



Sound Policy. Quality Care.

September 4, 2012

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

RE: CMS-1590-P Medicare Program; Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Part B for CY 2013

Dear Administrator Tavenner:

The undersigned members of the Alliance of Specialty Medicine (Alliance) are writing to share our comments on a number of provisions in the Medicare Physician Fee Schedule Proposed rule, published in the *Federal Register* on July 30, 2012. The Alliance is a coalition of 12 national medical specialty societies representing more than 200,000 physicians and surgeons. We are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. Below are some specific comments about the payment and quality provisions of the proposed rule that have a significant impact on specialty medicine.

SUMMARY OF COMMENTS

Payment Issues

- **Practice Expense (PE) for Low Volume Services**—The Alliance concurs with the American Medical Association/Specialty Society Relative Value Update Committee (RUC) concerns about the difficulty of establishing PE values for CPT Codes reported for Medicare fewer than 100 times in a year. We urge CMS to seek input from the appropriate dominant specialties for these codes, similar to the policy established by CMS in 2011 for Professional Liability Insurance for low volume services.
- **Device Tax Impact on Practice Expense for Physicians** – The Alliance remains concerned about the forthcoming federal excise tax on medical devices as required by the ACA. Specifically, we are quite concerned that medical device and other suppliers will pass this cost on to purchasers of these products, which include health care facilities and physicians.
- **Multiple Procedure Payment Reduction (MPPR)**—The Alliance strongly opposes the application of the MPPR to the technical component for diagnostic cardiovascular and ophthalmology services when these services are furnished by the same physician/physician group to the same patient on the same day finding that these services are not commonly performed together and CMS' assumptions in regards to potential efficiencies in staff time and tasks are completely inaccurate resulting in a flawed methodology in the calculation of potential efficiencies for these services.
- **Evaluation and Management Services in the Global Surgical Period**—The Alliance believes that the CMS goal of assuring appropriate valuation of work in the global surgical period will be accomplished as the RUC continues to review high volume codes that have not been previously RUC-reviewed.

- **Care Coordination Services**—The Alliance feels the agency has overstated the likely utilization for coordination of its proposed new code for Transitional Care Management (TCM). We recommend that CMS consider the work of the CPT and RUC in establishing payment for care coordination services and that specialties other than primary care be eligible to use the new code if they provide the required services.
- **Advance Primary Care Practice (Medical Home)**—The oversight and evaluation of any expansion to a national payment for a “medical home” practice is essential. Inaccurate assumptions about savings and an overstatement of the benefit provided can prove unproductive at a time when the Medicare program is struggling to implement many new initiatives. In addition, we feel that non-primary care specialties that meet the definition of a medical home should be eligible for participation.
- **CRNA Provision of Pain Management Services**—The Alliance is concerned the proposed new national policy which expands the ability of Certified Registered Nurse Anesthetists (CRNA) to provide chronic pain management services without the supervision of a physician.

Summary of Alliance Recommendations for the Value-Based Payment Modifier and the Physician Feedback Reporting Program:

- **Re-evaluate decision to use 2013 as the basis of the initial 2015 VBPM adjustment. Increase provider awareness of and education for the VBPM and Physician Feedback Program.**
- **Recognize additional quality improvement activities, including those not sponsored by the federal government.**
- **Enhance VBPM and the Physician Feedback programs with meaningful quality metrics for specialty physicians.**
- **Further evaluate cost measurement methodologies prior to widespread implementation.**
- **Improve risk adjustment methodologies.**
- **Focus only on high-priority conditions in the National Quality Strategy (NQS) and the specialties that treat and manage those conditions during the initial stages of the VBPM program.**
- **Improve quality and format of feedback reports.**
- **Provide a mechanism for interpretation of feedback reports and meaningful dialogue between physicians, specialty society staff and CMS.**
- **Adopt a Corrective Action Plan, or similar program, for outliers/poor performers prior to applying the payment adjustment.**

Detailed Comments: Payment Provisions

Practice Expense for Low Volume Services

We support the RUC position to maintain the use of the dominant specialty for Practice Expense (PE) for low volume codes. Under its PE methodology, CMS proposes to calculate the specialty mix for low volume services (fewer than 100 billed) using the same methodology for non-low volume services. CMS currently uses the dominant specialty for these services. The change would inappropriately disadvantage the true specialties that perform these services by accounting for billing errors in the reporting of these low volume codes. We support the RUC’s longstanding policy that for infrequently performed services (defined as fewer than 100 per year by the RUC), Medicare claims data should not be utilized. In 2011, CMS modified its professional liability insurance methodology to use only the dominant specialty in the claims data, at least eliminating some of the inherent anomalous claims that have significant impact on low volume codes.

CMS should revise its policy concerning low volume services and continue to seek specialty society input into the appropriate dominant specialty.

Device Tax Impact on Practice Expense for Physicians

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

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

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

Multiple Procedure Payment Reduction (MPPR) – Low/No Potential for Efficiencies

The Alliance strongly opposes CMS proposal to apply a 25 percent multiple procedure payment reduction (MPPR) to the technical component of certain diagnostic cardiovascular and ophthalmology services when these services are furnished by the same physician/physician group, to the same patient, on the same day. CMS' selection of the services to apply this MPPR is questionable as these services are not found to be commonly performed together and the assumptions made by CMS in regards to potential efficiencies in staff tasks and time are completely inaccurate resulting in a seriously flawed methodology in the calculation of potential efficiencies for these services

The diagnostic services selected are not commonly performed together as CMS has asserted. The AMA RUC has closely examined the frequency at which the identified services are billed together and has found that only a handful of the possible code pairs are typically reported together with all the other possible codes pair combinations being "reported together at or below 40 percent of the time, with over half below 20 percent."

In evaluating for potential efficiency in the technical component in the performance of these diagnostic tests when provided by the same physician/physician group, to the same patient, on the same day - CMS made the false assumption that there would be no duplication of the following clinical staff activities: Greeting and gowning the patient, Preparing the room, equipment and supplies, Education and consent, Completing diagnostic forms, Preparing charts, Taking history, Taking vitals, Preparing and positioning the patient, Cleaning the room, Monitoring the patient, Downloading, filing, identifying and storing photos, Developing film, Collating data, QA documentation, Making phone calls, Reviewing prior X-rays, lab and echoes.

However, careful review of these clinical staff tasks associated with the performance of each of these diagnostic tests finds that there is a very low to absolutely no potential for economy and that these tasks typically would be duplicated for each discrete diagnostic test performed. For example, when two diagnostic test are provided, it is still necessary to complete separate diagnostic forms; download, file, and store separate data; develop separate film (when images are not digital); collate separate data; and engage in separate quality assurance activities; the task of "education and consent" by clinical staff would be duplicated for each diagnostic procedure performed. One cannot consent a patient for any and every procedure to be done to them in a given day – informed consent must be provided; requiring discrete education and consent to be provided for each diagnostic procedure performed.

The Alliance strongly opposes the application of the MPPR to the technical component for diagnostic cardiovascular and ophthalmology services when these services are furnished by the same physician/physician group to the same patient on the same day finding that these services are not commonly performed together and CMS' assumptions in regards to potential efficiencies in staff time and tasks are completely inaccurate resulting in a flawed methodology in the calculation of potential efficiencies for these services.

Evaluation and Management Services in the Global Surgical Period

We support CMS's plan to get better information before taking action on concerns raised by recent HHS Office of Inspector General (OIG) audits of evaluation and management (E/M) work in the global surgical period. The OIG reports are flawed in many ways. The number of claims for each individual service reviewed is low and the report only reviews the number, not the level, of the visit. Global surgical services are based on the typical patient and any individual case could include more or fewer visits. We note the possibility that E/M work is under-reported in the patient record, precisely because the codes are not separately reportable. This issue could be addressed with improved education about the importance of accurately documenting that the visits have taken place. As CMS has pointed out, the recently RUC-reviewed codes are clearer in terms of evaluation and management work and we believe the RUC is the appropriate venue to address the valuation of the global surgical package. At the request of CMS, the RUC is in the process of examining high volume and high expenditure codes that have not been previously reviewed. We believe that this review by the RUC is the most effective method of addressing the issue and believe that that improved education and the on-going RUC review of high expenditure codes that have not been previously reviewed will adequately address concerns about the appropriate valuation of global surgical services.

Primary Care and Care Coordination

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

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

In its proposed rule, CMS uses the term community physician and practitioner to refer to the community-based physician managing and coordinating a beneficiary's care in the post-discharge period. CMS states that it anticipates that most community physicians will be primary care physicians and practitioners. It is important to emphasize, however, that not all community physicians will be primary care physicians and practitioners. This is particularly true for patients who are discharged following the completion of complicated surgical procedures or after complex medical care directed by a subspecialty physician, many of which require the specialist's unique knowledge base in the post-discharge period. In summary, many other physicians manage and coordinate care for beneficiaries in the post-discharge period, and should thus also qualify as community physicians under the proposed rule.

CMS states that the post-discharge transitional care management service would include functions such as assuming responsibility for the beneficiary's care without a gap, establishing or adjusting a plan of care, and communicating with the beneficiary and/or caregiver. CMS also stresses the importance of ensuring that the community physician furnishing post-discharge transitional care management either have or establish a relationship with the patient. Any physician who provides the services identified under the transitional care program should be eligible to receive payment under the proposed HCPCS code. Accordingly, CMS should specifically state in the final rule that reimbursement may be made to any physician who performs the covered post-discharge transitional care services, including the surgeon who performs a procedure.

CMS also proposes that a physician billing for a procedure with a 10-day or 90-day global period would not bill the proposed HCPCS code in conjunction with that procedure because any follow-up care management would be included in the post-operative portion of the global period. Community physicians billing separately for the proposed discharge management code would be paid for post-discharge transitional care management through the discharge management code. However, this distinction ignores the difference between a treating physician and a surgeon. When a surgeon treats a patient for a particular disease state via methods that culminate in surgery, for example, the surgeon generally provides post-discharge transitional care and ongoing treatment. We seek to clarify that a surgeon who performs a procedure and continues treating the beneficiary post-discharge would be eligible for payment under the transitional care HCPCS code.

Significantly, permitting a surgeon to receive payment under these circumstances would not result in duplicate payment for the same service. The follow-up care management included under global codes applies to clinical management of the patient, which is distinct from the transitional care management services discussed in the proposed rule. Moreover, if follow-up care management included in the post-operative portion of a global period can be reimbursed separately from the proposed transitional care management code when performed by two different physicians, they should remain separately reimbursable when these functions are all performed by the same physician. In fact, permitting such payment advances CMS' goals of care coordination and establishing ongoing relationships with beneficiaries.

Medical Home

We urge CMS to proceed with caution as it considers the implementation of payment for complex chronic care coordination services, or "medical homes." Should CMS go forward with the TCM payment in 2013, a reasonable amount of time should be allowed to assess the impact of that change before implementing another new national program to pay a monthly fee to "advanced primary care practice environments," or medical homes. The RUC conducted extensive work on the issue of the medical home in 2008 and we would urge the agency to consider that work in the implementation of a new service for the coordination of care for patients with complex chronic conditions. In addition, we feel that non-primary care specialties that meet the definition of a medical home should be eligible for participation

CRNAs and Chronic Pain Management Services

We have deep concerns about the CMS proposal to change the language regarding the description of CRNA services. In the NPRM, CMS clearly states that some Medicare Administrative Contractors (MACs) have concluded that the statutory description of "anesthesia services and related care" does not encompass chronic pain services provided by CRNAs. Therefore, CMS proposes add regulatory language to define CRNA services to include "medical and surgical services that are related to anesthesia and that a CRNA is legally authorized to perform by the State in which the services are furnished." This is essentially a national directive for the MACs to cover chronic pain procedures provided by CRNAs, if they are covered when performed by physicians and legal for CRNAs in the state in which they are furnished. We feel the change in language is unnecessary and inadvisable. The evaluation and assessment skills required to treat chronic pain involve complex medical decision making and, as CMS has acknowledged, the field is rapidly evolving. Chronic pain is treated by many

physician specialties, and encompasses a wide variety of procedures, some of which involve surgical implantation of devices around the delicate structures of the spine and nerves. We feel expanding the language to add “surgical services” to the description of CRNA practice unnecessary reduces the ability for MACs to determine best quality pain services offered to a very vulnerable population of Medicare beneficiaries and inappropriately inserts the agency into the practice of medicine

Detailed Comments: Quality Improvement Provisions

Value-Based Payment Modifier and the Physician Feedback Reporting Program

The Alliance of Specialty Medicine (the “Alliance”) is concerned about the Value-Based Payment Modifier (VBPM) and the dissemination of Quality and Resource Use Reports (QRURs) as part of the Physician Feedback Program.

According to CMS, the value-based payment modifier is an important component in revamping how care and services are paid for under the PFS that has the potential to help transform Medicare from a passive payer to an active purchaser of higher quality, more efficient and effective healthcare. CMS proposes to initially apply the VBPM to group practices of 25 or more eligible professionals. In previous rulemaking, CMS finalized its decision to use 2013 as the basis of the initial 2015 payment modifier.

CMS proposes that group practices of 25 or more eligible professionals who satisfy the PQRS GPRO reporting requirements will receive a payment modifier equal to 0 percent in 2015. These groups will also be given the option to be measured under a quality tiering system through which they can earn a bonus payment for higher performance on a composite of cost and quality measures, but also would be at risk for a payment adjustment should they perform below the average national threshold. Group practices that do not satisfy the PQRS GPRO requirements, including those who do not attempt to participate, would receive an automatic 1.0 percent downward adjustment.

While the Alliance appreciates CMS’ proposal to initially apply the modifier only to larger group practices that are more likely to have the resources to report this data and the patient sample sizes to ensure more accurate calculations of “value,” we are concerned that CMS’ aggressive timeline for the implementation of yet another quality program will ultimately lead to undue confusion as well as significant financial and administrative burden for physicians. The confidential resource use feedback reports distributed to physicians to date under the earlier stages of this program demonstrate the breadth of unresolved challenges related to the measurement of physician resource use, attribution, and the adjustment of physician payments based on value. As a result, the Alliance urges CMS to delay the implementation of the VBPM system.

Finally, we make the following recommendations to improve the VBPM and Physician Feedback Programs. We urge CMS to carefully review and evaluate each of the below recommendations and collaborate with the Alliance to move these initiatives forward:

- **Re-evaluate decision to use 2013 as the basis of the initial 2015 VBPM adjustment.** CMS finalized its decision to base the 2015 VBPM on 2013 data in a prior rulemaking, despite significant opposition by the provider community. The Affordable Care Act (ACA) does not require or specify that CMS must use 2013 as the initial performance period nor does anything in the law require that the initial performance period be based on a calendar year or an entire 12 months. As the agency is aware, physicians currently face an onslaught of overlapping regulatory mandates and reporting requirements, many of which are also being “back-dated” (e.g., the PQRS, the e-Prescribing Incentive Program, and the Electronic Health Record (EHR) Incentive Program). Problems associated with the QRURs used in the Physician Feedback Program demonstrate the breadth of unresolved challenges related to measuring resource use and the application of the value-modifier. We maintain that premature implementation will only exacerbate these problems, creating further confusion among both patients and physicians while imposing additional financial and administrative burdens that will hinder, rather than

improve, quality. We ask CMS to re-evaluate its decision to use 2013 as the basis for applying the 2015 payment adjustor.

- **Increase provider awareness of and education for the VBPM and Physician Feedback Program.** Specialty physicians are largely unaware of the VBPM and the Physician Feedback Program. Despite attempts by Alliance member organizations to provide as much information and education about these programs as possible, challenges remain. Specifically, CMS only recently released a proposal for the VBPM, which will not be finalized until two months prior to the start of the program. This short timeframe for educating physicians on the “rules” so they can ready their practices for the tasks associated with participating in the VBPM, is almost impossible.

When considering participation in the PQRS as described in CMS’ most recent experience report, the agency shows that more than 1 million providers were eligible to participate in the 2010 PQRS, yet less than a quarter participated. This is a very low number given the program (including the PQRI and PVRP) has been in place since 2006. If education and awareness remain a factor for PQRS participation, we can only imagine how these same challenges will compromise the VBPM program.

In addition, the PQRS continues to be a voluntary program, though it is now punitive; the VBPM is not voluntary and is budget-neutral. Physicians do not have a choice about participation in the VBPM, therefore, awareness about and educational strategies to support engagement in the VBPM are critical.

Again, physicians will need as much time as possible to ready their practices in an effort to avoid yet another financial penalty, particularly if the timelines are not adjusted. The Alliance stands ready to assist CMS with educating specialty physicians about the VBPM.

- **Recognize additional quality improvement activities, including those not sponsored by the federal government.** Our current understanding about the VBPM program is that quality of care will be measured in part based on provider and/or practice participation in the PQRS program. Where providers and/or practices do not participate in the PQRS, CMS will use claims data to generate an assessment of the physician’s provision of quality care. Many specialty societies, private payers and other non-government entities have engaged specialists in a variety of quality improvement programs. In fact, the Alliance has collected information on the extent to which our member organizations are engaged in these non-government activities. Many of these programs have demonstrated themselves to be more meaningful to improving care and health outcomes for specialists and their patients, and as a result, have benefited from increasing physician participation.

Unfortunately, these diverse quality improvement activities are overlooked in the current methodology CMS uses to determine if a provider is a “high performer.” Participation in the PQRS is simply not a fair measure on which to evaluate quality. Further, the use of claims data to derive a quality score is unfair and inappropriate.

We recognize that it is difficult to formulate the perfect way to measure quality. Given that, we encourage CMS to recognize participation and engagement in other quality improvement activities, government-sponsored or not, as a means by which CMS could deem a physician as being a high quality performer. Examples might include participation in a society-sponsored registry (not necessarily tied to PQRS), maintenance of certification (MOC) (not necessarily tied to PQRS), private payer quality improvement programs, or any other well-organized, trackable quality improvement activity.

With the appropriate authority, CMS could create a process by which entities could seek “deemed” status so the providers who are engaged in those activities can avoid financial penalties associated with the VBPM, since their quality will be based on activities that are not necessarily tied to PQRS or arbitrary quality measures derived from claims. The Alliance welcomes the opportunity to discuss developing and implementing these ideas with you further.

- **Enhance VBPM and the Physician Feedback programs with meaningful quality metrics for specialty physicians.** CMS’ VBPM will adjust physician payments based on cost and quality. Quality will be determined based on PQRS reporting or by indicators of quality collected through claims data. This poses a number of concerns for specialty physicians.

First, many quality measures in the PQRS are not geared toward specialists. In fact, some specialties still do not have any relevant measures in the PQRS. In some cases, specialty measures have been developed and are available, yet CMS has opted not to include them in the PQRS for a variety of reasons, including lack of NQF endorsement. We encourage CMS to reconsider the inclusion of specialty specific measures in its program regardless of NQF endorsement.

Second, we are concerned that those providers who are currently not reporting through the PQRS will be measured based on arbitrary indicators of quality determined through claims data. The QRURs distributed by CMS in preparation for the VBPM demonstrate the breadth of unresolved challenges related to attributing and measuring individual physician quality and resource use. CMS should not rely on PQRS participation nor claims data alone for determining whether a physician provides high-quality care to beneficiaries. We urge CMS to consider our aforementioned recommendation that would give credit to those physicians engaged in other, non-government sponsored quality improvement activities.

- **Further evaluate cost measurement methodologies prior to widespread implementation. The QRUR reports create angst and confusion among specialists, particularly when it comes to cost measurement.** The cost analysis is currently based on total amount billed per patient, not by the treatment of the individual provider. As a result, the reports incorrectly assume that providers have control over other providers’ care plan and treatment decisions, and therefore, play a role in or are responsible for the total cost of care being provided to a patient. For example, an ophthalmologist managing a patient for an ocular health issue does not have control over a cardiologist who orders tests and manages the same patient for heart disease. However, the QRUR reports are currently constructed in a way that gives that impression.

Although Medicare is beginning to hold hospitals and ACOs accountable for the “value” of care, the same models cannot be easily applied to the individual physician. Physicians see far fewer patients than do hospitals, making statistically accurate assessments of care more difficult. Comparing specialists is especially challenging since some focus on specific types of patients that are inherently more costly. CMS needs to continue to further refine and test more accurate methodologies for comparing physician resource use before holding individual physicians accountable.

We encourage CMS to continue to refine episode-based measures, which, unlike per-capita measures, at least compare patients with similar procedures or conditions. CMS should also test other alternative attribution methods that may more accurately assess how a physician affects costs. For specialists, in particular, cost measures must account for care that was provided because a patient was referred to a specialist or because the original physician failed to take the right preventive steps to avoid more expensive treatments later on.

- **Improve risk adjustment methodologies.** The reports do not take into account patients with conditions that are challenging and costly to manage. For providers that take on those high-risk

patients, the reports incorrectly assume the care provided is excessive and the provider is deemed an outlier, when in reality, the provider's practice consists of riskier patients. In addition, the methodology should adjust for socioeconomic and education levels, as well as patient compliance, given these factors have been shown to influence care and outcomes.

- **Focus only on high-priority conditions in the National Quality Strategy (NQS) and the specialties that treat and manage those conditions during the initial stages of the VBPM program.** The QRURs and VBPM should focus on high-priority conditions included in the NQS in order to realize true cost savings and care improvements. Engineering the system to accommodate all conditions and all providers will result in a program that does not drive meaningful change.
- **Improve quality and format of feedback reports. CMS should modify the reports to highlight information relevant to individual specialists who will be receiving the reports.** One means by which CMS could do this would be to develop QRUR templates based on specialty codes. As you know, providers identify their specialty during the enrollment process, which would allow CMS to determine which QRUR template to use. To determine which measures to highlight for each specialty code, CMS could use the PQRS Experience Report to identify the specialty that frequently reports measures planned for inclusion in the QRURs and create a relationship between the specialty code and the measures. While not perfect, it would give providers more meaningful and useful information up front.

Additionally, those that have received a report to date found it to be long and cumbersome. We are challenged on what aspects should be eliminated, particularly since the explanatory language in the fore matter is useful to understanding the report. CMS could shorten some of the background and explanation details (i.e., an abbreviated version) and include a web link that would direct feedback report recipients to a website that would provide more robust information on interpreting the report.

Finally, CMS should include potential action items that might help the provider improve their performance on quality and resource use. Of course, these should not be formal recommendations or requirements, but rather useful tips that the provider might be able to employ that he/she had not considered previously or could not deduce based on the data in the report.

- **Provide a mechanism for interpretation of feedback reports and meaningful dialogue between physicians, specialty society staff and CMS.** Specialists that were able to access their QRUR found it to be extremely confusing and cumbersome. Their sense was that the data did not apply to them, and if it did, they could not make sense of the report, despite explanatory language in the fore matter of the report. If the QRUR recipients wanted to learn more about the QRUR, obtaining answers was a challenge. Specialty society staff attempting to assist members had little information or education on how to interpret the reports. QRUR recipients noted the value of speaking to another physician, preferably in their specialty.

As a result, we encourage CMS to provide a mechanism for meaningful dialogue for feedback report recipients with a physician (preferably in their specialty) that is knowledgeable about the reports. CMS could use the QualityNet helpdesk as a starting point, but should elevate callers to a physician knowledgeable in the VBPM and feedback reports early on. To accomplish this, CMS could direct its MACs to train its existing Contractor Advisory Committee (CAC) representatives, of which there is one for most every major specialty, as "super users."

In addition, CMS could train interested specialty society staff on the reports, creating additional "super users." This could be accomplished by creating a similar dialogue with the specialty

societies, much like what they have done with the Measure Owners Group run by its contractor PMBR.

- **Adopt a Corrective Action Plan, or similar program, for outliers/poor performers prior to applying the payment adjustment.** The VBPM aims to downwardly adjust payments to those deemed as low quality, high-cost performers. The modifier is budget-neutral, meaning there will be winners and losers, and most specialists see this is a lose-lose situation for their practices. In light of the SGR and looming penalties associated with CMS quality improvement programs (PQRS, e-Rx, EHR), not to mention the impact of the Budget Control Act or the IPAB, the fear of financial penalties is significant.

It would be unfair for physicians to be penalized when they have no understanding of where they have gone astray in the eyes of CMS, and without an opportunity to improve their “score” before being penalized. This is particularly important since most physicians have not had a chance to receive a feedback report, and those who did, found them to be unhelpful, overall. Given CMS will be collecting data two years before the modifier will apply, but only two months after providing the full scope and details on the program, providers will need more time. We urge CMS to consider adopting a Corrective Action Plan, or similar program to allow specialists an opportunity to improve prior to being held to a payment adjustment.

Conclusion

We appreciate the opportunity to share our comments about the impact of the proposed rule on specialty medicine. We urge the agency to proceed with great caution in its implementation of new programs which shift resources away from specialty medicine and add to the regulatory burden on our nations physicians

Sincerely,

American Association of Neurological Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography American
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
Heart Rhythm Society
North American Spine Society
Society for Cardiovascular Angiography and Interventions
Society for Excellence in Eye Care

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