

THE AMERICAN GERIATRICS SOCIETY

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<http://www.regulations.gov>

Ms. Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Mail Stop C4-26-05
Attention: CMS-1413-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 2010; Proposed Rule (CMS-1413-P)

Dear Ms. Frizzera:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to comment on a number of proposals that were contained in the Physician Fee Schedule (PFS) Proposed Rule for Calendar Year (CY) 2010.

The AGS is a not-for-profit organization comprised of more than 6,700 health professionals who are specially trained in the management of care for frail, chronically ill, older patients. Our society is dedicated 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. Improving the health, independence and quality of life of all older people is the mission of AGS. In order to achieve this mission, our strategy is to help guide the development of public policies that support improved health and health care for seniors.

As a specialty society with a mission of advancing efforts that promote high quality of care, quality improvement, and increased payment accuracy, we support many of the proposals contained in the PFS proposed rule. However, there are several areas where we have some concerns, as expressed in our comments below.

SUSTAINABLE GROWTH RATE (SGR)

The AGS supports CMS' SGR proposal to remove drugs from the calculation of allowed expenditures for physicians' services, and to do this retrospectively to the 1996/1997 base year in order to eliminate the disproportionate impact that the large past increases in the costs of physician administered drugs would otherwise have on future physician payment updates. AGS further supports the proposal to remove drugs from the calculation of the SGR prospectively, beginning with CY 2010.

We understand that the proposal will not impact the currently anticipated PFS update of -21.5 percent, which will take effect on Jan. 1, 2010, unless Congress acts. We are pleased, however that the proposal may reduce the past discrepancy between target and actual expenditures, and may also reduce the number of years in which physicians will have a negative update.

We will continue to work with Congress on a permanent resolution to the sustainable growth rate problem.

RELATIVE VALUE UNIT (RVU) METHODOLOGY - PRACTICE EXPENSE (PE) RVUs

- **Physician Practice Information Survey (PPIS)**

AGS participated in the survey process, which was a collaborative effort by all specialties and effectively managed by the American Medical Association (AMA) using qualified independent agencies for data collection and cleansing. It eliminates the need to use less accurate CPEP data or data collected by different specialties with variable methodologies.

The previous SMS survey did not reflect the actual practice expenses of geriatricians and therefore PE RVUs have been understated for primary care in the past. The new PPIS survey better reflects geriatricians' practice expenses. We are extremely pleased that the use of the new AMA survey data had a positive impact on primary care, which we believe is the correct result, and is positive for geriatricians. We therefore support CMS' proposal to update the PE/HR data based on the new survey as of January 1, 2010. We also support the implementation of this proposal all at once, rather than phasing it in.

EQUIPMENT USAGE ASSUMPTION

AGS supports CMS' proposal to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over \$1 million, and believes that such a change is long overdue.

We understand that Congress is also looking at this issue, and that at least one proposal would increase the equipment usage assumption to 75 percent from the current 50. While we know that any revisions that may be passed into law by Congress could supersede a different policy choice

made by CMS, we support a policy that would increase the equipment usage assumption for expensive equipment, as we believe such a revision will discourage inappropriate capital investment in this type of equipment.

TELEHEALTH SERVICES

AGS supports CMS' proposal to continue to require direct physician evaluation of nursing facility residents, and agrees that Federally-mandated initial physician visits and subsequent periodic visits in SNFs should be furnished in person and not via telehealth. We believe that telehealth services do have the potential to bring geriatric expertise to the bedside when appropriately structured and performed. We also note that if consultation services are eliminated, the impact on telehealth services reporting and coverage will need to be considered. AGS would be pleased to work with CMS as those issues are reviewed and resolved.

INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE)

AGS strongly supports CMS' proposal to increase the payment for the initial preventive physical exam (IPPE, or "Welcome to Medicare" exam) provided to new Medicare beneficiaries during the first 12 months of Medicare enrollment. We had previously commented that this service was undervalued prior to the addition of several services as a result of the Medicare Improvements for Patients and Providers (MIPPA) Act of 2008, and we agree with CMS' assertion that the work and intensity are more equivalent to those services contained in CPT code 99204 (Evaluation and Management; new patient; office or other outpatient visit). We are especially pleased with the proposal as the increased payment will help to support the services, such as end-of-life planning, that were added by MIPPA and that are important yet time-consuming and work intensive.

CONSULTATION SERVICES

AGS generally supports policies that reduce regulatory complexity or make the regulatory situation less difficult to comply with. With the consultation proposal, CMS intends to eliminate in a budget-neutral manner the use of all consultation codes, and require physicians to bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. We commend CMS in taking actions that eliminate unnecessary regulatory burden or concern.

We believe that this effort, if finalized, will require significant education of our members on the use of the appropriate codes with respect to initial and subsequent care codes. We also believe that CMS will need to work with the AMA to eliminate confusion regarding CPT guidelines and use of the initial hospital care for services previously reported using inpatient consultation services. This may be especially relevant for persons with employer based insurance and Medicare.

PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) FOR 2010

- **PQRI Generally**

While AGS supports improvements with respect to quality measurement and reporting, we continue to have concerns that the PQRI quality measures are targeted only to single conditions, or to patients where classical treatment goals are appropriate, and do not address multiple, comorbid conditions. To some extent, this issue may be improved by the proposals in this rule for CY 2010 to allow group practices to report quality data.

We have commented in the past that a quality reporting system for Medicare must address the care of the large portion of Medicare beneficiaries who have multiple chronic conditions, are frail, of advanced age or require palliative care and for whom normal treatment goals are not appropriate (e.g., lowering blood sugars in patients with diabetes). For these beneficiaries, measures should account for comorbidities and assess aspects of health that are common to multiple conditions (e.g., cognitive status, functional status, and pain.) We applaud the addition of more geriatric-relevant measures addressing advanced care planning, falls, incontinence and osteoporosis.

Data reporting on quality measures has the potential to improve care for this population. Additionally, it is essential that any quality data reporting system, such as the PQRI, does not unintentionally impair the quality of care available to the most vulnerable elderly patients with multiple chronic illnesses, who may have different clinical care goals than other patients. We continue to believe that, for individual physician and non-physician professionals, the current system of quality data reporting does not typically provide meaningful information for beneficiaries and their families, and therefore, while we support data collection, we do not support moving to public reporting.

Recommendations: We recommend that CMS continue to encourage the development of improved measures that recognize the sometimes unique treatment goals in the frail elderly and other at-risk populations, and reward providers that care for them.

In addition, AGS supports the CMS proposal to implement a group practice option for reporting quality data for large group practices with 200 or more physician members; however we believe it would be beneficial for CMS to consider medium-sized group practices with fewer than 200 physician members as well. Allowing smaller to mid-sized group practices, perhaps ranging between 50-200 physicians, to report quality data using the group practice reporting option would be efficient; and there is no reason to believe that group reporting for such practices would be less valid or produce different results.

REPORTING THROUGH ELECTRONIC HEALTH RECORDS

AGS supports CMS' proposal to allow EHR-based reporting mechanism that will allow quality data to be extracted from a qualified electronic health record for a limited subset of quality measures.

PUBLICLY REPORTING NAMES OF SUCCESSFUL PQRI PARTICIPANTS

Pursuant to a statutory provision in MIPPA, CMS is proposing to post on a website the names of eligible professional and group practices that satisfactorily report quality data for 2010 and qualify to earn a PQRI incentive payment. That information is expected to be available in 2011.

Last year, AGS commented on our concerns with publicly reporting the names of those eligible professions (or group practices) that successfully report quality data. The public reporting of even limited information regarding a physician's success at reporting quality data has the potential to cause confusion and misunderstanding. While MIPPA has made public reporting of limited PQRI information a reality, we urge CMS to continue to work with the physician community to address our concerns about the public reporting of this information.

Several specific concerns include:

Potential for misunderstanding the significance of the list of names on CMS' web site.

The AGS is concerned about the potential for misunderstanding by health care consumers such as Medicare beneficiaries about the significance of these reports. There are still many valid reasons why a physician or other eligible professional either may not have participated in the PQRI in the first place, or why a physician may have participated but was not considered to be a successful reporter at the end of the year. Those reasons could include technical issues, financial issues or the fact that there simply were no available quality measures relevant to a particular physician's practice, or the relevant measures are still moving through the consensus process. In such cases, lack of reporting under a voluntary program does not signify evidence of poor quality of care.

Recommendation: It is vital that CMS include a disclaimer or some other bold statement on its website specifically stating that the PQRI is a voluntary program and that there are valid reasons why a physician may have elected not to participate, or why a physician that participated may not have successfully reported. Such a statement should clearly convey that the publication of a physician's name on the website indicates only that the physician was able to successfully report claims data on a defined percentage of his or her patient's to whom the measure applied, and the fact that a physician's name is not published on the website is not evidence of the provision of lower quality care. Additionally, physicians should have access to useful information regarding the reporting process, so that physicians who do not successfully report and whose names are not published are able to obtain more information about why they were not successful reporters of quality data.

It is important that CMS remain sensitive to these issues related to public reporting of this information, as well as the public perception, particularly given that the PQRI is still a voluntary program. We continue to believe it is just too early in the process to attempt to publicly report information that could be so easily misunderstood by consumers, however Congress has mandated such public reporting for 2010.

CMS should continue to work with the physician community, and to use public forums such as the National Provider Calls, Open Door forums and other public briefings to discuss the process with respect to public reporting moving forward and to gather feedback from physicians who will be impacted, whether their names are reported on the website or not.

PHYSICIAN RESOURCE USE MEASUREMENT AND REPORTING PROGRAM

MIPPA required CMS to implement the Physician Feedback Program to provide confidential feedback reports to physicians that measure the resources physicians use to furnish care to Medicare beneficiaries. In this rule, CMS renames this initiative the Resource Use Measurement and Reporting Program, and notes that the program is being implemented in phases.

Recommendation: While AGS is basically supportive of this concept and agrees that it is appropriate to measure resource utilization, we cannot emphasize strongly enough that attribution is a huge and difficult problem, particularly for geriatric patients with multiple, complex problems and care needs. Additionally, there are very serious methodological issues involved in making valid comparisons between individual practitioners.

We understand that the program is being phased in, but we urge CMS to move ahead cautiously, and limit the program to physician feedback until significant issues, such as attribution and how to adjustment for acuity/complexity, are resolved.

PLAN FOR TRANSITION TO VALUE-BASED PURCHASING PROGRAM

As CMS notes in the proposed rule, the MIPPA required CMS to develop a plan to transition Medicare physician payments to a value-based purchasing program for covered professional services made under, or based on, the PFS, and required the plan to be submitted in a Report to Congress by May 1, 2010. The stated purpose of this transition is to base professional payments not only on quantity of services provided but also on the quality and efficiency of those services. The plan will cover measures, incentives, public reporting, and data strategy and infrastructure.

The AGS is generally supportive of Value-Based Purchasing (VBP), and we note that fee-for-service Medicare has not adequately addressed important issues for geriatric patients, such as non-face-to-face care coordination, and the complexity of this population. As CMS develops the Report to Congress, we urge the Agency to focus on actions or activities that promote better care, such as improvements in discharge planning, care coordination, and readmission rates. We recommend a deeper investment in the development of more transparent risk adjustment, and on the development of quality measures that are appropriate for the older, sicker population. Any

VBP system must be fair and valid, and not only reward performance, but stimulate quality improvement by being comprehensible and actionable on the part of all health care providers.

In the proposed rule, CMS notes that the Physician Value-Based Purchasing (PVBP) workgroup within CMS is developing potential recommendations for the mandated Report to Congress, and for future work in this area. We recommend that CMS provide additional forums for physician involvement and feedback, such as national conference calls or town hall meetings, so that the physician community can understand and respond to CMS' thinking as it moves forward on a plan for VBP. AGS would be happy to participate in such forums, or to otherwise provide assistance to the PVBP workgroup as it develops and begins to operationalize these plans.

INCENTIVES FOR ELECTRONIC PRESCRIBING (E-PRESCRIBING)

- **Group Practice E-Prescribing Measure**

AGS supports the proposed modifications to the reporting criteria that will allow e-prescribers a choice of reporting mechanisms (claims, registries and electronic health records (EHR) products). AGS further supports the additional modifications that will make it less burdensome to report the e-prescribing measure, as well as the proposal to implement a group practice e-prescribing incentive.

Recommendation: Similar to our comments above under PQRI, we would urge CMS to consider not limiting group practices to groups of 200 or more, so that medium-sized practices with fewer than 200 physician members may participate.

- **E-Prescribing Denominator Codes**

With respect to the proposed expansion of the scope of the denominator codes for 2010 to professional services outside of the office or outpatient setting, we were pleased to note the addition of nursing facility and home care codes. However, we note that the range of domiciliary codes was not included in this expanded list. This may have been an oversight, however we recommend that those codes (CPT codes 99324-99328, and 99334-99337) be added to the list.

We think that, as CMS anticipates, expanding the scope of the denominator to these additional services, combined with the establishment of a minimum reporting threshold of 25 occurrences (rather than the current 50 percent requirement), will provide more eligible professionals with the opportunity to report the e-prescribing measure. We have maintained in the past that eligibility to participate in the e-prescribing program should be site neutral. Geriatricians in particular, and other physicians who see large numbers of patients in nursing homes, are likely to have greater opportunities to report the measure if these changes are finalized.

We recognize that some prescribers will still have difficulty establishing the necessary infrastructure to support e-prescribing, and this will be a concern to those providers in 2010 and in future years with respect to incentive payments under this the e-prescribing incentive program

and under the incentives established in the American Reinvestment and Recovery Act of 2009, and to the penalties that will be imposed later for providers that do not adopt e-prescribing or who are not successful e-prescribers.

Recommendation: We recommend that CMS add the domiciliary codes (CPT codes 99324-99328, and 99334-99337) to the expanded list of denominator codes for the e-prescribing measure.

PUBLICLY REPORTING NAMES OF SUCCESSFUL E-PRESCRIBERS

As required by MIPPA, CMS proposes to make public in 2011 the names of successful e-prescribers that participated in the program during 2010.

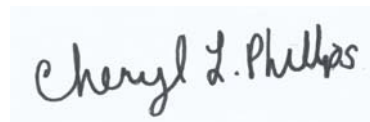
Recommendation: While this requirement is statutory, we have the same concerns about publicly reporting the names of successful e-prescribers that we stated above with respect to the public reporting of successful participants in PQRI. We believe it is important for CMS to include appropriate disclaimers or other statements on its website that provide information about the e-prescribing incentive program and specifically state that there are valid reasons why a physician may not have been a successful e-prescriber in 2010. As with PQRI, we recommend that physicians have access to useful information regarding the e-prescribing reporting process, so that physicians who do not successfully report and whose names are not published are able to obtain more information about why they were not able to successfully report this data. We further recommend that CMS continue to work with physicians on the sensitive issues that surround the concept of publicly reporting this information.

CONCLUSION

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,



Cheryl L. Phillips
President
American Geriatrics Society