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The Honorable Marilyn Tavenner, RN, MHA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-P

Submitted electronically to: <http://www.regulations.gov>

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule

Dear Administrator Tavenner:

On behalf of the members of the American Podiatric Medical Association (APMA), the national organization representing the vast majority of the estimated 15,000 podiatrists in the country, we welcome the opportunity to submit comments on the proposed rule relating to the Medicare physician fee schedule (PFS) for CY 2015 and other matters.

10- and 90-Day Global Surgical Services

CMS is proposing to unbundle 10- and 90-day global surgical services, re-value these services as 0-day global services through a yet-to-be-determined methodology, and make these changes effective in CY 2017 (for 10-day global services) and CY 2018 (for 90-day global services). This is a significant and rather startling policy proposal, especially as CMS moves in other domains to bundle more and more services together, such as under the comprehensive ambulatory payment classification groups (APCs) in the Medicare hospital outpatient prospective payment system and the Bundled Payments for Care Improvement Initiative being tested by the Center for Medicare and Medicaid Innovation. This proposal would have significant implications for doctors of podiatric medicine (DPMs), since we estimate that 10- and 90-day global surgical services account for roughly 14 percent of all Medicare payment for the podiatry specialty, based on proposed 2015 Medicare payments and 2013 utilization.

First and foremost, APMA strongly opposes any attempt to finalize an artificial deadline for unbundling global surgical services. It is evident from the proposed rule, that CMS is uncertain about whether and how this might be done in a fair and practical way. We believe that setting

implementation deadlines in the absence of more information regarding methodology both precludes adequate public input on the proposal and would be unreasonable.

Second, any unbundling of the 10- and 90-day global surgical services must guarantee that the values for the base procedures as 0-day globals can be determined accurately and fairly and not end up disadvantaging these services compared to other services paid for under the Medicare physician fee schedule. APMA believes the jury is still out on this. In particular, we believe there is considerable risk that the unbundling process will end up disadvantaging those who provide surgical services by reducing both direct and indirect practice expense payments to these specialties. As it is, CMS understands that direct and indirect practice expense costs are not fully reimbursed under the existing practice expense methodology, and we believe it would be important to demonstrate that any unbundling proposal would not worsen this situation for the affected specialties compared to non-surgical specialties. Unjustified reductions in practice expense payments do not miraculously eliminate real-world practice expense costs. If equipment and supplies used for post-procedure visits are not taken into account in valuing evaluation and management services for non-surgical problems, this would appear to disadvantage physicians furnishing post-procedure visits following the unbundling of 10- and 90-day globals.

APMA does see some value in the unbundling proposal in that it would allow more payment for difficult cases, where additional post-procedure visits are needed. This is not a feature of the existing global surgical definition in that the 10- and 90-day global surgical services are valued based on the typical patient, as are all other services reimbursed under the Medicare physician fee schedule. However, we also fear that, post unbundling of the 10- and 90-day globals, physicians furnishing surgical services would face inordinate scrutiny and find themselves constantly arguing with Medicare about the medical necessity of every single post-procedure visit. In the context of the current enormous backlog in Medicare appeals related to Part B claims, we see this additional potential area of disagreement as an enormous risk for physicians, beneficiaries and even the Medicare program itself. In addition, we worry that separate billing for each post-procedure service and the separate cost-sharing amounts for each such service might cause some beneficiaries to avoid medically necessary post-procedure care, even if their total cost-sharing obligations might otherwise end up being no different than they are today under the global surgical service policy. This unintended reduction in patient compliance could lead to greater postoperative morbidity and diminished outcomes, and even have professional liability implications.

In addition, there are other important issues that would need to be addressed if any unbundling initiative were to move forward. For example, it would be absolutely unfair to apply the existing multiple procedure payment reduction policy across all the newly created 0-day global surgical services. That policy was primarily justified by the fact that a single set of post-procedure visits would be furnished following multiple, same-day procedures, rather than the otherwise assumed post-procedure visits associated with each of the individual procedures. However, if and when the unbundling of 10- and 90-day global surgical services occurs, this issue would be addressed since physicians would bill separately for each visit. This multiple procedure payment issue was

not addressed in the proposed rule but is a major consideration. If this matter is not addressed properly, it could negatively affect patient care, as physicians would become understandably hesitant to furnish multiple procedures, even if this is clinically appropriate, if they knew that the Medicare payment result would unfairly penalize them. Similarly, there are a number of payment modifiers currently in use in relation to global surgical services and it would be necessary to review all of these and determine which would no longer be needed and which would continue to apply under certain circumstances. We also cannot rule out the possibility that the unbundling of global surgical services could impact the correct coding initiative. None of this was addressed in the proposed rule.

It is also true that the unbundling of 10- and 90-day global surgical services is likely to increase the volume of claims submitted to Medicare, thereby increasing the Medicare claims submission burden and claims processing costs, since physicians furnishing surgical services would probably end up submitting more than one claim for each procedure. We see this as another area of concern not acknowledged in the proposed rule. Are CMS and the U.S. Congress prepared to increase Medicare contractor budgets to accommodate the increased number of claims that would likely be submitted and processed? Or is CMS planning to force physicians furnishing surgical services to submit only a single claim covering both the 0-day global procedure and all post-operative visits? If so, this would unfairly distinguish between evaluation and management services furnished post-procedure and those furnished during an episode of care for non-surgical problems, or distinctly different conditions. This would be unacceptable. Resulting increases in the number of claims could also affect other contractor costs related to auditing, pre- and post-payment review, and other activities.

The proposed rule raises concerns about the impact of current global surgical service payment policies on alternative payment models. However, it is also true that alternative payment model constructions typically rely on historic Medicare data and it is far from clear to us how this historic data would be adjusted going forward in the context of alternative payment models. Any such adjustments to historic data once again risk disadvantaging physicians who furnish surgical services under one or another alternative payment model.

In short, while APMA can appreciate to some extent what CMS is trying to accomplish, and even see at least one potential advantage, we are not convinced it is possible to fairly and accurately unbundle the 10- and 90-day global surgical services and we fear that the side effects could be worse than the concerns identified in the proposed rule.

Valuing New, Revised and Potentially Misvalued Services

CMS proposes to revise its process for adopting relative values for new and revised codes and potentially misvalued codes, with the goals of eliminating or significantly reducing the use of interim relative values and generally providing the opportunity for public comment on proposed relative values prior to their adoption. In other words, CMS wishes to avoid, to the greatest extent possible, adopting interim values in a final rule and only then providing an opportunity for

public comment on these values, which nonetheless remain effective for a full year before CMS is able to respond to the comments and adjust the values, if this is determined to be appropriate. However, CMS proposes to adopt G-codes for revised CPT codes if it cannot provide an opportunity for public comment on new values, and this would preclude the timely adoption of new nomenclature and most likely require physicians to bill Medicare using outdated nomenclature while they simultaneously bill other payers using up-to-date CPT terminology.

APMA appreciates what CMS is attempting to do and we agree that every effort should be made to reduce the number of interim values. In this regard, we would urge CMS to be as flexible as possible in giving the American Medical Association/Specialty Society Relative Value Update Committee (RUC) as much time as possible to submit relative value recommendations that could be incorporated into each year's proposed rule. On the other hand, we do not believe that adoption of G-codes would be helpful. It would increase the administrative complexity of billing the Medicare program. We wonder about the alternative of adopting interim values in cases where public comment cannot be provided (as is done now) but revising those values sooner if justified by public comments. We recognize that the fee schedule must generally be budget neutral (in all cases where changes would otherwise increase payments by more than \$20 million). However, we note that CMS now updates the relative value file on a quarterly basis, and we wonder whether it might be possible to respond more quickly to comments on interim values and make necessary adjustments by April 1 of a calendar year rather than waiting until January 1 of the following calendar year (for example, by April 1, 2016 rather than January 1, 2017 in the case of interim values adopted in the CY 2016 final rule with comment).

We recognize that CMS would need to consider how to do this in the least disruptive way possible, which would be challenging given the budget neutrality requirement. However, if revised values were required for only a few services and these adjustments were not estimated to result in changes in aggregate payments exceeding \$20 million, CMS would be free to publish the revised values without tampering with the values for all other services. In other cases, budget neutrality might need to be achieved by making a one-time adjustment to the conversion factor on April 1 for the remainder of the calendar year (rather than by changing the relative values for all other services). In many instances, this adjustment might be quite minimal while allowing CMS to correct inappropriate values more promptly. And this is the approach CMS now uses for work value changes. In a subsequent regulation, CMS could make necessary adjustments in practice expense and malpractice relative values across all services to maintain budget neutrality and account for the prior adjustments in interim values.

We recognize, too, that the above alternative might be challenging to accomplish given CMS resource constraints. However, we offer it as an alternative that would not involve the confusing use of G-codes, which we consider an unhelpful approach.

Refinement Process/Appeals Process

APMA has a long history of participation with the American Medical Association's Relative Value Scale Update Committee. As CMS is aware, the AMA established this expert panel as well as the RUC process to develop relative value recommendations to CMS. Further, the Refinement Panel process exists as one consistent path available to the RUC and specialty societies to address potential errors adopted by CMS in establishing interim relative values. CMS proposes to eliminate the Refinement Panel process currently utilized by CMS to consider such comments. The CMS Refinement Panel Process has long been considered by stakeholders to be an appeals process. The Refinement Panel was organized and composed by CMS and consisted of members from the primary care organizations, contractor medical directors, and specialty society representatives. For many years, CMS deferred to the vote conducted by the Refinement Panel in finalizing values. Most often, the Refinement Panel would support the original RUC recommendations. Though CMS states that the Refinement Panel was not convened for the former Five-Year Review processes, as this process always involved proposed rulemaking, this is not accurate. CMS even convened multi-day face-to-face Refinement Panel meetings during the first two Five-Year Review processes.

There have also been concerns about how the current process has worked. Most recently, CMS modified the process to consider only codes for which new information was provided in the comment letter. CMS also began to independently review each of the Refinement Panel decisions in determining which values to finalize. In many cases, the Refinement Panel supported the original RUC recommendation and the commenter's request, yet CMS chose instead to implement their original proposed value. APMA and other societies have concerns that the complete elimination of the Refinement Panel indicates that CMS will no longer seek the independent advice of contractor medical officers and practicing physicians and will solely rely on CMS staff to determine if the comment is persuasive in modifying a proposed value. Removing this organized appeal process will likely lead to the dissolution of objective review. Those organizations with limited resources, such as APMA, are disadvantaged in comparison to those vendors or organizations that will spend significant resources to overturn a CMS proposed value. APMA joins the RUC in encouraging CMS to create a fair, objective, and consistently applied appeals process that would be open to any commenting organization. We also encourage CMS to participate in the RUC meetings and utilize the meetings to discuss concerns rather than relying largely on the notice of proposed rulemaking process to do so.

Reports of Payments or Other Transfers of Value to Covered Recipients

CMS proposes to eliminate the current exclusion for reporting indirect payments made to covered recipient physician speakers at certain accredited and certified continuing education events, in part because this exclusion has the unintended consequence of appearing to endorse or support specific sponsors of continuing education. CMS seeks to correct this unintended consequence by deleting 42 CFR § 403.904(g) to correct this unintended consequence and also because it believes that the current exclusion is redundant with § 403.904(i)(1).

APMA appreciates CMS' consideration of our feedback regarding the reporting of speaker payments associated with certain continuing education events. As we have previously communicated, APMA strongly disagrees with the decision of CMS to omit arbitrarily the accrediting entity for sponsors of continuing education in podiatric medicine, the Council on Podiatric Medical Education (CPME) as an accrediting or certifying entity under the current exclusion.

Also, APMA takes issue with the original rulemaking process in this particular case and questions whether CMS provided proper notice and opportunity to comment on the current exclusion. The proposed rule, published by CMS on December 19, 2011, solicited comments on its proposals regarding categorization of compensation made to speakers. 76 Fed. Reg. 78750. CMS stated that it was considering and welcomed comments on how to categorize CME-accredited speaking engagements and other speaking engagements. The proposed rule did not address, provide notice of, or solicit comment on exempting accredited and certified speaking engagements from reporting requirements, nor did it propose any list of accrediting and certifying entities that would be recognized for this purpose. As such, APMA was not able to provide information to CMS on CPME and its standards of approval for sponsors of continuing education in podiatric medicine and explain why they should be exempted in our comment letter, which was submitted on February 17, 2012.

Under 1861(r) of the Social Security Act, Congress defined doctors of medicine, doctors of osteopathic medicine, and doctors of podiatric medicine (as well as doctors of dental surgery and dental medicine, doctors of optometry, and chiropractors) as physicians; however, the current exclusion provides separate and not equal standards without consideration of legislative intent. Additionally, state laws and regulations require continuing medical education for podiatric physicians in order to maintain their licensure to practice, which is required of all physicians. To ensure the credibility of these programs and uniformity in standards, state law and regulations frequently require that podiatric physicians attend continuing medical education programs offered by CPME- approved sponsors. Because CPME was arbitrarily omitted from this list, covered recipients who lecture at continuing education in podiatric medicine programs run by CPME-approved sponsors will be treated differently than covered recipients who lecture at continuing medical and dental education programs run by sponsors accredited or certified by the listed entities.

As APMA has previously informed the CMS Center for Program Integrity's Data Sharing and Partnership Group and the Department of Health and Human Services Office of the General Counsel, CPME has adopted substantively the same standards and requirements as ACCME and the other entities listed. CPME approves sponsors of continuing education that demonstrate and maintain compliance with the standards and requirements stated in CPME publication 720, *Standards, Requirements, and Guidelines for Approval of Sponsors of Continuing Education in Podiatric Medicine*. The CPME approval standards are comparable to and seek to accomplish the same objectives outlined in the *ACCME*

Accreditation Criteria, specifically the criteria for full accreditation or re-accreditation for a 4-year term (criteria 1 through 15), as well as the *ACCME Standards for Commercial Support: Standards to Ensure Independence in CME Activities*. CPME and its Continuing Education Committee base approval on programmatic evaluation and periodic review. Like the accrediting and certifying entities listed under the current exclusion, CPME approves the sponsor itself rather than each of the sponsor's continuing education activities, but reserves the right to review any or all of a sponsor's activities, educational, or otherwise. Despite these parallels in the continuing medical education approval processes, CMS still chose to arbitrarily include ACCME, AAFP, ADA CERP, AMA and AOA, and not CPME on its list of accrediting or certifying entities.

APMA applauds CMS for proposing changes to resolve the inequity created by the current exclusion. The changes ultimately finalized by CMS should create an equal playing field for accredited or certified sponsors of continuing education who adhere to standards preventing improper industry influence. The current exclusion will result in adverse unintended consequences on the podiatric medicine community and the patients requiring foot and ankle care by podiatric physicians, especially Medicare beneficiaries. The current exclusion can serve as a deterrent for providing grants to sponsors of continuing education due to the additional and arbitrarily added burden to track transfers of value made to covered recipient speakers at these programs relative to exempted programs.

CMS proposes to exempt indirect payments made to speakers at certain accredited and certified continuing education events under § 403.904(i)(1), which excludes indirect payments or other transfers of value where the applicable manufacturer is “unaware” of, that is “does not know,” the identity of the covered recipient during the reporting year or by the second quarter of the following reporting year. The awareness standard under § 403.904(i)(1) is improper and unworkable in the context of continuing education as applicable manufacturers become aware during the time period specified of the identities of speakers at continuing education events through various avenues, including event attendance and electronic and print publications stating speaker information.

APMA respectfully requests that CMS finalize distinct regulatory language exempting indirect payments made to speakers at continuing education events as these indirect payments are unlike other indirect payments and transfers of value exempt from reporting requirements under § 403.904(i)(1). CMS should add the following regulatory text § 403.904(i)(1) to eliminate confusion regarding the awareness standard and prevent the need for subregulatory guidance:

The awareness standard shall not apply to covered recipient speakers, faculty, or attendees at a continuing education program if an applicable manufacturer or applicable GPO provides funding to a continuing education provider, but does not either select or pay the covered recipient speaker directly, or provide the continuing education provider with a distinct, identifiable set of covered recipients to be considered as speakers for the continuing education program.

CMS notes that it considered two alternatives, expanding the list of accrediting organizations for which an exclusion would apply or articulating accreditation or certification standards that would allow a continuing education program. Should CMS expand the list of organizations in 403.904(g)(1) by name, APMA respectfully requests that the accrediting organizations for all physicians, defined 1861(r) of the Social Security Act and adopted by § 403.902 of the Open Payments regulations, be included, including CPME. CMS has previously stated its concern regarding the administrative burden associated with expanding the list of organizations in 403.904(g)(1)(i) by articulating accreditation or certification standards that would allow a CME program to qualify for the exclusion. However, if CMS pursues this option further, the end result should ensure that all accrediting bodies meeting comparable standards are treated the same. Otherwise, the unlevel playing field created by the existing CME exclusion would remain unaddressed.

Physician Compare Website

CMS proposes an ambitious timetable and plan for populating the Physician Compare website with performance data for individual physicians and physician groups, while continuing to emphasize the agency's intent to move ahead only if technically feasible and only if the information to be posted meets certain statistical standards.

APMA remains concerned about the limited information currently available about the implications of the performance scoring methodology that underlies the data that CMS plans to publicly disclose. For example, we wonder whether some physician specialties or physicians who practice in certain locales will be systematically disadvantaged by the methodology. Instead of being asked to comment on a specific timetable for Physician Compare, we would prefer to be asked to comment on CMS analysis of performance data. Rather than hearing that CMS reserves the right to amend its plans at any time, we would prefer an opportunity to comment on CMS analysis that the agency believes justifies the public disclosure of certain data and provides assurance of fair treatment of all physicians and non-physicians serving Medicare beneficiaries.

In short, we believe there is too little transparency to the Physician Compare decision-making process. While it is appropriate that individual physicians and physician groups will be provided an opportunity to review their own data prior to its posting on Physician Compare, we do not believe this is the same as offering an opportunity for stakeholder associations to gain a better appreciation for why certain data should be publicly disclosed while other data should not be. Among other things, we would urge CMS to host Town Hall meetings during which it could share the results of its performance scoring system without attributing those results to named physicians or physician groups. CMS could also, for example, provide information about how different categories of physicians fare under the methodology, such as physicians in different practice sizes, urban vs. rural settings, across specialties, and across states. We suspect, for example, that some physicians will have their quality performance score set by only a few measures and could be advantaged or disadvantaged in the process. And some specialties may

not be scoreable on cost measures and/or may be deemed “average cost” and again either advantaged or disadvantaged in the process. We would argue, for example, that cost measures that apply only to some subset of physicians could be considered flawed and unfair, even if the remaining physicians are deemed to be “average cost.”

CMS also invited comment about the idea of adding specialty society-collected performance data to Physician Compare and/or linking to specialty society websites from Physician Compare. APMA believes that any data presented to the public under CMS auspices, whether on Physician Compare or through links from Physician Compare to other websites, need to be presented in a standardized way if it is to have value for consumers. For example, all data need to be comparable and subject to the same ground rules, risk adjustment methodologies, minimum sample sizes, validity and reliability checks, and consumer testing. We also believe it would be best to have all data presented on a single, Physician Compare website, rather than expecting consumers to navigate through multiple links to a disparate array of specialty society websites. In short, we believe that CMS should maintain control over the public disclosure process to the greatest extent possible. Otherwise, we see the potential for variable data disclosure outcomes that would not well serve the public.

Physician Quality Reporting System

CMS proposes a large number of changes to the Physician Quality Reporting System (PQRS). Failure to satisfy PQRS reporting criteria or the criteria for satisfactory participation in a qualified clinical data registry (QCDR) during CY 2015 would result in a 2 percent payment penalty in CY 2017. However, as discussed in more detail below, CMS proposes to increase this payment penalty for failure to satisfy PQRS reporting requirements to a total of 6 percent as a result of the combined effect of PQRS and value-based payment modifier (VM) policies.

With respect to the CY 2015 measure set, CMS proposes additions and deletions for individual measures and measures groups, changes to measure domain assignments, changes to the available reporting options for various measures, and a requirement that measures groups now have a minimum of 6 measures, rather than the current 4. CMS also proposes to require the reporting of “cross-cutting” measures under the claims and qualified registry reporting mechanisms, and increased reporting of outcome and/or certain other types of measures under the QCDR reporting option. CMS further proposes to set the reporting threshold at 9 measures across 3 domains in order to avoid PQRS and VM penalties, up from the current threshold of 3 measures without domain requirements, which is sufficient to avoid PQRS payment penalties for CY 2016. Admittedly, CMS warned stakeholders in the CY 2014 PFS final rule of its intent to move towards the reporting of 9 measures covering at least 3 domains for the CY 2017 PQRS payment adjustment.

APMA strongly opposes the proposed 6 percent combined payment penalty (adjustment) for failure to satisfy PQRS reporting requirements. This penalty is particularly unreasonable for those physicians in groups of 2-9 EPs and in solo practice who are being phased into the VM and

would not be at risk for a downward adjustment based on quality tiering. The “extra” 4 percent payment penalty should be eliminated or significantly reduced, leaving only the statutorily required PQRS penalty of 2 percent.

APMA is also concerned that the CY 2015 measure set will make it more difficult for our members to satisfy PQRS reporting requirements. Unfortunately, the proposed rule and its many Addenda and supporting documents do not contain a user-friendly listing of the 2015 PQRS measure set that would result if all of CMS’ PQRS-related proposals are finalized. In future rules, both proposed and final, we urge CMS to make such a helpful document available. By our count, the CY 2015 measure set would contain a total of 240 measures, 45 fewer than in CY 2014. More importantly, despite its own estimate that most EPs will use claims-based reporting in CY 2015, CMS is proposing to reduce the number of measures available for claims reporting, leaving a total of only 38—across all of medicine. This push towards registry, EHR or QCDR reporting further penalizes our members who because of their age or being a solo practitioner have chosen not to pursue CEHRT. Their only option is to do PQRS reporting by the claims method and the proposed changes make this even more difficult. By choosing not to pursue CEHRT and satisfy requirements of meaningful use, they are already subject to a 3% payment reduction in 2017. With a potential combined PQRS and VM penalty of 6% and the continued sequestration reduction of 2%, they will potentially see an 11% decrease in their payments in 2017. This is in light of the fact that there are no documented studies to demonstrate that performing quality measures or utilizing CEHRT to demonstrate meaningful use improves patient care.

Further, of the 16 measures we believe to be most commonly reported now by doctors of podiatric medicine (in various combinations, depending on the practice), CMS is proposing to delete 5 (measures 20, 21, 22, 245, and 246), almost one-third, and to eliminate the claims-reporting option for another 2 (measures 46 and 163). As the table below demonstrates, this leaves doctors of podiatric medicine (DPMs) with relatively few measures and domains without a single measure, depending on the reporting mechanism.

**Proposed 2015 PQRS Measure Set:
DPM-Relevant Measures by Domain and Reporting Mechanism(s)**

Domain	Number	Number via Claims	Number via Registry	Number via EHR
Effective Clinical Care	1	0	1	1
Communication and Care Coordination	2	1	2	0
Patient Safety	2	2	2	1
Efficiency and Cost Reduction	0	0	0	0
Person and Caregiver- Centered Experience and Outcomes	0	0	0	0
Community/Population Health	6	6	6	5
TOTAL	11	9	11	7

While we recognize that PQRS reporting criteria provide for reporting less than 9 measures across 3 domains, if less than 9 measures apply, providers may nonetheless be fearful that the Measure-Applicability Validation (MAV) process will conclude that they should have reported more. Other DPMs may be able to meet the 9 measure threshold only by including measures they do not consider appropriate for their practice. In general, it strikes us as odd for CMS to reduce the number of available measures, constrain reporting options, adopt more stringent reporting criteria, and significantly increase penalties for failure to satisfy these criteria—all at the same time. We strongly believe that our concerns will be broadly shared by other physician specialties and by non-physician practitioners as well. We urge CMS to reconsider. At the very least, we ask that the final rule:

- Retain measures 20, 21, and 22;
- Preserve the option of claims-based reporting for measures 46 and 163; and
- Reduce to 6 the number of measures that generally need to be reported under various reporting mechanisms.

With respect to the last bullet, this would reflect a doubling of the number of measures required in the previous year and would be reasonable considering how many measures are being removed from claims reporting.

With respect to QCDR reporting, CMS proposes to require the reporting of at least 3 outcome measures or, in lieu of 3 outcome measures, at least 2 outcome measures and at least 1 of the following “other” types of measures—resource use, patient experience of care, or efficiency/appropriate use. The proposed rule includes definitions for each of these measure types but this only serves to increase confusion about what CMS has in mind when it refers to outcome and “other” measures. For example, the proposed rule says that an outcome measure is “a measure that assesses the results of health care that are experienced by patients (that is, patients’ clinical events; patients’ recovery and health status; patients’ experiences in the health system; and efficiency/cost” [emphasis added]. But then CMS separately defines a patient experience of care measure as “a measure of person- or family-reported experiences (outcomes) of being engaged as active members of the health care team and in collaborative partnerships with providers and provider organizations” [emphasis added]. There also appears to be potential overlap between “efficiency/cost” outcome measures and two other measure types, resource use and efficiency/appropriate use. Thus, while the CMS QCDR-related proposal appears to wish to distinguish outcome measures from “other” types of measures, its proposed definitions do not effectively do so. And, unfortunately, the proposed rule in its entirety provides only a single example of an outcome measure, unplanned hospital readmission after a procedure.

Suffice it to say that APMA believes that the final rule must do a better job of describing the responsibilities of QCDRs and the EPs who choose to participate in them with respect to the reporting of outcome measures and any other CMS-specified measure types. Otherwise, stakeholders will be left wondering whether CMS will consider a given measure to be an outcome measure or not. In any case, given the confusing nature of the proposed rule, we would ask that CMS not finalize the 3 outcome measure requirement but instead require 2 outcome measures or in lieu of 2 outcome measures, 1 outcome measure and 1 measure from other specified measure types, all very clearly defined, with multiple examples of each measure type provided in the final rule. This more modest increase in reporting requirements (up from the current 1 outcome measure requirement) would acknowledge that the QCDR option is still quite new. In making this recommendation, we wish to acknowledge some concern about the potential confusion that will arise as CMS specifies measure types that do not match the measure domains being used under PQRS.

Value-Based Payment Modifier

As required under current law, CMS proposes to apply the value-based payment modifier (VM) to all physicians and groups of physicians for CY 2017. CMS further proposes that the performance period for this purpose would be CY 2015. This would complete the roll-out of the VM by including for the first time physicians in groups of 2-9 eligible professionals (EPs) and solo practitioners. Also, while not required under current law, CMS also proposes to apply the

VM to all non-physician practitioners paid under the Medicare physician fee schedule for CY 2017. Under the CMS proposal, groups with between 2 and 9 EPs and solo practitioners would be subject to only an upward or neutral VM in CY 2017, while larger groups would be subject to upward, neutral or downward adjustments, with the downward adjustments being as much as -4 percent. Further, as noted earlier, failure to satisfy PQRS reporting requirements would subject the affected EPs for a 4 percent payment penalty under the VM as well as the otherwise applicable 2 percent payment penalty under PQRS, for a total payment reduction of 6 percent, merely for failure to report quality data. Thus, even groups with between 2 and 9 EPs and solo practitioners could face substantial penalties in CY 2017 under the proposed VM policy, despite the CMS pledge of subjecting them only to upward or neutral VM adjustments in that year based on quality tiering results.

As noted above, APMA strongly opposes the proposed 4 percent payment adjustment under the VM for physicians and physician groups failing to satisfy PQRS reporting requirements, especially in the case of solo practitioners and groups of 2 to 9 EPs. On the other hand, we strongly support CMS' proposal to hold solo practitioners and small groups harmless for the CY 2017 VM under quality tiering. In fact, we believe that CMS should consider phasing in the amount at risk under the VM for solo practitioners and small groups as it has done for groups of 100 or more. In other words, in any given year, the amount at risk should not be the same for all physicians and physician groups, especially in the early years of the VM. While it might be appropriate for the amount at risk to be 4 percent for groups of 100 or more EPs, who are entering their third year under the VM, we do not believe that this same amount at risk should apply to smaller groups. This would allow all physicians and physician groups to benefit from the gradual application of the VM. Said another way, the smallest groups should not initially face a large amount at risk simply because they were the last ones to be subjected to the VM. As noted immediately above, we recognize that solo practitioners and small groups would be held harmless for CY 2017 under quality tiering but, for example, we do not believe it would be fair for them to have a 4 percent or even higher amount at risk for CY 2018.

In light of our comments on Physician Compare, APMA also urges the agency to host Town Hall meetings to provide more information about the results of the VM methodology, across physician specialties, geographic areas, practice sizes and types, and other factors. Once again, we believe that aggregate information that does not identify specific physicians or groups would be extremely useful and help stakeholders determine whether the VM methodology is or is not systematically advantaging or disadvantaging particular categories of physicians or non-physicians. Such analysis could, for example, determine which physician types are more likely to be deemed "average quality" or "average cost" under the VM methodology and thus unable to earn maximum rewards or incur maximum penalties. It could also provide information about which specialties are more likely to be scored on relatively few quality or cost measures and those being scored on a large number of such measures, and help determine whether some groups are being advantaged or disadvantaged in the process. We believe this type of information should be made available prior to proposing significant increases in the amount at risk under quality tiering. In short, while APMA appreciates the fact that CMS is attempting to

construct a fair and reasonable VM methodology, we believe the jury is still out on whether this effort will be successful across all physician and non-physician practitioners. Going beyond simulations of the potential effect of the VM across the physician community as a whole will be important if CMS wishes to ensure greater transparency with respect to the VM methodology.

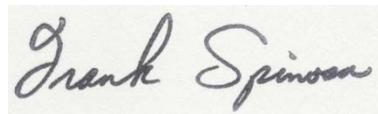
Physician Feedback Reporting Program

The proposed rule notes that CMS plans to disseminate Quality and Resource Use Reports (QRURs) based on CY 2013 data to “all physicians” in late summer. The proposed rule also says that QRURs based on CY 2012 data were made available to groups with 25 or more EPs on September 16, 2013.

APMA wishes to ensure that CMS intends to disseminate QRURs to all individuals who meet Medicare’s definition of “physician,” not just some subset of such professionals. More specifically, since CMS clearly intends to apply the VM to DPMs, it would obviously be problematic if QRURs—or their equivalent—were not provided to DPMs this summer. This would place DPMs at a distinct disadvantage as they attempt to prepare for the VM. APMA will be monitoring this situation closely and asks that CMS confirm in the final rule that DPMs—and hopefully all those EPs that will be subject to the VM—can expect the same treatment and assistance, including the ability to access QRURs or their equivalent.

APMA trusts that the above input will be helpful as the agency fashions a final rule. If there are any questions about our comments or additional information is needed, please contact Scott Haag, JD, MSPH, Director of APMA’s Center for Professional Advocacy and Health Policy & Practice Department, at 301-581-9233 or via e-mail at slhaag@apma.org.

Sincerely,



Frank Spinoso, DPM
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