



AMERICAN OSTEOPATHIC ASSOCIATION

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August 29, 2014

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

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and other revisions to Part B for CY 2015

Dear Administrator Tavenner:

Thank you for the opportunity to provide comments on the 2015 Medicare Physician Fee Schedule (MPFS) proposed rule, published in the July 11, 2014 Federal Register.

The American Osteopathic Association (AOA) represents its professional family of more than 104,000 osteopathic physicians (DOs) and osteopathic medical students nationwide. Approximately 65 percent of practicing osteopathic physicians specialize in primary care areas such as pediatrics, family practice, obstetrics and gynecology, and internal medicine. Many DOs fill a critical need for patients by practicing in rural and other medically underserved communities.

In addition, the AOA promotes public health; encourages scientific research; serves as the primary certifying body for DOs; is the accrediting agency for osteopathic medical schools; and has federal authority to accredit hospitals and other health care facilities. More information on DOs/osteopathic medicine can be found at www.osteopathic.org.

Physician Payment

Given the passage of the *Protecting Access to Medicare Act of 2014* (PAMA), the reduction in the Physician Fee Schedule (PFS) update, that would have occurred on January 1, 2015, has been replaced with a 0 percent update, effective from January 1 to March 31, 2015. Based upon the 0 percent update and adjustments to maintain budget neutrality, CMS estimates that the 2015 conversion factor will be \$35.7977 until March 31. Once PAMA expires, the conversion factor for the remainder of 2015 will be adjusted based on the Sustainable Growth Rate (SGR) formula, unless Congress acts to avoid the estimated 20.9 percent reduction to the 2015 payment update.

The AOA is deeply concerned that unless an agreement is reached in Congress to replace the flawed SGR formula, physicians will face insurmountable payment reductions caused by the current payment formula as well as possible payment penalties that begin in 2015 and beyond. If the proposed rule is finalized as is, physicians may experience up to an additional 11% payment reduction by 2017, due to the following payment penalties: -2 percent under the Physician Quality

Reporting System (PQRS), -4 percent under the Value-Based Payment Modifier (VM), and -3 percent under the Electronic Health Record (EHR) incentive program (assuming less than 75 percent of Eligible Professionals (EPs) are meaningful users) and -2 percent due to sequestration. The EHR penalty could increase to -5 percent by 2019. If the other two programs stay the same or increase, physicians could eventually face payment reductions greater than 11 percent.

These reductions do not take into account the costs related to participating in the agency's quality initiatives. CMS estimates the total cost burden related to PQRS at \$81,259,510. CMS also estimates that an eligible professional that has received no training from his/her specialty society will take longer to complete PQRS duties and therefore participation will cost more. While CMS expects "the ongoing costs associated with PQRS participation to decline based on an eligible professional's familiarity with and understanding of the PQRS, experience with participating in the PQRS, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices," that expectation has yet to come to fruition.

The AOA supports the creation and implementation of a payment system that promotes delivery models that enhance beneficiaries' overall care and experience in the Medicare program. Although we firmly believe that all physicians and other health care providers strive each day to provide the highest quality of care to Medicare beneficiaries, the current payment system, which is unsustainable and inequitable, often undermines their efforts to accomplish this goal.

The current Medicare physician payment system can and should be improved with respect to the delivery of coordinated, quality, and efficient health care. The flawed SGR formula contributes to access issues for millions of seniors, stifles innovation, and serves as a disincentive to physician participation in the Medicare program. Deep payment cuts threaten the viability of many physicians' practices and imperil patient access to care. Furthermore, the continuation of short-term and temporary solutions to the SGR further advances fragmentation in our health care system and escalates the costs of long-term health care reform. Such costs waste valuable resources.

Osteopathic Manipulative Treatment (OMT)

Issue: For more than a year, the AOA has been in communication with the Centers for Medicare and Medicaid Services (CMS) about revising the assigned global designation of Osteopathic Manipulative Treatment (OMT) CPT Codes 98925-98929 from 000 to XXX. In May 2013, we met with CMS representatives to discuss key issues summarized below:

In 1992, HCPCS M-codes for OMT were assigned an XXX global period. In 1993, the global period for OMT codes were re-assigned a 000 global period without an explanation in the final rule. Carriers were left to interpret payment policies for the global changes resulting in inconsistent guidance on how to correctly report OMT and Evaluation and Management (E/M) Services on the same day.

In an attempt to clarify OMT payment policies, the Office of Payment Policy in the Department of Health and Human Services (HHS) sent a memo dated July 25, 1994, to all Associate Regional Administrators. This memo included a requirement that when OMT and a significant, separately identifiable E/M service are performed on the same date, the E/M visit should be reported with a Modifier -25. Although the 1994 memo provided needed guidance, CMS contractors and other

payers are referring to the global designation without applying additional rules and regulations including exceptions to the global designation that governs these services.

CMS communicated with the AOA as recently as July 15, 2014 regarding OMT. According to CMS, rather than addressing individual codes in isolation, the agency prefers to look at the policies applicable to global codes as a package to assure that similar situations are being treated similarly. Given that the Medicare Fee Schedule is based on relativity, the agency believes this is critical. The agency noted its proposal to transform all 10- and 90-day global surgical codes to 0-day global codes and the timing for addressing global codes will depend on the action taken on this proposal.

Recommendation: CMS accepts that the work associated with OMT is separate from the E/M service, therefore the AOA requests that CMS reverse the assigned global designation from 000 back to XXX to accurately reflect that OMT provided to patients is often on the same day as E/M services. The current designation does not reflect the service being provided, therefore the designation is causing confusion with the MACs, CERT contractors, and PSC/ZPIC contractors. In addition, the current designation is causing administrative burdens on practices and creating additional expenses in response to medical record requests, denial of services, and defending audits. The undue audits are also adding increased costs to the program.

*While we understand the agency's preference to address the policies relating to global designations as a package, we are concerned that the complexities relating to the agency's proposal concerning global surgical codes will create delays in the agency's decision-making process. We believe OMT is a separate issue and can be addressed in an expedient manner. Over the past 20 years, the AOA has worked vigorously to educate members that they should appropriately code the E/M service billed with OMT, and that they should not omit the OMT service if they are providing such care. In addition, the AOA does not believe that other codes would be billed, concurrent with OMT, if the change was made. **We ask that CMS grant the requested change and announce revised OMT global periods in the Final Rule.***

FEE SCHEDULE PROPOSALS

Using OPPS and ASC Rates in Developing PE RVUs

Issue: CMS is seeking comments on the possible uses of the Medicare hospital outpatient cost data in potential revisions to the PFS Practice Expense (PE) methodology. CMS is looking to gather data on the shift toward hospital-based physician practices. CMS proposes to collect information on the type and frequency of services furnished in off-campus provider-based departments beginning in January 2015. CMS believes the best way to collect this data is through the use of a HCPCS modifier to be reported with every code for physician and hospital services furnished in off-campus facilities of a hospital.

Recommendation: The AOA does not support the use of Medicare hospital outpatient cost data in potential revisions to the Physician Fee Schedule. Using it to validate MPFS PE data is not plausible because the purchasing power of a hospital varies greatly from that of a physician office.

The AOA recommends that CMS create a new place of service (POS) code that is specifically for a provider-based outpatient clinic. We believe this would help CMS and others identify when physician offices, for example, have been re-designated as outpatient departments (OPD). The AOA is concerned that a modifier is going to create a significant administrative burden. Given that the modifier does not dictate whether or not a claim is paid, practices may not use it.

We also urge CMS to significantly revise its regulations that allow hospitals to re-designate physician practices as OPDs. Specifically, CMS should create a process that requires CMS approval for such re-designations. This would provide CMS an opportunity to determine whether a re-designation is appropriate and meets CMS criteria. CMS also should place a moratorium on all re-designations until data can be collected and analyzed to inform future policy decisions. CMS should consider further revising its re-designation criteria based on data collected.

Potentially Misvalued Services Under the Physician Fee Schedule (PFS)

Issue: CMS is reviewing high expenditure services across specialties with Medicare allowed charges of \$10,000,000 or more. CMS is looking at 65 codes as potentially misvalued – codes that account for the majority of spending under the physician fee schedule.

***Recommendation:** The AOA supports the ongoing work of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) and the Relativity Assessment Workgroup concerning the reviewing and valuation of these codes.*

Improving the Valuation and Coding of the Global Package

Issue: CMS proposes to transition all 10-day and 90-day global surgical bundles to 0-day global codes, starting in 2017 with the 10-day global codes. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. According to CMS, evidence suggests that the values included in the post-operative period for global codes may not reflect the typical number and level of post-operative E/M visits actually furnished.

The agency's proposal raises many issues such as the potential impact on patients. We are concerned patients will choose not to receive the follow-up visits they need in order to avoid copayments and out of pocket expenses if physicians bill separately for the post-operative visits as proposed. In cases where physicians work out of provider-based outpatient department clinics, the co-payment would be more because patients also would have to pay a "facility fee" for the post-op visits. We also are concerned that patients may not see the need for follow-up care if they "feel fine." However just because a patient feels fine does not mean he/she does not need to return for follow-up care. Neglecting post-operative visits could lead to complications and adverse events.

The AOA does not believe the agency's proposal will adequately measure the physician work, practice expense, and malpractice expense involved in the global surgical package. CMS needs to take into account the numerous services that would have to be separately reported if post-operative care were unbundled, such as dressing changes, incision care, removal of sutures, etc, which would require the use of new or existing HCPCS/CPT codes. In addition, there is a distinction between E/M services provided in a global surgical period and standard, separately billed E/M services. The E/M services in a global surgical package include more expensive equipment and supplies and also require additional clinical staff time.

The agency's proposal also raises questions about its current payment reduction policies for multiple surgery, bilateral surgery, as well as co-surgeon, team surgeon, and assistant-at-surgery payment reductions. If CMS finalizes this proposed rule, what impact will it have on the payment for these services that are already being reduced?

In the proposed rule, CMS refers to 3,000 services with 10-day and 90-day global periods. It is our understanding that there are more than 4,200 services with the global periods, which means the breadth of this proposal is larger than CMS estimates. In addition, if CMS finalizes its proposal, we do not know the impact on private payers. We are concerned with the potential administrative challenge that could arise if private payers do not remain consistent with Medicare.

It also is our understanding that if this proposal is finalized, more than 63 million additional claims could be generated to process, creating an administrative burden for the Medicare contractors. This ultimately could result in delayed payments for physicians. In conducting cost and impact analyses, CMS should consider the administrative burden on physician practices and the Medicare Administrative Contractors as well as the added expense for processing the additional claims.

Burdens on contractors and physicians shift resources from health care delivery to administrative processes that serve no benefit to the beneficiary. The AOA believes the agency's proposal has generated more questions than answers; therefore, more time is necessary for research and analysis because the impact will vary across procedures.

CMS requests comments on the most effective way to acquire accurate data regarding the number of visits and other services actually being furnished during the post-operative periods. CMS can obtain this data through analyzing the claims that are submitted, including post-operative inpatient claims. The AOA encourages CMS to work with the RUC on obtaining and analyzing post-operative data.

The AOA reiterates its support for efforts to improve the transparency and accuracy of physician payments. Such efforts must be conducted in a thorough and meaningful manner that includes stakeholder participation. The RUC is examining the global surgical packages and we encourage the agency to take RUC's findings into consideration before making any final determinations. Given the work that the RUC has done in collaboration with CMS to ensure that the values of the global surgical codes are accurate, we are concerned that the consequences of the agency's proposal will outweigh the benefits.

***Recommendation:** The AOA supports efforts to improve the accuracy of physician payments. Given the complexities of measuring the post-operative work related to a global surgical package, the AOA and the American College of Osteopathic Surgeons urge CMS to not finalize its global package proposal this year to allow more time for research and analysis. Better data is necessary to appropriately improve the valuation and coding of the global surgical package.*

Medicare Telehealth Services

The AOA supports the concept of telemedicine and believes that the utilization of technology in patient care should be used to increase access to care, and must not be used in a way that would diminish patient centered comprehensive personal medical care or the quality of care being provided to the patient. The AOA believes that the standard of care provided through the use of technology should be equivalent to that of care provided when the physician and patient are within close physical proximity.

The scope of care being delivered by the physician and other health care providers through telemedicine should not exceed education, training and applicable state and federal law. Clinicians must provide complete transparency to their patients regarding their location, jurisdiction of licensure, and any limitations of the technology used to deliver care.

The AOA believes that as physicians provide care in a variety of new ways, including telemedicine, advanced technology can be used to improve patient care. The AOA further believes that online medicine policies directly tie into the Patient-Centered Medical Home (PCMH) model of care, and recognizes that we must simultaneously implement advancements in telemedicine in order to be successful in that new model.

Issue: CMS proposes to add 90845 (Psychoanalysis) 90846 (family psychotherapy – without patient present); and 90847 (family psychotherapy (conjoint psychotherapy with patient present)); 99354, 99355 (prolonged service office codes), G0438 and G0439 (annual wellness visit codes). An expansion of the geographic qualification is also detailed in the proposal.

***Recommendation:** The AOA supports the agency's proposal to add the psychoanalysis, psychotherapy, prolonged services, and annual wellness services to the telehealth list.*

Issue: The agency noted in its proposal that last year it modified its definition of “rural” to allow a broader inclusion of sites within Health Professional Shortage Areas as telehealth originating sites. Last year, the AOA commended the agency’s efforts to expand Medicare’s telehealth footprint by increasing the number of beneficiaries eligible for telemedicine by modifying their urban/rural definitions. We also raised concerns that last year’s proposal added a complicated formula to the process, requiring local clinics and providers to search hard-to-find census tract information to determine their eligibility.

***Recommendation:** We recommend that CMS continue to provide the tools and educational materials necessary to help clinics and providers determine eligibility.*

Valuing New, Revised and Potentially Misvalued Codes

Issue: CMS proposes to modify its process. All changes in the work and malpractice Relative Value Units (MP RVUs) and the direct PE inputs for new, revised and potentially misvalued services under the PFS would be included in the PFS proposed rule beginning with the proposed rule for CY 2016. CMS proposes to include proposed values for all new, revised and potentially misvalued codes for which it has complete RUC recommendations by January 15 of the preceding year. Therefore, for the CY 2016 rulemaking process, CMS would need the RUC recommendations by January 15, 2015.

For codes which CMS does not receive RUC recommendations by January 15 of the preceding year, the agency would delay revaluing the code for one year (or until CMS receives RUC recommendations for the code before January 15) and include proposed values in the following year’s rule. According to CMS, for codes that were revised or deleted as part of CPT coding changes, when the changes affect the value of a code and CMS has not had the opportunity to consider RUC recommendations, CMS would create G codes.

AOA Position: Following the Notice and Proposed Rulemaking (NPRM) process will allow CMS to incorporate stakeholder insight into the payment decisions before the rates take effect. However, the agency’s proposal creates administrative challenges. We believe CMS should change the implementation date to 2017, instead of 2016 because under the current proposal CMS would have to receive recommendations by January 15, 2015 in order to be included in the 2016 proposed rule. Given the current timeframes of the CPT Editorial Panel and the RUC, numerous codes being reviewed would not be part of the 2016 PFS proposed rule.

Moreover, the CPT Editorial Panel will not conclude its cycle for the 2016 code set until February 7, 2015, therefore implementation of those codes would be delayed by a year. In addition, the RUC submits its recommendations no later than May 31 each year for consideration in the next payment schedule, under its current work cycle. CMS recognizes that “to the extent we do not receive RUC recommendations in time to include proposed values in the proposed rule, the most updated version of some CPT codes would not be used by the Medicare program for the first year.”

The AOA supports the proposal put forth by the American Medical Association to expedite the review process for new, revised and potentially misvalued codes. According to the AMA, the proposal would retain the current meeting infrastructure for CPT and the RUC and modify the workflow to accommodate publication in the proposed rule. The AOA recently signed onto a coalition letter urging CMS to adopt the AMA’s proposal. We appreciate that CMS would consider “alternative implementation dates to allow time for the CPT Editorial Panel and the RUC to adjust their schedules to avoid the necessity to use G codes.”

If CMS adopts the AMA proposal, the need for CMS to create G codes would be eliminated. The creation of G codes would compete with CPT codes and cause administrative problems for physicians. Practices would be forced to maintain one coding system for Medicare and another for other payers using the most recent CPT codes. CMS acknowledges that G codes could create burdens for practices as well as for the agency.

We commend CMS for noting that the CPT codes and RUC recommendations continue to play a major role in the agency’s valuations. We trust that CMS will collaborate with the AMA on a workable timeframe. Postponing the implementation date of the agency’s proposed valuation process to the 2017 Medicare Physician Fee Schedule will allow a more reasonable transition to a valuation process that will increase transparency.

***Recommendation:** The AOA supports transparency in the valuation process of codes. We agree that CMS should follow the full notice and comment rulemaking process with a 60-day comment period for the proposed payment rates, and supports the modified timetable and processes for implementing this change, as proposed by the American Medical Association.*

Chronic Care Management (CCM)

Issue: CMS proposes to reimburse chronic care management services at \$43.67 per patient per month in a physician’s office and \$32.58 in a facility, starting in 2015. CMS used the work RVU and work time associated with the non-face-to-face portion of CPT code 99495 as the foundation to determine its proposed values for CCM services. CMS proposes a work RVU for GXXX1 of 0.61. CMS proposes a work time of 15 minutes for GXXX1 for CY 2015 based on the time attributable to the non-face-to-face portion of CPT 99495. For direct PE inputs, CMS proposes 20 minutes of clinical labor time.

As established in the CY 2014 PFS final rule (Dec. 10, 2013 Federal Register), the services involve non-face-to-face care coordination for Medicare beneficiaries with two or more chronic conditions expected to last at least 12 months, or until death, which pose significant risk of death, decline in function, or acute exacerbation or decompensation. At least 20 minutes of services must be furnished per 30-day billing interval, usually by clinical staff.

Physicians and other practitioners would be able to employ clinical staff either directly or under contract, and could provide general supervision at all times, not just after hours, according to the proposed rule. Requirements such as 24-hour coverage, medication review, ongoing coordination, and a patient-centered care plan will continue, but CMS no longer plans to adopt broad practice standards to ensure the capability to provide CCM services.

AOA Position: The purpose of CCM services is to provide patients with the benefit of advanced primary care. The AOA appreciates the agency's commitment to supporting primary care and for recognizing that care management is "one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth." We commend the agency for proposing to eliminate certain restrictions on billing and for choosing not to adopt broad practice standards for providing CCM services.

However, the agency's proposal does not sufficiently address the needs of the more complex chronically ill patient. The AOA is concerned that high-risk, high-cost chronically ill patients who need CCM services would not benefit from the agency's proposal. CMS should take into account the distinction and differences between chronic care management and chronic disease management.

Chronic care management is required for the sickest and most frail patients who cannot and should not be treated using standard clinical guidelines due to the complexities of their conditions and the high risk of adverse events. Chronic care management is more intensive because the patients have a higher risk of death or hospitalization or emergency care. On the other hand, chronic disease management is more appropriate for lower risk patients who have chronic conditions that can be effectively managed using standard clinical practices, preventive care, and immunizations.

The agency's proposal fails to take this distinction and differences into account. For example, the minimum of 20 minutes time allowance for clinical staff labor is insufficient for chronic care management. The severity of a patient's chronic conditions will determine the amount of staff time necessary for establishing a care plan for a new patient. Depending on the patient's condition, establishing a care plan could take 20 minutes to an hour or possibly more. Under the agency's proposal, the CCM code is used and the payment rate remains the same no matter how much staff time is spent on a patient – a minimum of 20 minutes or 120 minutes – providing CCM services. Under the agency's proposal, the only service that will be paid correctly is a minimum service.

We believe the proposed payment rate is too low and would not cover the costs of nursing staff, overhead, computer equipment, and insurance needed to provide chronic care management services. The time, intensity of services and staff time, as well as the degree of physician supervision, are much higher for chronic care management than for chronic disease management. We also need to take into account the negative impact of the SGR payment rate reduction scheduled to take effect April 1. The AOA is concerned that the agency's proposal will prohibit a physician's practice from providing CCM services.

Recommendation: *In last year's final rule, CMS noted that paying separately for non-face-to-face chronic care management services is a significant policy change. CMS also said last year that as it gains more experience with separate payment for this service, the agency may consider additional changes in the coding structure in future rulemaking. While we commend CMS for moving in the right direction, we believe the agency needs to revise its requirements and redefine its scope of services for the proposed G code to be more*

consistent with chronic disease management. We also believe CMS should refer to a “per calendar month” rather than “per 30 days.” In addition, CMS should implement 99487, with the RUC recommended values and a minimum 60 minutes of clinical staff time, as its chronic care management code. We also recommend that CMS define the required scope of services for billing 99487 as those services currently proposed to be required for GXXX1. We encourage CMS to set the payment rate for the CCM code at a level that takes into account the infrastructure physicians must have to facilitate robust care coordination.

Issue: CMS is now proposing to require the use of certified electronic health record technology (CEHRT) which is certified to at least 2014 Edition certification criteria and includes an electronic care plan, as a condition of payment for CCM services.

AOA Position: Given the challenges with timing, backlogs and the certification caseload, the current availability of 2014 Edition CEHRT has been limited. Until all challenges affecting the availability of latest CEHRT are addressed, CMS should not require a specific stage of meaningful use certification. In addition, certification of an EHR system has little to do with how effectively a physician manages patients with chronic conditions. Looking for markers such as frequency of lab tests or results alone does not necessarily translate into higher quality medical care. We believe applying CEHRT standards to reimbursement for CCM services will likely harm the very beneficiaries who need these services the most.

In addition, the AOA is concerned that physician practices will have difficulty meeting the around-the-clock, 7 days a week access to healthcare providers requirement which will prevent many or most practices, particularly those in rural areas, from being reimbursed for providing CCM services, especially when EHR systems still face interoperability challenges.

Recommendation: *AOA recommends that CMS refrain from finalizing the EHR requirements for CCM services set forth in the proposed rule.*

Issue: CMS proposes to preclude physicians participating in the Multi-payer Advanced Primary Care Practices Demonstration or the Comprehensive Primary Care Initiative from billing Medicare for CCM services for patients participating in these initiatives.

Recommendation: *Practices involved in the demonstration initiatives are being paid on a per-patient per month basis to provide comprehensive non-face-to-face services that are attributed to their practice and AOA supports CMS’ proposal to preclude them from billing for CCM services for patients participating in these initiatives. We also support the agency’s proposal to allow these physicians to bill Medicare for CCM services furnished to beneficiaries who are not attributed to the practice’s participation in the initiatives.*

Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models

Issue: The Center for Medicare and Medicaid Innovation has the task of testing innovative payment and service delivery models that could reduce program expenditures while improving quality of care. HHS is required to conduct an evaluation of each model tested. These evaluations require research. CMS proposes to require model participants, providers and suppliers to produce individually identifiable health information and other information HHS defines as necessary to conduct research.

Recommendation: *While the AOA appreciates the agency's need to conduct research on the delivery models, we are concerned about the amount of information the agency would require a practice to provide. The agency's proposal could create a significant and costly administrative burden on the practice. We suggest that an additional payment be made as a "grant" to reward participation. Such a grant would compensate for the time and effort expended to modify a practice in order to study potential outcomes.*

Local Coverage Determination Process for Clinical Diagnostic Laboratory Testing

Issue: CMS proposes to change the local coverage decision (LCD) process for new draft clinical diagnostic lab tests by: 1) shortening the public comment period for physicians and others from 45 days to 30 days (with option to extend); 2) making Carrier Advisory Committee (CAC) meetings optional with no requirement for open stakeholder meetings; 3) requiring MACs to respond to all comments and publish a final LCD within 45 days of the comment period closing; and 4) making the LCD effective immediately upon publication as opposed to allowing 45 days before it became effective.

AOA Position: The AOA believes this proposal restricts stakeholder input and limits the quality of relevant clinical information. Will this proposal restrict access to tests? Does CMS plan to apply this process to other services? Will a physician's ability to meaningfully impact coverage policies be further restricted? Will physicians' access to CACs be more limited which appears to be the trend?

Reports of Payments or Other Transfers of Value to Covered Recipients

Issue: CMS proposes to remove in its entirety the provision providing the continuing medical education exclusion (section 403.904(g)), contending that it is redundant with a provision (section 403.904(i)(1)) that excludes indirect payments or transfers of value where the applicable manufacturer is unaware of the identity of the covered recipient during the reporting year or by the end of the second quarter of the following reporting year.

AOA Position: The AOA along with the American Association of Colleges of Osteopathic Medicine recently submitted a joint letter expressing our opposition and recommendations regarding this proposal as well as our concerns about the Open Payments System overall.

The AOA disagrees with the agency's contention that the continuing medical education exclusion is redundant with section 403.904(i)(1). The proposed provision states that the manufacturers may not know who presenters are for up to a year and a half after the indirect payment is made. As soon as the advertisements and conference agenda are made public, the drug or device manufacturer who sponsors the CME conference would know the doctors and other medical professionals making presentations. The manufacturer would then need to contact the CME entity putting on the conference to get an accounting of how much money he/she donated as an indirect payment went to each doctor for travel, food, and speaking fees.

The AOA also is concerned that the proposal as currently written could be subject to various interpretations by manufacturers. If the agency finalizes its proposed rule, CMS must provide educational material to all stakeholders to ensure that the provision is explained in the same way in order to avoid adding confusion to what already exists with the overall Open Payments System.

The AOA also points out that in the agency's final rule released February 8, 2013, CMS stated: "We have finalized at 403.904(g)(1) that an indirect payment made to a speaker at a continuing education program is not an indirect payment or other transfer of value for the purposes of this rule and,

therefore does not need to be reported.” Certain conditions have to be met including: the program meets the accreditation or certification requirements and standards of the American Osteopathic Association, Accreditation Council for Continuing Medical Education, American Academy of Family Physicians, American Medical Association, or the American Dental Association’s Continuing Education Recognition Program.

Accredited/certified CME providers should be exempt. These parties have rules and regulations in place to ensure that the payment is for objective, evidence-based, scientific activities that will benefit patients and health care professionals. The AOA adopted, with minor additions, the Uniform Guidelines for Accrediting Agencies of Continuing Medical Education. In addition, the AOA Standards for Commercial Support (SCS) are well-aligned with policies set forth in the Accreditation Council on Continuing Medical Education (ACCME) standards for commercial support. These rules create strict firewalls to prevent any conflict of interest.

It is important to note that there is a clear distinction between accredited/certified CME and promotional education. Faculty in commercially-supported CME programs/activities has a relationship with the accredited CME provider, *not* with any company supporting the activity/program. For example, the AOA adapted the Standards for Commercial Support (SCS), which *require* that faculty relationships be with accredited providers of CME, and *not* be directly paid by companies which might be supporting the program/activity. In addition, attendees at commercially-supported CME programs have a relationship with the sponsoring organizations (i.e. the specialty society) and *not* with any company supporting the activity/program. In contrast, speakers at promotional events have a direct relationship with a company.

The AOA believes CMS should maintain that distinction between accredited/certified CME programs and promotional education. Direct compensation for serving as a speaker in a promotional educational program offered by an applicable manufacturer should be reported under the Open Payments System. However, in accredited and certified CME programs, manufacturers do not have relationships with CME faculty.

We strongly believe that the agency’s current proposal will have a chilling effect on physicians’ willingness to serve as faculty because listing their names on a public website without context could be misinterpreted. If this proposal is finalized, it would deter physicians from presenting at conferences because of the perceived impropriety, and increase costs to state affiliates and national organizations that could not receive sponsorships for presenters. This cost would have to be passed onto the physician attendees.

Overall, the AOA believes that current standards of professional self-regulation should be maintained. Any organization that follows the SCS standards or equivalent should be exempt.

Recommendation: CMS should retain the CME speaker exclusion as currently written, and CMS should offer an alternative exemption from reporting for other organizations that follow the ACCME and/or AOA Standards for Commercial Support or equivalent. We also suggest CMS consider modifying section 403.904(i)(1) so that the exemption would apply when the applicable manufacturer is unaware of the speakers/faculty and other participants before committing to fund the activity.

Physician Compare Website

Issue: For 2015, CMS proposes to expand public reporting of group-level measures by making all 2015 PQRS GPRO web interface, registry, and EHR measures for group practices of 2 or more EPs and ACOs available for public reporting on Physician Compare in 2016. If it is technically feasible, CMS also proposes to expand measures for individual EPs by making all 2015 PQRS individual measures collected via registry, EHR, or claims available for public reporting on Physician Compare in late 2016.

AOA Position: The AOA commends CMS for the improvements it has made to the Physician Compare website. According to CMS, “consumer testing has shown including too much information and/or measures that are not well understood by consumers...can negatively impact a consumer’s ability to make informed decisions.” The AOA agrees. We are also concerned that, depending on how the data are presented, such information can damage the reputation of the physician. For this reason, we appreciate that CMS “will continue to reach out to stakeholders in the professional community, such as specialty societies, to ensure that the measures under consideration for public reporting remain clinically relevant and accurate.” We request that CMS continue this collaborative approach and share with professional associations any information obtained through consumer concept testing.

Recommendation: *The agency should extend its preview period from 30 days to 60 days because 30 days is insufficient and does not provide physicians with the time needed to review the data, identify errors, and to gather the evidence needed to refute any errors. We also urge CMS to provide details regarding the recourse available to a physician who identifies a problem or error during the short preview period. CMS should not publicly post data until all concerns registered during the preview period have been resolved. Any errors identified by EPs also should be published so that the accuracy as a whole may be determined.*

Information Accuracy

We have strong concerns about the 20-patient minimum threshold for reporting performance information on Physician Compare, which we believe is much too low and will compromise the validity of the data, result in inaccurate judgments and useless information for patient decisions-making, and potentially harm the reputation of the physicians within a group practice.

Recommendation: *CMS should consider increasing the minimum threshold to strengthen the data collected.*

Composite Measures

CMS requests comments on creating composites using 2015 data and publishing composite scores in 2016 by grouping measures based on PQRS GPRO measure groups, if technically feasible. The AOA believes the timeline is aggressive. There are many unanswered questions about the validity, reliability, and utility/meaningfulness of composites. Composites are relatively new and have not been widely used. CMS should not publicly report them until adequate testing has taken place.

Recommendation: *CMS should consider providing composite results to physicians confidentially through the QRURs, but public reporting should be delayed.*

Timing of Public Reporting

CMS proposes to expand public reporting of individual EPs. It plans to publicly report 20 measures for 2013 PQRS data in early 2015. CMS also proposes to “make all individual EP-level PQRS

measures collected via registry, EHR, or claims available for public reporting on Physician Compare for data collected in 2015 to be publicly reported in late CY 2016, if technically feasible.”

Overall, the AOA believes public reporting of performance data should occur gradually and carefully to ensure the data are accurate and presented in a format that is easy to understand, meaningful, and actionable. The AOA is concerned about the agency’s aggressive timeline. CMS only started public reporting of physician performance data this year and it is for select measures reported by large group practices. We question the likelihood of CMS being able to conduct sufficient testing within one year to verify the accuracy of publicly reported data, whether it is presented in a format that is easy for both physicians and patients to understand, and whether this data are even meaningful and valuable to patients.

CAHPS Data Reporting

CMS proposes to publicly report in 2016 patient experience data from 2015 for all group practices of two or more EPs, who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor. While we recognize the importance of patient experience and appreciate the work that has gone into validating tools such as the CG-CAHPS survey, we have remaining concerns about the subjectivity of patient experience measures and the inability of some of the CAHPS measures, such as “Getting Timely Care, Appointments and Information” and “Access to Specialists,” to accurately capture aspects of care over which an individual physician has direct control.

***Recommendation:** Until CMS can refine these measures, we urge the agency to only report these measures on an aggregate, large group practice level.*

Specialty Society Measures

CMS seeks comments on posting specialty society measures on Physician Compare as well as the option of linking from Physician Compare to specialty society web sites that publish non-PQRS measures. While we support the concept of posting specialty society measures on the web site, we question whether this information would take the place of PQRS measure data or would it be made available to the public in addition to PQRS data.

***Recommendation:** A mechanism should be in place to ensure measures are supported by scientific evidence and have been comprehensively vetted. CMS should post a disclaimer on the Physician Compare website informing the public of the limitations of the PQRS measure set and in certain cases, specialty-selected measures may provide patients with more relevant and meaningful information.*

In addition we recommend that the website include AOA Certification data in addition to ABMS Certification data since the AOA ensures that board-certified DOs maintain currency and demonstrate competency in their specialty area.

Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System (PQRS)

CMS proposes to increase the requirements to achieve satisfactory reporting under the 2015 PQRS and to avoid the 2017 PQRS penalty of -2 percent. For 2015, CMS also maintains all of the reporting options – claims, registry, qualified clinical data registry, group practice reporting option and EHR submission. Among the agency’s specific proposals:

Changes to the Qualified Registry Requirements

Issue: CMS proposes that in addition to being required to be able to collect all needed data elements and transmit to CMS the data at the TIN/NPI level for at least 9 measures covering at least 3 of the NQS domains, a qualified registry would be required to be able to collect all needed data elements and transmit to CMS the data at the TIN/NPI level for ALL cross-cutting measures for which the registry's participating EPs are able to report. CMS also proposes to extend the deadline for qualified registries to submit quality measure data to March 31 following the end of the applicable reporting period. CMS also seeks comment on whether to propose to allow more frequent submissions of data, i.e., quarterly, year-round, etc.

Recommendation: *Overall, the AOA supports the concept of allowing more frequent submissions of measure data which would give physicians more flexibility to choose what works best for their practices. We believe more frequent reporting should be an option, not a requirement, because some physicians may find it more challenging than the current structure.*

Proposed Criterion for Satisfactory reporting of Individual Quality Measures via Claims and Registry for Individual Eligible Professionals for the 2017 PQRS Payment Adjustment

Issue: CMS proposes for the 12-month reporting period for the 2017 PQRS Payment Adjustment, the EP would report at least nine measures, covering at least three NQS domains and report each measure at least 50 percent of the EP's Medicare Part B Fee-for-Service (FFS) patients seen during the reporting period. If the EP sees at least one Medicare patient in a face-to-face encounter, the EP would report on at least two measures contained in the proposed cross-cutting measure set. An EP reporting on less than nine measures would still be able to meet the satisfactory reporting criterion via claims and registry if the EP reports on 1-8 measures. According to CMS, EPs that report on less than nine measures would be subject to the Medicare Applicability Validation (MAV) process which would allow the agency to determine whether an EP should have reported quality data codes for additional measures.

Recommendation: *In our comment letter last year, we expressed concerns about the agency's proposal to increase from 3 to 9 the number of measures an EP must report, covering at least three of the National Quality Strategy domains. We continue to have concerns that specialists including, but not limited to, pathologists, dermatologists, orthopedic surgeons who specialize in one type of procedure, for example, have difficulties finding measures that are relevant and truly meaningful to their practice.*

We again urge CMS to refrain from creating situations that will lead to either non-compliance or reporting simply for the sake of reporting as physicians try to find more general "check-box" measures that are easy to report, but not specifically relevant to their practice.

In addition, while the AOA appreciates the agency's efforts to provide information on the MAV process, we find that the process is confusing. We urge CMS to streamline its educational material to be as clear and concise as possible. More transparency in the MAV process will help improve the understanding of how the process works.

Proposed Criterion for Satisfactory Reporting of Measure Groups via Registry for Individual Eligible Professionals for the 2017 PQRS Payment Adjustment

Issue: CMS proposes for the 12-month reporting period for the 2017 PQRS payment adjustment, the eligible professional would report at least one measures group and report each measures group

for at least 20 patients, the majority of whom would be required to be Medicare Part B FFS patients. CMS proposes to change the definition of a PQRS measures group.

Recommendation: *The AOA is concerned that the agency's proposal to increase the number of measures that may be included in a group from a minimum of four to a minimum of six measures would increase the reporting burden especially for smaller practices. Smaller practices do not have the same level of infrastructure as larger practices do to comply with the PQRS requirements. The agency's overall goal is to increase the requirements to achieve satisfactory reporting; however, CMS must factor in the limitations of smaller practices when developing measurement requirements.*

Proposed Criterion for the Satisfactory Participation for Eligible Professionals in a QCDR for the 2017 PQRS Payment Adjustment

Issue: For the 12-month reporting period for the 2017 PQRS payment adjustment, the EP would report at least nine measures available for reporting under a QCDR covering at least three of the NQS domains, and report each measure for at least 50 percent of the EPs patients. The EP would report on at least three outcome measures, or if three outcome measures are not available, report on at least two outcome measures and at least one of resource use, patient experience of care, or efficiency/appropriate use.

Recommendation: *The AOA understands the agency's efforts to move toward reporting more outcome measures. However, the increase to three outcome measures would also heighten the administrative burden practices now face with participating in PQRS. The alternative that CMS proposes is no less burdensome. In addition, we believe the requirement of three outcome measures is premature since there are not enough approved and validated outcome measures. We recommend that CMS should phase in the use of outcome measures such as increasing the use from one outcome measure to two outcome measures.*

Proposed Criteria for Satisfactory Reporting for Group Practices Selected to Participate in the Group Practice Reporting Option

Issue: CMS proposes to change the deadline by which a group practice must register to participate in the GPRO to June 30th of the applicable 12-month reporting period.

Recommendation: *The AOA supports the change to the deadline to allow CMS to provide timelier feedback.*

Proposed Criteria for Satisfactory Reporting on Individual PQRS Quality Measures for Group Practices Selected to Participate in the GPRO to Report the CAHPS for PQRS Survey Measures via a CMS-Certified Survey Vendor for the 2018 PQRS Payment Adjustment and Subsequent Years

Issue: Beginning with the 12-month reporting period for the 2018 PQRS payment adjustment, and for subsequent years, CMS will require that group practices, comprised of 25 or more eligible professionals that are participating in the GPRO, report and pay for the collection of the CAHPS for PQRS survey measures.

Recommendation: *We recognize the importance of patient experience and appreciate the work that has gone into validating tools such as the CAHPS survey; however, we have concerns about the subjectivity of patient experience measures and the inability of some of the CAHPS measures to accurately capture aspects of care over which an individual physician has direct control. CMS should maintain CAHPS as an option, not a requirement.*

Statutory Requirements and Other Considerations for the Selection of PQRS Quality Measures for Meeting the Criteria for Satisfactory Reporting for 2015 and Beyond for Individual Eligible Professionals and Group Practices

Issue: As part of its proposed criteria for the satisfactory reporting of PQRS measures for the 2017 PQRS payment adjustment via claims and registry that requires an eligible professional or group practice to report on at least two cross cutting measures, CMS proposes 18 cross-cutting measures for 2015 and beyond. For 2015, CMS also proposes to add 28 new individual measures and two measures groups to fill existing measure gaps. In addition, the agency proposes to remove 73 measures from PQRS. CMS also proposes to increase the number of measures that may be included in a measures group from a minimum of four to a minimum of six.

AOA Position: The AOA believes the cross-cutting measures are reasonable. The agency's rationale is that most eligible professionals perform these services. We do, however, believe that most of these measures are more conducive to primary care than to specialty practices. The AOA also is supportive of the measures CMS proposes to add to PQRS as they appear to be more specialty-specific. We also commend the agency for proposing measures related to depression and mental illness.

The AOA opposes the agency's proposal to remove so many measures at one time when most specialties find it challenging to find nine relevant measures. In addition, we question what evidence was used to claim that a measure has topped out and therefore removed from PQRS given that approximately one-third of eligible professionals participate in the program.

We are concerned that CMS removed measures because the measure owner/developer indicated it will not be able to maintain the measure. CMS does not indicate why the owner/developer can no longer maintain the measure. Is the measure no longer useful? Are we losing good measures because they can no longer be maintained? CMS needs to provide a more detailed explanation as to why the measure is no longer clinically applicable when the measure steward will no longer maintain this measure.

We also want to note that we appreciate the agency's efforts to help eligible professionals, particularly first-time participants, determine what measures best fit their practices. As we stated earlier, we continue to have concerns that some specialists have difficulties finding measures that are relevant and truly meaningful to their practice. In collaboration with specialty societies, CMS is grouping its final measures available for reporting according to specialty. We urge CMS to continue its collaborative efforts with specialty societies to alleviate the difficulties with PQRS participation.

Recommendation: *We urge CMS to be more transparent in its decision-making process with regard to measures proposed for removal. We also recommend that CMS adopt a one-to-three-year transition period between announcing the removal of a measure and officially retiring it from the program to give specialties time to develop alternative measures in light of the dearth of measures available for certain specialties and the relatively low level of physician participation in PQRS.*

Informal Review

Issue: CMS proposes to reduce the period from 90 to 30 days that an EP has to request an informal review of the PQRS penalty. CMS proposes limitations as to what information may be taken into consideration.

Recommendation: *Thirty days is an insufficient amount of time for physicians to access, sift through, and identify/confirm errors in feedback reports. While we understand this would allow the agency to respond quicker to review requests and provide physicians a brief period to make limited corrections to PQRS data before they are used for the value-based payment modifier, we recommend 60 days for the informal review.*

Electronic Health Record Incentive program

Issue: CMS proposes that beginning in CY 2015, EPs would not be required to ensure that their CEHRT products are recertified to the most recent version of the electronic specifications for the Clinical Quality Measures (CQM). In addition, CMS proposes if the agency discovers errors in the most recently updated electronic measure specifications for a certain measure, it would use the version of the electronic measure specifications that immediately precedes the most recently updated electronic measure specifications.

Recommendation: *Given the recent challenges and delays that practices are experiencing with the EHR Incentive Program, we support the agency's proposals and commend CMS for taking stakeholder feedback into consideration.*

Medicare Shared Savings Program (MSSP)

Issue: CMS proposes to revise the quality scoring strategy to recognize and award ACOs that make year-to-year improvements in quality performance scores on individual measures. The proposed changes also increase the number of measures calculated through claims and decrease the number of measures reported by the ACO through the GPRO Web Interface.

In addition to participating in the Medicare Shared Savings Program, participants will be subject to the Value-Based Payment Modifier (VM) starting in 2017. Physicians participating in the MSSP also may have fee-for-service patients which may be cause for confusion with the value-based payment modifier. Participants also will be subject to payment adjustments under VM and MSSP. Plus, downward payment adjustments begin in 2015 under the EHR incentive program, starting at -1 percent. The adjustment increases each year that an EP does not demonstrate meaningful use to a maximum of -5 percent.

Recommendation: *We support recognizing and rewarding ACOs for year to year improvements. We agree that adding an explicit incentive places greater emphasis on quality improvement, encouraging all ACOs to continue to improve quality for their patient populations over time. We also believe ACOs that have reached the top 10 percent nationally should be recognized and paid appropriately due to their high relative performance across the country.*

Valued-Based Payment Modifier (VM)

Issue: The proposed rule doubles potential VM penalties to 4 percent, subjects ALL physicians to 2017 VM adjustments based on performance in 2015, extends the modifier to ACOs and other alternative payment models, and includes limited license practitioners as well as physicians. Groups of 100 or more become eligible for VM penalties or bonuses in 2015 based on 2013 cost and quality performance and groups of 25 to 100 will be eligible in 2016 based on 2014 performance.

AOA Position: While the AOA understands that the law requires the VM to be phased in over a three-year period beginning in 2015 and apply to all physicians by 2017, we believe implementing the program at such a rapid pace leaves CMS with very little time to evaluate the results of the first year and practically no time to make changes to the program based on lessons learned. The VM is yet

another regulatory requirement that will only compound the burden that practicing physicians already face and further erode the physician-patient relationship if carried out too aggressively.

Scope of the VM Program

We support the agency's proposal to hold harmless groups with between 2 and 9 eligible professionals and solo practitioners from any downward payment adjustments under quality tiering in CY 2017. CMS noted that its quality-tiering methodology identifies a small number of groups and solo practitioners that are outliers – both high and low performers – in terms of whose payments would be affected by the VM, limiting any widespread unintended consequences. We request that CMS provide more demographic details regarding the outliers.

CMS proposes to clarify that it would apply the VM only to assigned services and not to non-assigned services starting the 2015. CMS explains applying the VM to non-assigned claims would directly affect the Medicare payments to beneficiaries, not the physicians which is contrary to the agency's intent. While we understand the agency's intent, we question how would the agency's policy affect physicians who choose to opt out of Medicare in mid-year? Under those circumstances it is possible for a physician to have assigned claims for only part of the year and non-assigned claims for the remainder of the year.

VM Program Penalties

CMS proposes to double the payment penalty to -4 percent and increase the upward payment adjustment to +4 percent in CY 2017. CMS believes it “needed to increase the amount of payment at risk...to incentivize physicians and groups of physicians to report PQRS data, which will be used to calculate the VM. We strongly oppose the agency's proposal to double the VM penalties, particularly since the ACA statute does not mandate increases in the penalties. We also are concerned that physicians who treat Medicare's sickest patients will be at a disadvantage and face penalties under the VM because these practices have higher costs and greater risks than other practices. In addition, we question the agency's plan to default practices into the “average” tier when there is insufficient data, which could put them at risk for a VM penalty.

***Recommendation:** Any further penalty increases should be delayed until CMS has more experience in demonstrating the validity and lack of errors in its methodology that determines total per capita cost, claims-based quality measures, patient attribution and the informal review process. Given the complexities and challenges related to VM's methodology and tiering process, we recommend that CMS make tiering voluntary for all practices.*

We want to point out that private plans tend to reward performance improvement rather than incentivizing high performers and penalizing low quality. We urge CMS to consider this concept for the VM since it would minimize confusion and provide a much more reliable understanding of how CMS sets performance benchmarks. CMS should consider revising the quality and potentially cost scoring strategy to recognize and reward not only physicians who meet a certain benchmark, but those that make year-to-year improvements in performance scores, as the agency is proposing for MSSP ACOs in this rule.

VM Program Informal Corrections Process

For the CY 2015 payment adjustment period, to align with PQRS, the agency is proposing to expand the informal inquiry process to establish an initial corrections process that would allow for

some limited corrections to be made. The AOA believes the expansion of the review process is reasonable, but the agency does not fully address the real problem which is the implementation of a methodology/process that has not been fully tested. The ability to identify errors and correct them in a timely fashion also has not been fully tested.

According to the agency, it will not be feasible initially to fully evaluate errors with regard to quality measure data and accept data for the CY 2015 payment adjustment period. Therefore the agency would classify a TIN as “average quality” in the event the agency determines it made an error in the calculation of quality composite. CMS proposes to continue the expanded informal inquiry process starting with the CY 2016 payment adjustment period. Provided it has the infrastructure in place, CMS would recompute a TIN’s quality composite and/or cost composite if the agency has determined it made an error in the calculation. If the operational infrastructure is not in place, the agency would continue the approach of classifying a TIN as “average quality,” in the event the agency has determined it made an error.

We question the agency’s methodology for its corrections process, particularly if it turns out the TIN should be classified as high quality. What impact would this average quality classification have on the physician’s overall rating? How does CMS plan to determine whether it has made an error? Once it has the operational infrastructure in place, will the agency re-examine the cases where it classified a TIN as average quality in the error review process?

The agency also proposes to establish a 30-day period that would start after the release of the Quality and Resource Use Reports (QRUR) for a group practice or solo practitioner to request a correction.

***Recommendation:** We believe the informal review process should be 60 days to allow physicians sufficient time to detect any errors.*

VM Program Attribution

CMS proposes to modify its two-step attribution methodology of the total per capita cost measure. The agency proposes to move NPs, PAs, and CNSs to Step One from Step Two of the attribution process insofar as they provide primary care services. The agency also would remove the “pre-step” that identifies a pool of assignable beneficiaries that have had at least one primary care service provided by a physician. The proposal would eliminate the criterion that a beneficiary have at least one primary care service furnished by a physician in the group practice. What impact would this have on the assignment process? Would this proposed process shift patients from primary care practices to specialty practices?

VM Program Support

Given the complexities of the VM process, we urge CMS to improve its outreach efforts and have well-qualified staff available to answer physicians’ questions. We realize outreach is a challenge and if the agency sends out information too early in the process, it may not get the attention of the physician practice.

Physician Feedback Program/Quality and Resource Use Reports (QRUR)

Issue: CMS says it will continue to develop and refine the annual QRURs. Later this summer, CMS plans to disseminate the QRURs based on CY 2013 data to all physicians even though groups with

fewer than 100 EPs will not be subject to the VM in CY 2015. According to CMS, improvements to this year's reports include: additional supplementary information on the specialty-adjusted benchmarks; inclusion of the individual PQRS measures for informational purposes for individual EPs reporting PQRS measures on their own; enhanced drill down tables; and a dashboard with key performance measures. The reports will be based on VM policies that were finalized in the CY 2013 PFS final rule and will affect physician payment starting January 1, 2015.

AOA Position: The AOA commends CMS for its continued work to improve the QRUR feedback reports. This task is critical since the reports serve as the basis for the value modifier. We also appreciate CMS' efforts to solicit feedback from the physician community in its work to make the reports more user-friendly and understandable so that physicians can use the report's data to further improve their practice in the areas of quality and efficiency. We urge CMS to continue its outreach as well as educational efforts regarding the reports.

We question what the impact of removing numerous PQRS measures will have on future QRUR reports. CMS proposes to remove 73 measures for CY 2015. Physicians affected by the removal of these measures likely will be working with new measures and therefore there would not be comparison data from the previous year. We would appreciate more information from CMS regarding the effects of eliminating PQRS measures will have on the QRURs.

In summary, the AOA appreciates CMS' efforts to further align its quality initiatives and for engaging stakeholders to further improve its programs. However, we have serious concerns about the increased penalties and urge CMS to improve its educational efforts to help the physician community to succeed in these initiatives. We also urge CMS to focus more of its efforts on alleviating the administrative and regulatory burdens caused by its programs.

Thank you for the opportunity to provide comments. We look forward to working with CMS on this and other issues of importance to the osteopathic profession.

Sincerely,

A handwritten signature in black ink, reading "Robert S. Juhasz, DO". The signature is written in a cursive, flowing style.

Robert S. Juhasz, DO
President