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Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Mail Stop C4-26-05
Attention: CMS-1524-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012; Proposed Rule (CMS-1524-P)

Dear Dr. Berwick:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to comment on several proposals included in the Physician Fee Schedule (PFS) Proposed Rule for Calendar Year (CY) 2012.

The AGS is a not-for-profit membership organization comprised of over 6,000 geriatrics healthcare professionals who are devoted to improving the health, independence and quality of life of all older people. The Society provides leadership to healthcare professionals, policy makers and the public by implementing and advocating for programs in patient care, research, professional and public education and public policy.

Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians. While we support many of the proposals contained in the proposed rule, there are a few areas where we have some concerns, as expressed in our comments below.

In previous comments, we have acknowledged that there are issues CMS cannot change without specific authorization from Congress; however, we felt it appropriate to raise them last year, and again this year, because Medicare has definitely begun to take steps toward broad changes in the fee schedule to address these important issues, either at the request of Congress or through its own initiatives.

Re-Framing Physician Payments Under the Fee Schedule

As CMS is well aware, the number of Americans aged 65 and older is rising and is likely to double by 2030. Americans are living longer and have more chronic and complex health conditions than in the past. Individuals aged 85 and older are the fastest growing segment of our population. Many of these individuals suffer from multiple co-morbidities, often have poor quality of life, physical disability, high healthcare use, multiple medications and increased risk for adverse drug events and mortality. Caring

for older adults, particularly those with multiple chronic conditions/geriatric syndromes, is complex, time-intensive and commonly requires a team.

Historically, fee schedule payments have been entirely resource-based, based upon the typical patient for the service (CPT® or HCPCS code). In other words, payments take into account only the resources that go into performing a procedure or service, i.e., physician work, practice expenses and the expenses related to liability insurance, with certain adjustments, such as those based on geographic area, but not the *value* (e.g., cost effectiveness or social value) associated with the work.

The resources needed to care for very complex Medicare patients are vastly understated in the fee schedule as it currently exists. These services, such as patient counseling, care coordination and teaching, particularly when furnished to a population of elderly, frail patients with multiple, chronic conditions and comorbidities, are multidisciplinary, and require a team approach and significantly more resources than the typical office visit services furnished to younger, healthier patients. The Evaluation and Management (E/M) service codes were not designed to describe care rendered by a multidisciplinary team. E/M valuations are based on “typical” patients who do not require care for multiple chronic conditions, impairments in cognition or activities of daily living, and the provision of social support. These are the patients using the greatest resources in Medicare; yet, Medicare cannot or does not recognize or adequately value certain types of services, such as non-face-to-face care coordination activities, team conferences, and polypharmacy issues, such as managing multiple medications to avoid duplication or potential adverse reactions, which are essential to the care and treatment of the Medicare population generally, and particularly to the care of older, sicker adults with complex care needs. Even when Medicare does recognize some non-face-to-face management such as care plan oversight of the home care patient, time spent coaching family care givers is not recognized and excessive documentation expectations minimize the utility of the defined service.

The level of work involved in treating this population, the dynamics of the interactions that must take place amongst physicians, patients, and families, and the work involved in coordinating care with a multidisciplinary team that includes other physicians and health care professionals are simply more complex and intense than they are when treating younger, healthier patients.

We are gratified that CMS appreciates the need to recognize the significant interest in recent years in reforming health care delivery to make primary care the focus of managing patients’ chronic conditions. As CMS notes in the preamble to the proposed rule, the chronic conditions challenging the Medicare population, such as heart disease, diabetes, Alzheimer’s disease and others have changed the focus of primary care “from an episodic treatment-based orientation to a focus on comprehensive patient centered care management in order to meet the challenges of preventing and managing chronic disease.”¹ We agree that the focus of primary care has begun to evolve to address this shift toward a more coordinated, patient-centered approach to care, but there is still work to be done.

Our past comments have focused on the notion that fee-for-service (FFS) Medicare has not adequately addressed these issues for geriatric patients who have complex care needs; suffer from multiple chronic conditions, and whose care requires substantial coordination in order to ensure appropriate services and medications provided. In the past, we have recommended a more meaningful investment in the development of a more transparent risk adjustment methodology, and have provided numerous

¹ 76 Fed Reg 42793 (July 19, 2011).

comments on the development of quality measures that are appropriate for the older, sicker population.

As we recommended in previous years, we urge CMS to continue to provide multiple forums for physician involvement and feedback, such as national conference calls or town hall meetings, so that physicians and other health care professionals can understand and respond to CMS' thinking as it moves forward with its plans for improving the delivery of healthcare in a way that advances the goals of higher quality, more efficient, better coordinated, patient-centered care with its plans for value-based purchasing and other initiatives. AGS looks forward to participating in such forums and providing assistance to CMS as it develops and begins to operationalize these plans.

We recommend that CMS work to facilitate the development of payment policy, procedure descriptions and valuations that will address some aspects of the short-comings of the current payment system.

Below are our recommendations, followed by more extensive comments on specific proposals contained in the CY 2012 Physician Fee Schedule proposed rule:

- **We recommend that CMS withdraw its proposal to conduct a comprehensive review of all E/M codes over the next two years.** Instead, CMS should work with the primary care specialties to develop and implement new codes that describe modern primary care, such as codes for care coordination, geriatric assessments, team care, and medical homes. AGS recommends that CMS announce in the final rule that it intends to create such codes and propose them in next year's proposed rule.
- **We recommend that CMS finalize its proposal to incorporate a health risk assessment (HRA) into the annual wellness visit, as required by law.**
- **We recommend that CMS not finalize its proposal to expand the multiple procedure payment reduction (MPPR) to the professional component of certain advanced imaging procedures, or to further expand the MPPR to both the technical and professional components of all imaging and diagnostic procedures.**
- **We recommend that CMS not implement the value modifier in a way that would include any geriatric health care professionals, including geriatricians, until 2017.**

Our comments on the specific proposals contained in the CY 2012 Physician Fee Schedule proposed rule follow.

Resource-Based Practice Expense (PE) Relative Value Units (RVU's)

CMS solicits comments regarding reliable sources of interest rates. We believe that a more appropriate interest rate assumption is necessary. The current rate which lacks face value validity over values services with high equipment cost inputs. In a relative value system with budget neutrality, this results in under-valuing such services as primary care to complex elderly patients.

CY 2012 Identification and Review of Potentially Mis-Valued Services

Evaluation and Management Codes

CMS states that in its examination of the highest PFS expenditure codes for each specialty, E/M services consistently appeared in the top 20 high PFS expenditure services, and that most of the E/M services have not been reviewed since the third Five-Year Review of Work in 2006. Therefore, CMS proposes to request that the AMA RUC conduct a comprehensive review of all E/M codes, noting that since the last comprehensive review there has been significant interest in delivery system reform with a focus on primary care and on the chronic conditions that challenge the Medicare population, such as heart disease, diabetes, respiratory disease and others. CMS believes that the focus on primary care and on improved care coordination and management of chronic disease warrants a more current review of the E/M codes.

The proposed rule does not contain a clearly articulated rationale to explain CMS' decision to review all E/M codes over the next two years. Therefore, CMS' ultimate goal with respect to this review is unclear. AGS believes that this is an ill-advised project and for the reasons set forth below, we recommend that CMS withdraw its proposal.

While AGS would support a restructuring of the E/M codes to better address primary care and chronic care management, we do not support a comprehensive review of the current E/M codes. Any effort to revalue the current codes will not address the real problem. This is because the E/M codes do not describe the work of primary care in the 21st century which typically involves caring for patients with multiple chronic conditions.

The current E/M codes describe an acute care model. The current codes do not describe work performed by a health care team, or the coordination and management of complex patients with multiple conditions. Revaluing codes that do not describe what primary care doctors do is, in our opinion, an attempt to fix the system that is irrevocably broken. As discussed above, one of the problems with the current codes is that geriatricians are not able to report essential services they provide to Medicare and therefore are not paid for them. Specifically, there are no codes that allow geriatricians to get paid for performing complex geriatric assessments on the frail, multiply-ill elderly or for the care coordination they provide to patients who have multiple illnesses such as Alzheimer's in combination with heart disease, diabetes, arthritis and osteoporosis. Work differentiation based upon patient complexity as defined in CPT was never adequately accounted for and has been further degraded by CMS documentation guidelines and coding algorithms based on those guidelines that are built into electronic health records.

Therefore, AGS recommends that CMS withdraw its request to have the RUC review all the E/M codes. Instead, it should work with the primary care specialties to develop and implement new codes which describe modern primary care. These could include codes for care coordination, for geriatric assessments, for team care, and for medical homes. AGS also requests that CMS announce in the final rule that it intends to create such codes and propose them in next year's proposed rule. CMS should also facilitate review of the current E/M code structure. Below are recommendations for specific steps that CMS should take to achieve these goals.

Specific Steps CMS Should Take Regarding E/M Services

AGS is pleased that the CMS policy goal of requesting that the RUC review the E/M service codes is to increase payment for primary care. In order to achieve this goal it will be necessary to create procedure codes, and make separate payment, for the services actually performed by primary care physicians, including geriatricians. Many of these services are non-face-to-face services such as the activities of case managers, care coordination activities and managing patients as they transition across care settings (e.g., from a hospital to a nursing home). Medicare has usually declined, as a policy matter, to make separate payment for non-face-to-face services because of the potential for abuse and because it believes that at least some of these services, such as care coordination, are included in the pre- and post-service work of face-to-face E/M services. AGS believes that the potential for abuse can be minimized (see discussion below) and disagrees that any of these activities are included in the pre- and post-service work of face-to-face E/M services for patients with multiple chronic illnesses.

A review of the office visit code 99215 is very illustrative and serves to make the point that the current E/M service codes are meant to describe patients with acute illnesses, not multiple chronic illnesses. 99215 is the highest level office visit for an established patient. It only includes 5 minutes of pre-service and 15 minutes of post-service physician time. In addition there are only 4 minutes of pre-service and 8 minutes of post-service clinical staff time. According to the RUC vignette, this small amount of time is supposed to include the following:

- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary

Performing all of these activities in 15 minutes is simply not possible for a patient with multiple chronic illnesses. AGS believes that there is a complete disconnect between the post-service time for the current E/M codes and the medical needs of the multiply ill elderly who require multiple contacts from physicians and other health professionals between face-to-face visits.

The Medicare policy to not make separate payment for non-face-to-face services has had the unfortunate, if unintended, result that Medicare does not pay primary care doctors for many of the services they perform on a daily basis for their patients with multiple chronic illnesses. This has a disproportionate effect on geriatricians whose patients panels are made up entirely of such patients.

Although AGS recommends that CMS withdraw its proposal to have the RUC review the E/M codes, there are other steps CMS can take to address this issue.

AGS believes that, in the long term, a completely new code set describing, among other things; the activities performed by case managers, care coordination activities, team care and managing transitions of care will need to be created. However, developing such a code set will take several years and CMS

needs to move more quickly to provide relief to geriatricians who are taking care of the sickest Medicare patients and not being paid for a number of their services.

Therefore, in the short term, AGS asks that CMS take the following actions - either in this year's final rule or in the CY 2012 proposed rule.

First, CMS should explicitly recognize that primary care physicians, especially geriatricians, are regularly performing services for patients with multiple chronic medical conditions for which Medicare does not make separate payment.

Second, CMS should start making separate payment for the CPT codes for Telephone Evaluation and Management, Online Consultations, Anticoagulation Management and Team Conferences. These are listed below:

- 99441, Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- 99442, Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
- 99443, Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
- 99444, Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
- 99363, Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)
- 99364, Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)
- 99366, Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
- 99367, Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
- 99368, Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional

Each of these codes has RUC recommendations for work and direct inputs for practice expenses. In order to minimize abuse, CMS should limit separate payment for the telephone, online consultation and team conference codes as follows:

1. Payment should only be made when these services are provided to patients with four or more chronic conditions (i.e., when four ICD-9 diagnosis codes for four completely different illnesses are on the claim)
2. Medical record documentation should include documentation that at least two of those conditions were the subject of the service
3. Payment should be limited to physicians with the self-designated specialties of geriatrics, internal medicine, family practice and pediatrics
4. Payment should only be made for a small number of calls or one online consultations per calendar quarter

CMS should also consider creating G-codes with similar descriptors for non-physician health professionals to report these services.

Third, CMS should implement the RUC coding and payment recommendations for care provided by medical homes. These recommendations were included in a 2008 letter to Kerry Weems, at that time Acting Deputy Administrator of CMS (see attached letter). AGS would be pleased to work with CMS in implementing these G-codes and in making them available to make them available to only those physicians who are actually performing these services.

Multiple Procedure Payment Reduction (MPPR)

CMS proposes to expand its longstanding policy, currently applied to surgical procedures and to the technical component of certain advanced diagnostic imaging procedures performed on contiguous body parts, of reducing by 50 percent the payments for the second and subsequent procedures when furnished to the same patient by the same physician on the same day. This reduction is based on the presence of efficiencies, e.g. with respect to labor, supplies and equipment time. CMS proposes to expand the multiple procedure payment reduction (MPPR) to the professional component of those advanced imaging procedures (CT, MRI, ultrasound). In the proposed rule, CMS also states that it is considering expanding the MPPR to additional codes in the future, including the PC and TC of all imaging services and to the TC for all diagnostic services (e.g., radiology, cardiology, audiology, etc.).

We recommend that CMS not finalize its proposal to extend the MPPR to the PC of the advanced imaging services to which the MPPR is currently applied with respect to the TC. Further, we do not support expanding the MPPR across the board to all diagnostic and imaging services in the future.

CMS states in the proposed rule that the MPPR reflects efficiencies in terms of clinical labor, supplies and equipment time, and we generally agree with respect to the TC of these services. However, with respect to the PC, the argument is not only not compelling, but we are very disturbed about introducing the concept of efficiencies into the realm of cognitive work. When it comes to cognitive work, AGS agrees that CMS should not pay for duplicative work, but the concept of duplicative work is much different than the concept of “efficiencies.”

Instead, AGS believes that each professional component must be examined individually to determine if duplicative work exists when more than one PC is provided by the same physician for the same patient on the same date. Just because there are practice expense economies of scale achieved when two imaging services are performed on the same date, this does not mean that there is also a duplication of physician work when two imaging interpretations or other test interpretations are performed on the same date. Additionally, some valuations have already considered services that are commonly performed together, such as services performed the same day as E/M services.

AGS believes that any rule that reduces payment for the cognitive work of second and subsequent imaging procedures across-the-board, without examining combinations of services individually, sets a very dangerous precedent, and we urge CMS to move cautiously in this area. For example, finalizing the CMS policy will clearly create an incentive for performing imaging services on different dates of service instead of on the same date of service, and could be expanded to other sets of services provided on the same date. If CMS believes that the work for multiple imaging or diagnostic procedures, when performed on the same date, is overvalued, there are other policy options that should be considered before establishing an across-the-board reduction in physician work values associated with the PC of the second and subsequent services. CPT and RUC are already addressing services commonly performed together and AGS believes this careful approach should continue.

CMS should focus on duplicative work instead of applying a blunt tool that reduces payments by 50 percent when it should instead develop a more appropriate tailored tool aimed at eliminating duplicative payments. AGS does not believe general rule is appropriate when in fact, codes should be evaluated on an individual, case-by-case basis.

Incorporation of a Health Risk Assessment as Part of the Annual Wellness Visit

We support the proposal to incorporate a health risk assessment (HRA) into the annual wellness visit as required by Section 4103 of the Affordable Care Act. The AGS provided comments to the Center for Disease Control and Prevention (CDC) on the HRA last year, and we were pleased to see that many of our comments relative to the content and associated burden of an HRA seem to have been considered by CMS.

We feel strongly that an assessment of health risk should facilitate data gathering that enables physicians and other practitioners to provide the best possible care, but should not add a layer of work that could be viewed by clinicians as burdensome if it does not facilitate or promote better care.

In our comments to the CDC, we pointed out that the exam elements of the Annual Wellness Visit (AWV), which are required by statute, could potentially be assisted by an HRA that the patient and physician/clinician could discuss, in order to determine health risk and to help clinicians and patients work together and to contribute to shared decision-making. The HRA would also help to identify those patients who are in need of relatively intensive interventions immediately. For geriatric patients, an HRA could help to identify individuals who need care coordination for multiple chronic conditions.

Ideally, a health risk assessment should support shared decision-making by the health care provider and the patient by first helping the provider to gather important information about the patient, and then facilitating communication between the provider and the patient as to the best approach to the patient's care, in terms of both short term needs and in planning for the future.

We note that many physicians are not currently incentivized to utilize an HRA in their practice as a means of improving communication with their patients and with other providers. There may be concern that the time burden associated with the use of an HRA may only add a layer of administrative burden, without actually improving communication or outcomes. Many physicians would prefer to see improved reimbursement for the AWP that reflects the work involved in administering an HRA, but more importantly, physicians and other clinicians want to ensure that the work involved will actually improve patient care, and not increase the time and administrative burden that already faces most primary care physicians.

AGS recommends that CMS review the level of physician work associated with administering an HRA as part of the annual wellness visit, and adjust the payment for the service accordingly.

Telehealth Services

AGS supports CMS' proposal to refine the Category 2 review standard for services requested to be added to the list of Medicare telehealth services that are not similar to the current list of telehealth services by requiring such requests to include evidence supporting "demonstrated clinical benefit" when the service is furnished via telehealth. CMS states in the proposed rule that since it adopted its process for evaluating additions to the telehealth list almost 10 years ago, CMS has consistently observed that requestors have difficulty meeting the current requirement of demonstrating that the outcomes of the service delivered via telehealth are similar or comparable to the outcomes of the in-person service; and therefore CMS has not added any services to the telehealth list under Category 2.

The ability to provide certain services via telehealth allows providers such as geriatricians to bring services to areas that typically may have little or no access, particularly in rural areas. Therefore, AGS supports the CMS proposal to change its current standard for review when a request is made to add a service to the list of telehealth services under Category 2. We believe that this proposal will allow more requests for the addition of telehealth services to the current list to be granted in the future, while still requiring a rigorous evidentiary standard for demonstrating clinical benefit.

PQRS-Core Measures for Certain Specialties

CMS proposes that certain specialties -- internal medicine, family practice, general practice and cardiology -- reporting PQRS measures via the claims-based reporting mechanism or the registry-based reporting mechanism be required to report on at least one PQRS "core" measure identified in Table 29 of the proposed rule, along with at least two additional measures that apply to the services furnished by the professional. For those four specialties reporting data on individual quality measures via electronic health records (EHRs), CMS proposes that those specialties report on ALL of the core measures identified in Table 29. In the proposed rule, CMS seeks comment on whether geriatrics or other specialties also should be included as a specialty required to report on at least one of these core measures. **AGS agrees with this proposal to exclude geriatrics in the requirement to report the core measures, as the core measures do not reflect the typical care furnished by most geriatricians.**

TABLE 29—PROPOSED 2012 PHYSICIAN QUALITY REPORTING SYSTEM CORE MEASURES AVAILABLE FOR EITHER CLAIMS, REGISTRY, AND/OR EHR-BASED REPORTING

Physician quality reporting system measure No.	Measure title	NQF measure No.	Measure developer	Reporting mechanism
204	Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic.	0068	NCQA	Claims, Registry, EHR.
236	Controlling High Blood Pressure	0018	NCQA	Claims, Registry, EHR.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus.	0064	NCQA	Claims, Registry, EHR.
226	Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention.	0028	AMA-PCPI	Claims, Registry, EHR.
TBD	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control < 100.	0075	NCQA	Claims, Registry, EHR.
TBD	Proportion of adults 18 years and older who have had their BP measured within the preceding 2 years.	N/A	CMS	Claims, Registry, EHR.
TBD	Preventative Care: Cholesterol-LDL test performed	N/A	CMS	EHR.

CMS asserts it would be easier for eligible professionals to find applicable measures on which to report if the measures were grouped according to applicability to medical specialties. CMS says it seeks to move toward having specialties report on certain measures that are relevant to the respective specialty. CMS proposed to apply this reporting requirement to the four specialties listed above because prevention of cardiovascular conditions has been identified as a top priority, and these PQRS core measures for CY 2012 focus on prevention of cardiovascular conditions.

For a number of reasons, AGS does not support the inclusion of geriatrics as a specialty that would be required to report at least one proposed “core” measure. First, the practice of geriatric medicine in the U.S. is very diverse. While some geriatricians predominantly focus on certain specific chronic diseases or conditions, including cardiovascular conditions, many are in primary care practice, or focus on palliative care or institutional care furnished in skilled nursing facilities and other settings. Many of the core measures listed above (Table 29) are not relevant to the practice of geriatrics, and therefore a requirement that a geriatrician report on one of these measures, rather than being able to continue to choose three measures that more accurately reflect the type of care furnished by that physician, does not make sense and would create an unnecessary reporting burden.

We are not aware of any evidence suggesting that these measures are relevant to most geriatricians’ practices. Some geriatrician may choose to report one or more of these measures, however we do not believe that such reporting should be required of all geriatricians. In addition, AGS has commented on many occasions that the research that forms the evidence-base for many quality measures often does not include older adults, or individuals with multiple chronic conditions, rather than just one condition (e.g., diabetes). The quality of the evidence also deteriorates as the number of chronic conditions increases. Very old, frail individuals with a short life expectancy and individuals with multiple co-morbid conditions have multiple and competing priorities when it comes to measuring their health and outcomes. Our current quality measures inadequately address this and reflect assumptions about patient preferences which while probably correct in younger populations are less clearly held by those of advanced age and illness. Because of the heterogeneous nature of geriatrics practice and our patients, we do not agree that all geriatricians should be required to report core measures at this time.

Dementia Measures Group

AGS strongly supports the proposal to add a new measures group for reporting dementia measures, which AGS played a major role in developing. **We recommend that CMS finalize its proposal to include the dementia measures group in the PQRS for CY 2012.**

Interim PQRS Feedback Reports

AGS supports CMS' proposal to provide interim feedback reports to eligible professionals in 2012 for EPs reporting individual measures and measures groups through the claims based reporting mechanism.

Even a simplified version of the annual feedback report will be useful for physicians who previously may have thought they were eligible to receive an incentive payment, only to discover at or near the end of the reporting period that they did not meet the criteria to qualify for the bonus. Interim reports will provide the feedback necessary for an EP to make any mid-year changes necessary to meet the qualifying criteria for being a successful reporter under the PQRS.

Physician Resource Use and Measurement Reporting Program

CMS states that it will continue to phase in its confidential feedback program (the Physician Resource Use and Measurement Reporting Program, or RUR). **AGS supports the RUR program and is happy to assist CMS with any information that might be helpful in improving the physician feedback reports.**

The AGS is very interested in the current and next phases of the RUR program, under which CMS proposes to include in its feedback reports to physicians per capita cost information for beneficiaries with five common chronic diseases: diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and prostate cancer. For the population of beneficiaries that our members care for, information on total Part A/B per capita cost information, as well as service category breakdowns, for treating the subset of beneficiaries with those diseases will likely provide valuable information. The RUR program demonstrates the relationship between Part A and Part B utilization and costs and then need to consider the Part B cost in managing the total care of the patient. We are hopeful that the RUR reports will be useful and will provide information on which physicians can actually act to improve care and at the same time to improve efficiency, particularly when beneficiaries have not one, but multiple chronic conditions.

AGS commends CMS for its efforts to improve the Physician Feedback Program and to increase production and dissemination of the Physician Feedback Reports in 2011 and 2012. We also commend CMS for its proposal to use PQRS quality measures in the Physician Feedback Report program as a way of aligning the requirements of multiple programs that require quality data reporting (such as the PQRS and Electronic Health Record Incentive Program) and reducing potential program inconsistencies. We understand and appreciate the challenge of producing feedback reports that include resource utilization and quality measures that are meaningful, actionable and reliable.

It is considerably more challenging to produce meaningful feedback reports that reflect the services provided by physicians when those physicians are treating individuals who have multiple chronic diseases, such as heart disease, diabetes and COPD, not just one.

Development of a Value-Based Payment Modifier

The proposed rule does not contain specific information regarding how it intends to implement the ACA requirement to apply a separate, budget neutral payment modifier to the fee-for-service physician fee schedule payment formula, beginning January 1, 2015.

We understand that the payment modifier is intended to provide for differential payment under the fee schedule based on the relative quality and cost of care furnished to Medicare beneficiaries. The AGS fully intends to engage with CMS in its efforts to involve stakeholders in aspects of the program design and implementation.

We are very supportive of efforts to improve provider payments under the physician fee schedule in a manner that takes into account the complexity of the work associated with many frail, elderly adults who live with multiple chronic conditions. Standard E/M codes under the fee schedule simply do not account for that complexity factor. **However, we strongly emphasize that the provider community must be included in all aspects of the development of a value-based payment modifier in an open and transparent process and that CMS ensure adequate time to field test the payment modifier, and to allow adequate time for physicians to implement systems within their practices.**

It is very difficult to provide meaningful and actionable comments at this time as the proposed rule does not contain specific or complete information regarding the value modifier and its application. However, below we provide specific comments on a number of issues.

Proposed Quality Measures for the Value Modifier

CMS proposes a set of quality measures on which it will measure performance for the value modifier, including:

- The PQRS "core set" of measures,
- The GPRO measures in the PQRS for 2012, and
- The core measures, alternate core measures and 38 additional measures in the EHR incentive program for 2012.²

Once finalized CMS says it will address any duplication across these programs to achieve one set of measures. CMS also states in the proposed rule that it seeks to begin a discussion about potential measures that could provide a richer picture of the quality of care furnished by physicians and specifically seeks comments from specialists about measures that are not included in the list of proposed measures.

Of the measures included in Table 62 as proposed, we note that only a minimal number of the measures potentially apply to geriatricians. As we have noted above in this comment letter, and in previous comments to CMS, the practice of geriatrics and the patient population we represent is extremely heterogeneous in nature and there are very few developed measures that represent the services geriatricians furnish. While we are aware of NQF measures under development for complex patients

² Table 62, 76 Fed Reg 42909.

that may be available in the next few years and that will most certainly be more applicable to geriatrics, such measures are not currently available.

Application of the Value Modifier to a Subset of Physicians in 2015

CMS has the authority to apply the value modifier to specific physicians or physician groups in 2015 before it applies the modifier to all physicians in 2017. CMS suggests that it could:

- apply the value modifier to physicians identified as outliers (as identified individually, by practice group, or within a national or regional area); or
- Apply the value modifier to physicians that treat the conditions that are the most prevalent and/or most costly, among Medicare beneficiaries.

AGS is very concerned that CMS would consider implementing the value based modifier in a way that could include geriatric health professionals in 2015. In fact, we strongly believe that CMS should avoid applying a value-based modifier to any geriatric health professional until there is agreement from the community that there are adequate measures available to evaluate the quality of care provided by geriatricians and other geriatric health professionals. We also are concerned about measures of efficiency and attribution. Our typical patients are the most costly beneficiaries, our specialty is small in number and we have significant concerns about risk adjustment. We do not believe that measurement at the individual physician/professional level will be valid, but do support the use of programs that promote systems of care. Working to create and improve such systems has been a cornerstone of geriatrics care. We also believe that efficiency and quality require communities to cooperate in the care of the elderly as improving care transitions is a key factor in improving care of the most vulnerable beneficiaries. Therefore, we recommend that CMS acknowledge in the final rule that the current measures are not adequate for geriatricians, and that it will work with geriatricians and other geriatric health to ensure that appropriate measures are developed, tested and understood before applying a value-based modifier to geriatricians in 2017.

Summary

In conclusion, the AGS continues to be supportive of many of CMS' proposals that improve quality of care. Our offer stands to serve as a resource for CMS if additional data or information is needed as CMS moves toward its goals in this area.

Please do not hesitate to contact us at (202) 308-1414 if we can provide additional information or assistance.

Sincerely,

Barbara Resnick

Barbara Resnick, PhD, CRNP, FAAN
President

Jennie Chin Hansen

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