



September 2, 2014

Ms. Marilyn Tavenner  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1612-P  
P.O. Box 8013  
Baltimore, MD 21244-8013

**RE: CMS-1612-P – 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 and Other Revisions to Part B for Calendar Year 2015**

Dear Administrator Tavenner:

On behalf of the Society of Gynecologic Oncology (SGO), we are pleased to submit comments in response to Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for CY 2015 and other Changes to Payment under Part B. The SGO is the premier medical specialty society for physicians trained in the comprehensive management of gynecologic cancers in women. Our purpose is to improve the care of women with gynecologic cancers by encouraging research and disseminating knowledge, raising the standards of practice in the prevention and treatment of gynecologic malignancies and collaborating with other organizations interested in women's health care, oncology and related fields. As medical professionals with a special interest and expertise in gynecologic cancers, we dedicate our work to helping women conquer the cancers unique to them. We uphold the highest standards of quality care, and through research, we are creating new and innovative ways to improve the treatment and care of patients. SGO members advocate and contribute to a comprehensive approach to screening, diagnosis and treatment; empowering women with the knowledge to provide answers, support and hope.

Our comments will address the following CMS proposals:

**Resource-based Practice Expense RVUs - Using OPPS and ASC Rates in Developing PE RVUs**

In the CY 2014 rulemaking process for the Medicare Physician Fee Schedule (MPFS), CMS acknowledges proposing but not finalizing a policy limiting the nonfacility PE RVUs for individual codes so that the total nonfacility PFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting. CMS is not proposing a similar policy for CY 2015 and SGO commends CMS for this action.

SGO opposes the use of Hospital Outpatient Prospective Payment System (OPPS) or Ambulatory Surgical Center (ASC) payment rates or data sets in setting practice expense payments for services performed in a physician's office. Patients prefer to receive these services in a physician's office and timely access to these procedures ensures that patients do not have a delay in treatment. Patients are already anxious with many concerns about having a disease such as a gynecologic cancer where there are issues of outcome and mortality to be discussed and cared for. Driving chemotherapy infusion out of physician offices altogether and requiring patients to obtain these services in a more costly, less convenient facility setting may cause them to be less compliant and to suffer complications in silence that could lead to an emergency room visit. Any payment policies in this regard in the future could cause a major step back in caring for women with gynecologic cancer and it would detract from the progress that has been made.

SGO strongly disagrees with CMS' previous assertions that when a service is more expensive in the non-facility setting it is not because of appropriate payment differentials between the separate provider settings, but rather due to anomalies in the data. There are explicit instructions in the CPT manual regarding the appropriate coding and billing of chemotherapy services and that all of the supplies be provided by the physician. Hospitals do not have these same instructions regarding ensuring that all the costs of providing these services are placed on each claim.

We believe that if there are anomalies in the data, it is in the hospital outpatient fee schedule data set since it is becoming less specific, with hospitals receiving the same APC payment regardless of whether they get all of the charges for every element of a procedure on their claim. Also, the OPPS payment system is moving forward with the implementation of policy proposals to "package," and not provide separate payment for additional time regarding for a chemotherapy service, if that additional service is billed using an add-on CPT code. Without some type of claims processing edit that requires a hospital to put the charges for packaged services on the claim for that claim to be paid, hospital claims data sets will deteriorate over time. SGO again reiterates our support for CMS not proposing any policy changes for CY 2015 regarding the use of hospital cost data in setting physician office practice expense payments.

#### **Misvalued Services under the Physician Fee Schedule – Improving the Validation and Coding of the 10- and 90- Day Global Surgical Package**

SGO urges CMS to not implement its proposal to transition all 10- and 90-day global bundles to 0-day global codes with medically reasonable and necessary visits billed separately during the pre- and post-operative periods outside the day for the surgical procedure.

We believe that our members should receive fair pay for their work and that quality patient care is first and foremost what we all should be trying to accomplish in any policy decision that we make. Coordinated team-based care is appropriate and it is facilitated with the surgeon as the "Captain," of the team and through the use of the current global surgical packages. SGO believes that we need to focus on care delivery models and then determine a payment model. This policy that CMS is proposing is exactly the opposite of this approach.

SGO believes that CMS' concerns regarding the accuracy of PFS payments for global surgical bundles will not be addressed by its proposal. In fact, CMS acknowledges that it would need to estimate the values for all 4,246 affected codes. Given the proposed timeline, this process of estimation would result in numerous errors. CMS would be operationalizing this policy using a "reverse building block," method and SGO is strongly opposed to this action. Also, determining a "typical," patient from CMS' claims data if the agency were to establish global payment bundles in the future would be challenging and difficult to achieve with this proposal. Many global surgical procedures have already been re-surveyed for accuracy

through the misvalued services review process. If CMS has specific concerns with particular codes, those procedures should be nominated and then reviewed through the RUC process.

Also, many of the post-operative activities performed in a global surgical period in the days immediately following surgery do not have CPT codes to bill separately for those services, such as removal of a Foley catheter or a breathing or feeding tube, or change of dressings. If CMS's proposal is implemented, these other physician services would also need to have their physician work, practice expense, and malpractice risk separately compensated—using either new or existing CPT/HCPCS codes. If post-operative care is unbundled, examples of services that would need to be separately reported include:

- Dressing changes;
- Local incision care;
- Removal of operative pack;
- Removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints;
- Insertion, irrigation and removal of urinary catheters;
- Routine peripheral intravenous lines;

Thus, there would be no opportunity under this proposal for data to be collected regarding these types of activities and surgeons would no longer be reimbursed for these activities. This is another reason that the proposal is premature and not well thought out. CMS needs to be proposing solutions to address the traditionally undervalued immediate pre- and post- operative work that a surgeon provides on the day of the surgery that is part of what is involved in a surgeon providing good, high quality care to patients.

We understand that CMS wants to avoid potentially duplicative or unwarranted payments when a beneficiary receives post-operative care from a different practitioner during the global period. However, there are other ways to accomplish this goal that do not involve the disruption of dismantling the 10- and 90-day global periods. CMS, its contractors, and physicians have successfully used modifiers on claims to notify the contractor when an assistant is utilized during a surgical procedure or when two surgeons are working together as co-surgeons in a complicated case. There are rules for when to bill these modifiers and rules for how much the reimbursement will be for the entire case and for each surgeon.

In fact, if this proposal was implemented, all CMS payment reduction policies that impact 010-day and 090-day global codes would need to be analyzed in detail and the reduction percentages would need to be lowered by a substantial amount, if not just outright eliminated. CMS has several payment reduction policies that impact 010-day and 090-day global procedures. These include the multiple surgeries reduction, bilateral payment reduction, co-surgeons and team surgeon payment reductions, and the assistant-at-surgery reduction. These reductions are largely based upon, and justified by, the redundancy of bundled post-operative E/M visits between multiple services, or when multiple surgeons are performing the same surgery.

The multiple surgery payment reduction policy pays for multiple surgeries performed by a single physician or same group practice on the same patient at the same operative session or on the same day at 100 percent of the fee schedule amount for the highest valued procedure; 50 percent for the second highest valued procedure; 25 percent for the third through fifth highest valued procedures. The vast majority of the efficiency between multiple surgeries is due to the overlap of bundled E/M services between the surgeries. Continuing to apply the same reduction percentage to current codes after they were converted to 000-day global codes would be onerous and greatly reduce the payment for second and subsequent surgical services. This same issue would apply to all other payment reductions that currently impact 010-day and 090-day global procedures, including but not limited to, bilateral surgery reductions, co-surgeon and team surgeon reductions, and assistant-at-surgery reductions.

SGO believes modifiers can be used to avoid Medicare paying for duplicative post-operative care from a different practitioner during the global period. This is not unlike the situation of co-surgeons during the procedure itself and the need to use modifiers to identify who is doing what work. This could be helpful to patients that live in a rural area and need to go to an academic medical center in the city for their surgery and then return home for follow-up care. This practice could also test whether using modifiers for the purpose of attribution when separating a longer term episodic payment can work. And, this could provide a step forward in testing this concept for use in attribution of payments under future alternative payment models.

In addition, this proposal would create burdens for all, including physicians, CMS and Medicare beneficiaries. SGO is concerned about the administrative burden to both SGO members and their practices and for CMS and its contractors. We also feel it is not appropriate for CMS to make a proposal such as this where the basic intent is the collection of data, while the proposal has the potential to increase an individual Medicare beneficiary's co-payments.

The American Medical Association estimates that the elimination of the global period will result in 63 million additional claims being filed with Medicare contractors to account for post-surgical evaluation and management services. The increase in costs to Medicare to pay the contractors to process these claims and the appeals that may occur does not seem to have been taken into consideration when CMS was deciding to propose this policy. There is also the additional administrative burden on the practice to submit all these additional claims. Driving up the cost of healthcare in this fashion is not a good use of physician and staff time resources.

In addition, SGO is concerned that this proposal will potentially increase the amount a patient has to pay, in total, for an episode of care. 10- and 90-day global surgical packages shift the risk of managing a patient's care to the surgeon, which SGO members have agreed to accept. This mechanism of payment promotes high quality, efficient care that does not create incentives for increases in volume, which could happen by eliminating the global bundles. Global surgical bundles are good for the patient as they have a predictable, guaranteed co-payment for that surgical procedure and all of its follow-up care. Also, this proposal is counter to CMS' support for bundling of payments.

For all of these reasons, SGO urges CMS to not implement its proposal in the CY 2015 MPFS Proposed Rule to transition all 10- and 90-day global bundles to 0-day global codes.

### **Malpractice RVUs**

CMS is proposing its third five-year review and update of the professional liability insurance (PLI) RVUs for 2010, and has requested comments on the proposed methodology for updating the PLI RVUs. It is unclear to the SGO why CMS' contractor had difficulties finding recent malpractice premium data for gynecologic oncologists. The SGO has over 1,100 members of which approximately 900 are actively practicing and taking care of women with gynecologic cancer on a daily basis.

For the CY 2015 PLI update, CMS has chosen to crosswalk the Gynecological/Oncology specialty to Obstetrics Gynecology. Over the past several updates, the SGO has consistently recommended, and CMS has agreed, that Gynecological/Oncology should be directly crosswalked to either General Surgery or Surgical Oncology, both having the same PLI risk factor. If CMS proposal is finalized, the resulting PLI risk factor would see a large decrease from the current (5.91 to 3.80).

Gynecologic oncologists are predominantly cancer surgeons, with advanced surgical training being received as part of the three-four year gynecologic oncology fellowship. SGO members are the “captain” of the team with regard to care for women with gynecologic cancer.

The relationship with a patient usually begins when the patient is referred with signs and symptoms of a gynecologic cancer, or in the case of cervical cancer, an abnormal pap smear. The gynecologic oncologist diagnoses the cancer which may include performing a surgical procedure. Once diagnosed, the gynecologic oncologist surgically removes and stages the cancer, and in the case of ovarian cancer it can be a very long and technically challenging surgical procedure involving removing tumor from much of the abdominal cavity, since this disease is rarely detected early. The gynecologic oncologist then puts together a follow-up treatment plan which may include chemotherapy, delivered by the SGO member and/or radiation therapy, where the patient is referred to a radiation oncologist. The elements of the treatment plan depend on the stage and type of gynecologic cancer being treated. The gynecologic oncologist will coordinate and provide the women’s cancer care, including follow-up surgeries for recurrence, chemotherapy, office visits, etc. for up to five years and in some cases for longer than that. Finally, with ovarian cancer having a survival rate at five years of only 47%, gynecologic oncologists also coordinate hospice care and work with patients and their family members regarding end of life planning.

Gynecologic oncologists can spend as much as 40% of a given week performing major surgical procedures, represented by 90 day global period codes. This is similar to the surgical work load of a general surgeon. Therefore, the PLI risk for procedures provided under Gynecological/Oncology is more akin to General Surgery procedures rather than non-surgical OBGYN procedures.

The SGO requests that for the purposes of calculating malpractice RVUs for the 2015 final Medicare physician fee schedule, CMS crosswalk gynecologic oncology, specialty code 98, to general surgery.

#### **Valuing New, Revised and Potentially Misvalued Codes**

SGO appreciates CMS’ proposal regarding a new timeline and process for the publication and implementation of changes to physician codes and relative value units. The current process in which changes for new, revised and misvalued codes are first announced as interim values in the final rule at the beginning of November and then implemented on January 1 for that final rule year, does not allow adequate public comment, the correction of mistakes or sufficient time for physicians to prepare for the changes in payment, including how the revisions might impact their practices and patients.

We agree with CMS and their statements in the CY 2015 MPFS Proposed Rule that the agency needs to follow a process where values for new, revised, and misvalued codes are listed in the proposed rule and available for comment. CMS would be able to consider additional information contained in these comments prior to making final decisions on revised payments for services. The current proposals in this rule need additional work and thus SGO would recommend that CY 2016 be used as a transition year for misvalued and revised CPT codes that have been completed with information conveyed to CMS by the RUC as of April 1, 2015, including misvalued services for CY 2015 that would be delayed by one year to be part of the CY 2016 proposed rule and this transition process.

CY 2017 could be the first year that includes all new, revised and potentially misvalued codes. During the 2016 transition year, CMS could hold a town hall meeting to collect additional information from all stakeholders on the process and timing. They could also continue discussions with the CPT Editorial Panel and the RUC regarding moving back the dates for these meetings within the annual, yearly cycle to allow for all three meetings and the transmission of data to CMS to occur such that everything could meet the timelines to be included in the annual proposed rule.

We agree with CMS' observation in the proposed rule that "the RUC recommendations are an essential element that we consider when valuing codes. Likewise, we recognize the significant contribution that the CPT Editorial Panel makes to the success of the potentially misvalued code initiative through its consideration and adoption of coding changes." Also, "for many codes, the surveys conducted by specialty societies as part of the RUC process are the best data that we have regarding the time and intensity of work. The RUC determines the criteria and the methodology for these surveys. It also reviews the survey results. This process allows for the development of survey data that are reliable and comparable across specialties and services than would be possible without having the RUC at the center of the survey vetting process. In addition, the debate and discussion of the services at the RUC meetings in which CMS staff participate provides a good understanding of what a service entails and how it compares to other services in the family, and to services furnished by other specialties. The debate among the specialties is also an important part of the process." Therefore, CMS working with the community to move the meetings within the cycle back a few weeks and CMS also agreeing to move their date back for transmission of the data several weeks is a solution that is necessary to make this proposal work.

Starting this process in 2016 has major ramifications for the CPT and RUC process. Therefore, using 2016 as a transition year with only misvalued codes being included in the proposed rule for 2016 that have had their review completed in 2014 or the first three months of 2015 could be a good test case scenario to validate this process.

In order to effectively implement the revised process, SGO recommends using 2016 as a transition year for misvalued services reviewed in 2014 and the first three months of 2015 and delaying the new timeline and process until 2017.

CMS has also proposed creating HCPCS G codes to cover new and revised codes until the 2017 payment schedule. Unfortunately, this would create an administrative burden for physicians who would be required to maintain one coding system utilizing G codes for Medicare and another for payers using the new and revised CPT codes. SGO urges CMS to not implement this proposal.

SGO does not support the elimination of the refinement panel process. There needs to be a final appeals process where new data can be brought to a panel for final arbitration of the values assigned to a specific code/service.

#### **Reports of Payments or Other Transfers of Value to Covered Recipients**

SGO is concerned about CMS' proposal that would revoke the existing Sunshine Act exclusion for Continuing Medical Education activities, mainly due to requests from other accrediting bodies that they be added to the list of exempt organization covered by the exclusion. CMS' proposal is adding confusion to a process that is already very complicated and hard to understand regarding what is and is not reportable. This proposal could have a negative effect on continuing medical education (CE), which runs counter to the public's interest.

SGO recommends that if CMS moves forward it needs to modify the proposal to add explicit language that the exemption applies under section 403.904(g)(1)(i) when an applicable manufacturer provides funding to a CE provider, but does not select or pay the covered recipient/speaker/faculty directly or provide the CE provider with a distinct, identifiable set of covered recipients to be considered as speakers/faculty for the CE program. The agency should provide additional guidance in this regulation to achieve the aforementioned ensuring that the industry donor is unaware of the speakers/faculty and other participants before committing to fund the activity. This accomplishes CMS' goal while eliminating the potential negative impact to CE. To allow CE providers time to ensure that their processes comply with

the modified exemption, we urge CMS to make this change effective six months after the Final Rule is issued.

Also, when Congress enacted the Sunshine Act, 12 specific exclusions from the reporting requirements were outlined, including “educational materials that directly benefit patients or are intended for patient use.” CMS concluded that medical textbooks, reprints of peer-reviewed scientific clinical journal articles and other services used to educate physicians were not covered by this exclusion even though these clearly have a direct benefit for a patient’s medical care. CMS’ decision to not cover these materials under the educational materials’ exemption is inconsistent with Congressional intent. We urge CMS to reconsider its decision to not cover medical textbooks and journal articles within the existing statutory exclusion for educational materials that directly benefit patients.

In addition, there are widespread concerns that the implementation of the Open Payments system for data collection is not ready and will likely lead to the release of inaccurate, misleading and false information. CMS has already taken the Open Payments system offline several times because of technical problems. As previously recommended, there should be a minimum of six months to upload the data, process registrations, generate aggregated individualized reports and manage the dispute communications and process. CMS has also not provided effective notification to the vast majority of physicians nor provided SGO a reasonable amount of time to educate its members on the registration and dispute process. Thus, it is extremely likely that many physicians impacted by Sunshine Act reporting are not aware of the requirements. And, there is frustration at the overly complex, 11 step registration process. For these reasons, SGO urges CMS and the Office of Management and Budget to postpone for six months, until March 31, 2015, the publication of the information collected in the Open Payments System.

Finally, the May 5, 2014 [Federal Register](#) supplementary document entitled “Agency Information Collection Activities; Submission for OMB Review” relating to dispute of Open Payments information stated that manufacturers “after reviewing the disputed information, if they determine that no change is required to the data, may dismiss the dispute or request that physician or teaching hospital who initiated the dispute to withdraw it”. The February 2013 Sunshine Act Final Rule does not authorize manufacturers to dismiss disputes without both parties agreeing that the dispute is resolved. We understand that CMS officials have stated their intent to issue clarifying guidance that manufacturers are not authorized to unilaterally dismiss disputes. We would appreciate receiving this guidance in writing.

#### **Physician Compare Website**

SGO has concerns with the accuracy of the information that is being used for the Physician Compare Website, particularly since CMS is proposing to expand public reporting of group-level measures by making all 2015 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO), registry and EHR measures for group practices of two or more Eligible Professionals (EPs) available for public reporting by 2016. CMS is also proposing to expand measures for individual EPs by making all 2015 PQRS individual measures collected by registry, EHR or claims available for public reporting on Physician Compare in late 2016.

CMS states that “consumer testing has shown including too much information and/or measures that are not well understood by consumers on these pages can impact a consumer’s ability to make informed decisions”. Most consumers are not familiar with PQRS, registry and EHR measures, so using these measures without explanation continues to be problematic. Benchmarks using percentiles will also be difficult for consumers to understand. Testing consumers to determine how well they understand each measure that will be placed on the website must occur prior to placing these additional measures on the website in late 2016.

We do appreciate that CMS will continue to reach out to specialty societies to ensure that the measures under consideration for public reporting remain clinically relevant and accurate and will link to their websites for information on non-PQRS measures. SGO recommends that this outreach be organized and a specific process articulated in the CY 2015 Final Rule.

More relevant for consumers is patient experience data collected via a certified Consumer Assessment of Healthcare Providers and Systems vendor that includes: getting timely care, appointments and information; patient's rating of provider; access to specialists, etc. SGO supports making these measures available for public reporting for all group practices.

We also support processes for physicians whose information is being publically reported to have a reasonable opportunity to review their results before these are posted in Physician Compare. CMS needs to lengthen the review period for physicians to at least 90-days versus the proposed 30-day preview period which is a relatively short time for physicians to review their data as it will appear on the website.

### **Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting System (PQRS)**

CMS is proposing changes in several key areas of PQRS, particularly the requirements for the 2017 PQRS payment adjustment of -2 percent, which will be based on an eligible professional's (EP) or a group practices' reporting of quality measure data during the 12-month calendar year reporting period occurring in 2015. CMS is proposing to maintain a two-year look-back for applying PQRS penalties. CMS also proposes the addition of 18 cross-cutting PQRS measures that must be included in a "qualified clinical data registry," to allow for an EP or group practice that see at least 1 Medicare patient in a face-to-face encounter to report on at least two of these cross-cutting PQRS measures.

The complexity and administrative burden of the PQRS program remains a serious concern for SGO members. Monitoring the yearly changes to the PQRS reporting options, measures, measures groups, and physician group participation options requires an overwhelming layer of administrative burden that is extremely costly and resource-intensive. For some physicians, this is simply not feasible.

Furthermore, the Measure Applicability Analysis (MAV) Process is retrospective meaning a physician can do their best to report the measures they believe are applicable to them and then after the fact, CMS could determine that it believes they should have reported on additional measures. SGO urges CMS to make the MAV process prospective with the physician having a specific time window at the beginning of the year to report to CMS on the measures they believe are available for them to report and to then receive a response from CMS that gives them confidence that what they are planning to report will meet the CMS requirements for that reporting year.

To ensure high quality health care across the country, every practicing clinician must have workable options for implementing quality measurement. These options must function within routine practice, with measures captured as an integral part of ongoing clinical workflow. Templates for electronic medical health records are not yet specialty specific and that makes it difficult to collect data for the reporting of measures. There is also the concern of intra-operability between computer systems and the need for more time to figure this out. CMS has expanded the recognition of registry reporting across its performance programs, but it also needs to continue to allow for claims-based reporting for the foreseeable future. Many of the existing PQRS quality measures have not been tested in an electronic health record or registry environment. SGO has recently launched the test sites for a clinical data registry. ~~This registry will be available to all SGO members for the purpose of quality reporting [Is this a true statement?].~~ However, given the CMS requirements and deadlines, SGO members will not have a registry option for PQRS reporting until at least the 2016 reporting period for 2018 payment. There is currently no registry

option in gynecologic oncology for PQRS reporting. **[Is this true? Is there more to add about the registry activities?]**

- **Proposed 2015 PQRS Reporting Changes**

CMS proposes to increase the number of measures that must be reported via the claims and registry-based reporting mechanisms, from three to nine measures to avoid a 2 percent penalty in 2017. These nine measures must cover at least three of the National Quality Strategy (NQS) domains: Patient and Family Engagement; Patient Safety; Care Coordination; Population and Public Health; Efficient Use of Healthcare Resources; and Clinical Processes/Effectiveness and include 2 of the proposed cross-cutting measures. CMS believes that requiring the reporting of nine measures covering three NQS domains across all of its performance programs will promote alignment and make it easier for physicians to participate in one performance program and get credit across many programs.

While SGO understands CMS' interest in aligning the PQRS program with the National Quality Strategy, SGO members do not have nine measures to report, especially since CMS is proposing to remove some of the measures from the Perioperative Care Measure Group. Increasing the current reporting requirement threefold, from three measures to nine, covering at least three NQS domains in one program year, is an unreasonable leap and disregards the realities of the existing PQRS measure portfolio. Therefore, SGO opposes the dramatic increase from three to nine measures, due to the unavailability of meaningful measures relevant to our specialty. We believe the number of measures that need to be reported should continue to be three measures with the possible addition of the two cross-cutting measures for a total of 5 measures for the CY 2015 reporting period to avoid the 2017 penalty.

- **Proposed Cross-Cutting Measures**

SGO does not support CMS's proposal to require PQRS-reporting registries, including those in the QCDR program, to also be capable of reporting on all 18 cross-cutting measures. The listed measures are extremely problematic for surgical specialties, and are not representative of measures that are meaningful to SGO members. They also present an additional reporting burden on top of an increasingly high threshold of reporting for PQRS and an additional cost to registries to upload all the data elements and then maintain them, even if only one physician is reporting said measure. We urge CMS to reconsider this requirement or at least to consider an exemption from the requirement when an overwhelming majority of the cross-cutting measures listed are not applicable to a given specialty.

- **PQRS Feedback Reports**

Lastly, SGO encourages CMS to continue to work toward more timely feedback reports, as feedback to physicians on their participation and performance in the numerous CMS reporting programs will help physicians to perform more efficiently in future reporting years.

- **PQRS Qualified Clinical Data Registries**

As SGO prepares to apply to the CMS Qualified Clinical Data Registry Program (QCDR), it still proves to be a challenge to meet many of the additional provisions in order for a registry to participate in the QCDR program. SGO would urge CMS to continue to refine the program to account for the challenges faced by smaller registries, particular the proposed requirement regarding the 18 cross-cutting measures being available for reporting.

SGO also strongly objects to the proposed requirement to publically report data received by a QCDR in order to remain in the QCDR program. SGO feels that the requirement to public report data discourages the voluntary and honest reporting of quality measures by EPs. The concerns that surround public reporting make the requirement contradictory to the purpose of quality reporting and will negatively affect the data needed for true quality improvement. Thus, we believe that the public reporting requirement is premature and does not give EPs participating in the QCDR program ample time to assess the data from their participation in previous years to see if performance improvement is needed, nor the time to make those improvements if necessary prior to that data being made public. We urge CMS to reconsider this requirement because of the negative impact it will have on quality improvement. ~~[Are there other QCDR requirements that SGO is not going to be able to meet in a timely fashion and thus we should argue against them?]~~

**Value-Based Payment Modifier (VBM)**

In this rule, CMS is proposing to expand of the ACA-mandated value based payment modifier (VBM) to all physicians and to increase the percentage at risk to +/- 4%. SGO believes that a large number of its members are likely to see both a two percent PQRS and a four percent VBM penalty in 2017. By the agency’s own analysis, the physicians who are most likely to face penalties tend to practice in specialties such as gynecologic oncology that treat complex patients with higher risk profiles. This is not acceptable.

SGO is also concerned that physicians who report for PQRS via a QCDR will be at a disadvantage for the first year that any measure is new in the QCDR because of a lack of set benchmarks for these measures. SGO urges CMS to address this issue prior to increasing the VBM percentages.

SGO is opposed to increasing the VBM penalty from two percent to four percent; mandating participation in the tiering option for practices greater than 10 EPs; and making Medicare Spending per Beneficiary an additional cost measure, if it includes Medicare Part A costs.

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If the SGO can provide CMS with additional information regarding this matter, please do not hesitate to contact Jill Rathbun, SGO Director of Government Relations at 703-486-4200.

Sincerely,



[Richard R. Barakat, MD](#)  
[President](#)

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