving). Many tools also collect data such as age, sex, number of diagnoses, and medications. We believe that an instrument with a limited number of such variables could help explain and differentiate the costs of providing outpatient therapy to different categories of patients.

One page from the CMS study, Developing Outpatient Therapy Payment Alternatives (DOTPA), where CARE tools for outpatient therapy are currently under study captures much of this information. The Reason for Therapy form is concise, easy to assess and document for clinicians, and collects information on function and limitations across the three therapy disciplines. CMS should consider adding demographic items, and refining this page from the CARE tool as a

starting point for a common assessment. Adoption of such a concise assessment tool would imposes limited additional burden on clinicians who would ordinarily collect this information as part of their practice. The adoption of a uniform tool to measure and report functional status and complexity to CMS does not prevent the use of other tools clinicians currently use for care planning.

Primary care and care coordination

The rule proposes to establish a new HCPCS code on the fee schedule for use by community-based physicians treating a patient recently discharged from an inpatient hospital stay, a SNF, partial hospitalization, or a hospital observation stay. This proposed post-discharge transitional care management code would cover 30 days of post-discharge care coordination services provided by a community physician or qualified nonphysician practitioner. The transitions code itself would not require a face-to-face visit within the 30-day timeframe, but CMS proposes that only a provider who had an E&M visit with the beneficiary either 30 days before the hospital or SNF admission or 14 days after discharge would be eligible to bill for the new code.

The proposed rule describes the new transitions code as intended to reimburse community-based providers for care coordination services, but the proposed billing criteria also allow it to be billed by both community-based and hospital-based providers. While any eligible practitioner could bill for the code, only one code may be billed for a given beneficiary within a 30-day post-discharge period. The care management services reimbursed through the new code may actually be furnished by clinical staff or office-based case managers who are under the supervision of the community-based physician or other type of practitioner who is allowed to bill under the physician fee schedule.

Comment

The Commission strongly supports CMS's focus on improving care coordination and facilitating transitions between settings. Transitions are of critical importance for the Medicare program because of the danger they pose to frail and vulnerable beneficiaries. The Commission also feels that the work done by primary care clinicians is critical in supporting the care coordination that currently occurs.

The Medicare program should expect that a clinician receiving payment for post-discharge management of a beneficiary assumes all responsibility in the post-discharge period, including: talking with the patient and their families, scheduling and conducting follow-up visits; assessing the beneficiary's medical and psychosocial needs, and establishing, updating, and participating in the beneficiary's plan of care. Furthermore, a clinician furnishing post-discharge care coordination services would also need to coordinate with hospital-based physicians and clinicians as well as other community resources.

The Commission is concerned that the proposed care transitions code is not defined in a way that would meet this threshold. While the proposed rule highlights the importance of primary care clinicians, there is nothing to limit the billing of the code to only those clinicians providing

comprehensive primary care to the beneficiary. Under the proposed rule the code could be billed by any physician of any specialty, with only limited or no prior contact with the beneficiary. Because the proposed billing rules for the code itself do not require a face-to-face visit, beneficiaries may not be aware that a clinician is billing for coordinating their care, and wouldn't know that they (or a family member) should seek care coordination assistance from that clinician.

Of more promise, in the Commission's view, are proposals to improve payment for clinicians who provide comprehensive primary care to a beneficiary over a sustained period time, across care settings, and holistically across acute and chronic health conditions. These approaches could include supplemental payments to primary care clinicians meeting certain quality standards and care delivery capabilities, or other models of payment reform that use financial incentives to improve quality and cost. Within the existing physician fee schedule, there may be a role for a targeted transitions code, but it should be targeted more narrowly and be broader in scope than that proposed by CMS. The Commission has the following specific comments on the proposed code:

As proposed, the new code would not be well-targeted to community providers with an established relationship with the beneficiary

CMS proposes to allow physicians and other eligible practitioners in all specialties and all settings to bill for the new code. The only linkage between the provider and the beneficiary established in the proposed rule is that the provider must have billed for an E&M visit that occurred in the 30 days prior to admission **or** the 14 days following discharge. This rule would not ensure that only those clinicians who are truly providing post-discharge care coordination can bill for the code. The rule's proposal that the Medicare program would pay the first claim received means that the provider billing for the code may not necessarily be doing the largest share of the coordination.

For example, a clinician considering whether to admit a patient may schedule an E&M visit with them that results in an admission to the hospital, and be able to bill for 30 days of transitional care even if there was not a longstanding relationship with the beneficiary and the purpose of the E&M visit was solely to decide to admit the beneficiary. If the beneficiary has a primary care physician in the community who in fact provides the majority of care coordination for the beneficiary, but the admitting physician bills for the code immediately after a hospital discharge (for an admission that the community physician may not even be aware took place), the community physician will not get reimbursed for his or her ongoing care coordination services.

In order to ensure that the physician who bills for the care coordination code has at least some degree of continuing relationship with the beneficiary and so the beneficiary knows which clinician is coordinating their care after an inpatient discharge, CMS could require that the billing provider must have billed for an E&M visit (that is, a face-to-face visit) that took place within the 30 days prior to admission **and** within the 14 days following discharge.

As proposed, the new code may duplicate payment for care management services under global surgical fees

Medicare's payments for procedures with 10- or 90-day global surgical periods currently include follow-up visits that are related to recovery from the surgery, complications from the surgery, and pain management. The global surgical fee policy recognizes that the clinician's interaction with the

beneficiary doesn't end when they are discharged from the hospital. The proposed care transitions management code would duplicate some of these services that are included within the global surgical fee. While under the proposal the surgeon who bills for the global surgical fee cannot also bill for the care transitions code, other physicians may bill for it during the global surgical period, which would result in two payments covering about the same timeframe after the same hospitalization.

Physician value-based payment modifier and the Physician Quality Reporting System

CMS is required by statute to establish a value modifier starting in 2015. The statute is prescriptive. The value modifier must provide for differential payment under the physician fee schedule to a physician or group of physicians based on the quality of care furnished to Medicare beneficiaries compared to the cost of that care. It must be applied to specific physicians and groups of physicians in 2015 and apply to all physicians and groups of physicians by 2017. It must be budget neutral.

In the 2013 proposed rule, CMS proposes to apply the value modifier in 2015 to physicians practicing in groups of 25 or more eligible professionals. These groups would fall into two categories. The first are those physician groups who do not satisfactorily participate in the Physician Quality Reporting System (PQRS). These physician groups would receive a value modifier of -1.0 percent. This reduction would be in addition to the current law penalty for not participating in PQRS in 2015 of -1.5 percent.

The second group consists of those physician groups that meet the requirements to satisfactorily participate in PQRS. The proposed rule outlines five ways that a physician group can satisfactorily participate: the group practice reporting option; the enhanced claims-based option; the EHR option; the registry option; and a new administrative claims-based option. The last option poses the lowest barrier for physician groups—groups would tell CMS that they elect this option, and CMS would attribute patients to the group and calculate a number of claims-based quality measures for the group. In general, the enhanced claims, EHR, and registry options require a physician group to select and report on at least three quality measures from the list of measures specified by CMS, in order to satisfy the requirements for participation in the program.

Physician groups that satisfactorily participate in PQRS would receive a value modifier of 0 percent without further action required. If, however, the physician group wishes to be evaluated based on their cost and quality, they could elect a quality tiering approach to determine their value modifier. The proposed approach would assess the group's actual performance (as opposed to simply reporting) on their selected quality measures and on per-capita cost measures as compared to the national mean for each measure. The quality measures would be those that the group selected to report through PQRS, as well as four claims-based, population-level outcome measures which would be attributed to the physician group using an attribution rule. The cost measures would be five different types of per capita standardized cost measures, which also would be attributed to the physician group using an attribution rule. For both quality and cost attribution, CMS proposes to apply either a "plurality of care" or a "degree of involvement" attribution rule;

the former relies solely on the percentage of a beneficiary's office visits (measured by E&M codes) billed by the physician group, while the latter would be based on the percentage of office visits/E&M codes and the group's share of a beneficiary's total professional services costs. The per-capita cost measures would be risk-adjusted using the CMS Hierarchical Condition Categories (HCC) model. Under the proposed tiering approach, groups would get a positive, negative or zero value modifier depending on the alignment of their quality and cost relative to the national mean for their selected quality and cost measures.

Comment

Most of the Commission's concerns about the value modifier are concerns about the provision in the statute. As noted earlier, the statute constrains CMS to implementing a modifier that can be applied to groups of physicians or specific physicians and that applies to payments under the physician fee schedule. The Commission continues to believe that, in the long run, such an approach of relying on the current fee-for-service (FFS) payment system may be incompatible with the delivery of integrated, coordinated, and reliably high-quality care. Another way to pursue such a high-value health care system may be to apply payment incentives based on population-level outcomes, such as avoidable hospital admissions or emergency department visits within a hospital service area, and offer clinicians and hospitals the opportunity to avoid potential negative payment adjustments by opting into other payment systems, such as accountable care organizations (ACOs), medical homes, or other models where clinicians organize themselves into care delivery systems and accept financial responsibility for the holistic care of beneficiaries. For those clinicians remaining outside of such systems (that is, in FFS Medicare), Medicare could apply an outlier policy that penalizes physicians who deliver care using significantly more resources than their peers year after year. While the Commission has significant concerns about the statistical limitations of reliably measuring outcomes at the individual physician level, we have much more confidence in the ability of the Medicare FFS program to identify individual physicians who are persistent outliers in terms of resource use.[8]

As to the current proposal, we recognize the difficulties that CMS had to overcome to reconcile the statute's requirements. However, we do have three comments. First, the Commission's overarching concern with the PQRS and the value modifier stems from the fundamental challenges inherent in any effort to assess the performance of individual physicians and physician groups. Under the proposed framework, physicians receiving a payment adjustment are unlikely to understand why their payments are getting adjusted and what they need to do to improve their value modifier. For a pay-for-performance system to be effective, it must have clarity and credibility with front-line practitioners, and it must incorporate economic incentives of sufficient size and immediacy so that the motivation to improve quality and reduce costs is strong enough to change behavior.

Second, the PQRS includes a large number of measures—264 across all reporting mechanisms—as CMS attempts to ensure that physicians in all or almost all specialties have at least a few measures on which they can report and successfully participate in the program. Despite this considerable and

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

ongoing effort by CMS, specialty societies, and other stakeholders to develop measures—and all the resources that will need to be devoted to gathering, validating, and reporting on these measures—the Commission is concerned that many of the PQRS measures still do not address significant gaps in the quality of care for beneficiaries, either because they represent marginally effective care or capture care that most physicians should be doing. If the measures do not capture differences in quality that are clinically meaningful and that impact outcomes, a payment adjustment based on them will not be effective at improving the quality of care for beneficiaries. The Commission has emphasized that the Medicare program should focus on tracking a few key population-based outcome, patient experience, and clinical process measures.[9] We are concerned that the quality measurement approach embodied by most of the PQRS measures reinforces the fragmentation of care delivery under FFS Medicare.

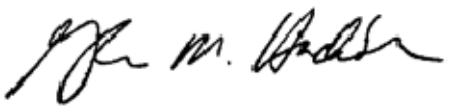
Third, for many physicians, there may not be enough patient encounters to produce robust measures of cost and quality, particularly in cases of the quality measures that capture relatively rare occurrences. In implementing the value modifier, CMS proposes to address this issue by establishing a statistical measurement threshold for applying the value modifier—that is, the modifier would be applied only if a physician group's performance on the quality and cost measures is statistically significantly different from the national mean. The Commission has supported the use of such an "outlier" approach for cost measures, as a reasonable way to identify physicians or groups with extraordinarily higher or lower costs than average.[10] Thus, we support CMS's proposal to apply the value modifier bonus or penalty only when a physician group's performance is statistically significantly different from the national mean.

Conclusion

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

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

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

[9] Medicare Payment Advisory Commission. 2010. *Report to the Congress: Medicare payment policy.*
[10] Medicare Payment Advisory Commission. 2009. *Report to the Congress: Improving incentives in the Medicare program.*