

August 24, 2010

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1503-P, Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Proposed Rule; (Vol. 75, No. 86), July 13, 2010.

Dear Dr. Berwick:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule with changes to the physician fee schedule (PFS) and other Medicare Part B payment policies for calendar year (CY) 2011, including the implementation of a number of provisions in the *Patient Protection and Affordable Care Act of 2010* (ACA).

Physicians are critical partners with America's hospitals, which employ more than 188,000 physicians (including interns and residents), or approximately 20 percent of all doctors in the U.S. Hospitals are paid for certain outpatient services, such as physical and occupational therapy, under the Medicare PFS. In addition, the proposed rule discusses payment changes under the ambulance fee schedule (AFS) and clinical laboratory fee schedule (CLFS), as well as payments for Part B drugs – all of which impact our members. This letter addresses our issues of concern, including those related to the physician payment formula, the application of a multiple procedure payment reduction (MPPR) to therapy services, and the incorporation of productivity into marketbasket updates.

PHYSICIAN PAYMENT FORMULA

The AHA supports a permanent, long-term replacement to the physician payment formula. This fix must be done in a non budget-neutral manner so that it does not result in reduced payments to other providers.



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The Medicare physician payment formula is severely flawed and, in recent years, would have resulted in significant payment cuts for physicians without legislative intervention. In fact, over the past seven months, Congress intervened on four separate occasions to delay a 21.2 percent cut in physician payments, which was to take effect on January 1, 2010. Specifically, on December 19, 2009, the *Department of Defense Appropriations Act* provided a two-month zero percent update to the PFS through February 28, 2010. On March 2, the *Temporary Extension Act of 2010* extended the zero percent update through March 31, and, on April 15, the *Continuing Extension Act of 2010* extended the zero percent update through May 31 (retroactive to April 1). On June 25, the *Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010* was signed into law providing a 2.2 percent update to the 2010 PFS for services provided between June 1 and November 30, 2010. Beginning December 1, absent any additional congressional action, the conversion factor will drop by approximately 23.4 percent (21.2 + 2.2 percent). In the proposed rule, CMS indicates that the conversion factor will decline an additional 6.1 percent beginning January 1, 2011. This will result in a cumulative decrease in physician payments of almost 30 percent (21.2 + 2.2 + 6.1 percent) from present levels.

A 30 percent reduction in physician payments is unacceptable. The success or failure of health care reform depends on the ability of the newly insured to obtain health care services. Yet many physicians report they are limiting the number of Medicare patients in their practices due to inadequate government payment rates. Others indicate they are laying off staff in anticipation of additional cuts. In addition, many experts are projecting a significant shortage of physicians over the next 15 years. The uncertainty around Medicare physician payment rates, and the ongoing risk of future cuts, is threatening patient access to quality health care services. **Congress cannot continue to provide short-term, temporary fixes to the flawed physician payment formula. It must be fixed permanently and we urge you to work with Congress to solve this problem.**

MULTIPLE PROCEDURE PAYMENT REDUCTION FOR THERAPY SERVICES

The AHA strongly urges CMS to withdraw the flawed and unjustified application of a multiple procedure payment reduction (MPPR) to therapy services.

CMS proposes to apply the MPPR policy to therapy services beginning January 1, 2011. This policy would apply to outpatient therapy services – including physical therapy (PT), occupational therapy (OT) and speech language pathology services – that are delivered in the physician office setting, as well as in hospital outpatient departments, comprehensive outpatient rehabilitation facilities, home health agencies, and other entities. Specifically, CMS proposes to make full payment for the separately payable “always therapy” service with the highest practice expense (PE) value, and apply a 50 percent reduction to the PE component for any second or subsequent therapy service provided to the same patient on the same day. The agency estimates this policy would reduce payments for therapy services delivered in hospital outpatient departments by approximately 13 percent in CY 2011. This estimate does not account for the almost 30 percent additional reduction in PFS payments due to the flawed physician payment formula, which would make the total cut to therapy services provided by hospitals about 43 percent.

The PE values for the therapy codes were deliberately reduced during the relative [value] update committee (RUC) process to avoid duplication. The process used to develop the PE

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values for these codes presumed that the typical therapy visit was 45 minutes, during which time there would be two 15-minute therapeutic procedures and one 15-minute therapeutic modality furnished – for an average of *three* total services per patient per session. Thus for therapy service codes, the procedure inputs were divided in half, and the modalities were given zero inputs because they would not be performed alone.

For example, a typical therapy session of 45 minutes would have three codes billed to Medicare: code 97110 (Therapeutic exercise or more areas, each 15 minutes), code 97110 (Therapeutic exercise or more areas, each 15 minutes), and code 97035 (Ultrasound therapy). Code 97110 has been billed twice because patients typically receive 30 (rather than 15) minutes of therapeutic exercises. Each of these codes is made up of a series of PE inputs – such as “clean room,” “greet patient/provide gowning,” “obtain vital signs” – with a certain amount of time allocated for each task. For the input “greet patient/provide gowning,” the RUC committee approved a total of three minutes. This amount has been divided in half, and code 97110 has been assigned one-and-a-half minutes for this input because one-and-a-half minutes are sufficient when the codes are billed together. Yet CMS proposes to eliminate payment for the second PE input – the one-and-a-half minutes – when the code is billed twice in the same session. The result would be a total allocation of one-and-a-half minutes to greet and gown the patient, when a total of three minutes is what was approved and what is necessary. CMS’ policy would reduce the PE inputs when duplication does not actually exist.

In its preamble, CMS admits that the timing associated with these pre- and post-service periods has been reduced, often by half:

While we acknowledge that the PE inputs per service for some therapy services were included in the direct PE database based on one-half of the total PE inputs required for two services provided in a single session, which would account for some duplication, this was not the case for all combinations of therapy services. [Emphasis added.]

The American Physical Therapy Association’s review of the always therapy codes has shown that nearly all the codes received a reduction. Hence, implementation of an MPPR policy is unjustified. CMS’ proposed policy would actually result in greater distortion and misvaluing of the codes and significant underpayment for therapy services.

CMS’ data analysis is seriously flawed and is based on only a subset of therapy claims. In the rule, CMS states that the CY 2009 PFS claims data show that when multiple therapy services are billed on a claim for the same date of service, the median number is *four* services per day. Given that there are not enough data or information in the proposed rule to understand or replicate this analysis, on July 12, in conjunction with a number of other organizations, the AHA sent a letter to CMS asking that the agency make available the data files it used to conclude that a 50 percent reduction in PE values for outpatient therapy services was justified. CMS’ response letter of July 28 actually helped raise a number of additional concerns we now have with the data the agency used in its analysis.

First, CMS' analysis only includes data from private practice offices. In its July 28 response letter, CMS clearly states that its data analysis “excluded institutional claims, such as claims for outpatient therapy services provided by outpatient hospitals and skilled nursing facilities.” Based on 2007 data from CMS contractor RTI, 35 percent of outpatient therapy services are provided in private practice therapist and physician offices, while the remaining 65 percent are provided in other institutional settings. In its analysis, CMS excluded approximately two-thirds of all claims. More importantly, CMS is now proposing a 13 percent payment cut to hospitals based on a data analysis that does not include any hospital data. This is unjustified and unwarranted. We urge CMS to include a calculation and analysis of the median number of therapy services performed in institutional settings, including hospital outpatient settings, as well. CMS cannot impose such significant policy change with such a significant impact on hospitals without any analysis or rationale to support it.

Second, CMS' analysis excludes all single service therapy claims. In its July 28 response letter, CMS states that its data analysis included only claims with “multiple therapy services on a day, [and] therefore, it excluded claims submitted with only one service on the day.” CMS has thus created a faulty “median” amount based on a subjective subset of claims. CMS' analysis of a median of four therapy services per patient per day is overstated because it excludes all single-service claims.

Third, CMS' analysis merges all therapy disciplines. CMS combined all professional disciplines (*e.g.*, PT, OT and speech language pathology) in determining a median of four therapy services. The median number of services may differ for different disciplines. While CMS released some data, it was not in a usable format for us to replicate their analysis, nor could we determine the *distribution* of services per day, per discipline – which is critical when applying an MPPR policy. CMS is proposing a very broad policy based on a very incomplete analysis.

Fourth, CMS' analysis overstates the possible savings. CMS' average of four services per *day* (rather than per therapy *session*) may overstate the achievable efficiencies. In certain settings, such as skilled nursing facilities, it is common for a patient to receive one therapy service in the morning (*i.e.*, PT) and another in the afternoon (*i.e.*, OT). In this situation the application of the MPPR is illogical since there are no economies of scale when the patient sees different individuals on the same date of services. In these instances, it would be appropriate for the aide to, for example, greet and gown the patient, clean and equip the room, and obtain patient vital signs during the morning PT visit and the afternoon OT visit. There are no PE efficiencies in this scenario. If CMS proceeds with this misguided policy, we urge the agency to limit it to therapy services provided to the same patient, during the *same therapy session*, and for the *same therapy discipline*.

Whether the median number of services is three or four, any additional reduction would unfairly result in underpayment for therapy services. Based on how the codes were valued, if one unit is billed, currently there is an underpayment. If two units are billed (*e.g.*, one therapeutic procedure and one modality), there is an underpayment. If three units are billed (*e.g.*, two therapeutic procedures and one modality), payment is accurate. If four units are billed, payment either may be accurate (*e.g.*, two therapeutic procedures and two modalities), or it may be overstated (*e.g.*, three therapeutic procedures and one modality). However, even if a portion of

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therapy service code pairs are overstated, to take the second, third and fourth code billed and reduce them by 50 percent would result in significant underpayments due to the process used to value these codes.

The 50 percent PE reduction is arbitrary and excessive. While we believe CMS' data analysis is flawed, even the agency's own analysis suggests that a 50 percent reduction is too high. In the preamble, CMS states:

For five high volume therapy code pairs that each occur over 2 million time in PFS claims for multiple therapy services and account for almost half of such claims, we estimated that the resulting reduction in the PE for the lower paying code would range from 28 to 56 percent. [Emphasis added.]

CMS' proposal to apply a 50 percent reduction to all multiple procedure claims when, at its highest estimate, the agency itself indicates that the resulting reduction would be at most 56 percent, is excessive. And this payment reduction is based on data from only half of all multiple-therapy claims, which, as stated earlier, are further derived from only one-third of total outpatient therapy claims.

Finally, this policy would have a significant impact on patient care and access to therapy services. This is especially true for those patients with multiple chronic conditions who might benefit the most from intensive therapy treatment programs, and for patients with certain diagnoses, such as stroke, who may be receiving PT, OT *and* speech language pathology services. While AHA supports the evaluation of potentially misvalued codes in the PFS, and we acknowledge that there are efficiencies when two or more therapy services are delivered to the same patient during the same *session*, the majority of therapy service codes already have been reduced to account for duplication in practice expenses and, thus, are not inappropriately valued. **The AHA urges CMS to drop its proposal to apply an MPPR to therapy services.**

INCORPORATION OF PRODUCTIVITY INTO MARKETBASKET UPDATES (ACA SEC. 3401)

The ACA requires that the update factor for ambulatory surgery centers (ASC)s, the AFS, the CLFS and the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) fee schedule be reduced by an annual productivity adjustment beginning January 1, 2011. The rule discusses this requirement and states that changes in payment rates resulting from the update and the productivity adjustment will be announced by instruction and on CMS' website. The factor used for this adjustment, 1.6 percent, was subsequently announced in the outpatient prospective payment system (OPPS) and ASC proposed rule for CY 2011. The OPPS proposed rule states, "Comments on the specific mathematical calculation of the MFP [multi-factor productivity adjustment] should be made to that [Medicare PFS] proposed rule" (page 541). However, CMS provides no details on the data and calculations that it used in making these estimates, instead referring readers to the Bureau of Labor Statistics, which provides only historical data. This level of information is insufficient for public comment. **Before implementing these adjustments,**

which will cut billions of dollars from providers, CMS should fully disclose for public comment the methods and data sources used for this estimate.

The AHA is further concerned that current economic conditions are distorting the factor used for the productivity adjustment, potentially leading to unintended consequences. The original intent of the productivity adjustment was to hold providers to a standard of productivity improvement achieved by the rest of the economy. However, when productivity gains are driven by undesirable trends in the economy, this adjustment could lead to excessive cuts. The current “jobless recovery” is inflating productivity as output increases but a key input – employment – continues to stagnate. Cutting providers by this inflated figure could hurt hospitals and other health care providers that have been one of the few sources of continued job growth in this economy.

CLINICAL LABORATORY FEE SCHEDULE: SIGNATURE ON REQUISITION

CMS proposes to require the signature of a physician or qualified non-physician practitioner (NPP) on requisitions for clinical diagnostic laboratory tests paid through the CLFS. CMS claims this policy change would result in less confusion because a physician’s signature would be required for both requisitions and orders; uncertainty would be eliminated regarding whether the documentation is a requisition or an order and whether the type of test being ordered requires a signature.

The AHA strongly opposes this policy change and believes it will actually cause additional confusion. It is unnecessary, redundant with common practice, and contrary to the agreement struck in the Clinical Laboratory Negotiated Rulemaking. It could result in delays in hospital laboratory testing that would be harmful to beneficiaries, and would unfairly hold hospital laboratories financially accountable for non-compliance that is outside of their control.

The November 23, 2001 Clinical Laboratory Negotiated Rulemaking Final Rule (66 *Federal Register* 58787) reflected the negotiated rulemaking committee’s decisions that a physician’s signature not be the only permissible way to document the ordering of a test, and that physician signatures not be required on requisitions for clinical diagnostic laboratory tests. These decisions, arrived at through a comprehensive process involving 18 laboratory and health care organizations and CMS, should not be overridden by a misguided attempt to eliminate confusion about CMS policy. We do not believe that requiring physician signatures on requisitions would accomplish this goal. Rather, the confusion that exists regarding the difference between an order and a requisition and under what circumstances a physician’s signature is required is primarily a result of unclear and contradictory language in CMS manuals and related correspondence, which we believe could be addressed without mandating an additional and repetitive policy requiring a physician to sign all requisitions.

The proposal would significantly increase administrative burden for both physicians and hospital laboratories, leading to unnecessary duplication of effort as a physician would have to sign both the original order in the patient’s medical record as well as the requisition. For instance, in many physician offices, office employees collect laboratory specimens from patients based

upon the physician's charted orders and use pre-printed requisition forms for specifying the required tests. Imposing a new requirement that the physician also sign the requisition layers another redundant process upon the implied approval gained through on-site office specimen collection and the use of the pre-printed requisitions. The proposed policy also would create additional and unnecessary administrative burden in skilled nursing facilities, where staff would have to obtain physician signatures for daily laboratory orders and for urgent requests, without any patient benefit or improvement in the order validation process.

At a time when more providers are using electronic health records and electronic signatures, imposing redundant signature requirements is burdensome, unnecessary and does not benefit patient care. For instance, many hospital and reference laboratories utilize electronic systems in which physician orders are entered from the patient's medical record or from a signed written order, resulting in an electronic requisition. This requisition is transmitted directly to the hospital's laboratory to initiate testing. Since most physicians do not yet utilize electronic physician order entry, a requirement to have the ordering physician sign the resulting requisition would be tremendously burdensome and could result in delays in testing for beneficiaries.

Further, CMS' proposed policy would hold hospital reference laboratories financially accountable for non-compliance that is outside of their control. That is, community physicians who order clinical diagnostic laboratory tests do not have much of an incentive to comply with signature requirements, nor do they experience direct consequences for their non-compliance. If CMS' proposed policy is finalized, unsigned requisitions would place the hospital laboratory in the unreasonable position of either having to delay providing the testing service in order to obtain a physician signature or being unable to bill for the services rendered. Delaying testing would conflict with the laboratory standard of care, which requires that once a written request is received, regardless of whether it is signed by the ordering physician or not, the laboratory is obligated to perform the test immediately. Immediate testing is in the patient's best interest and, ultimately, is a quality of care issue, as laboratory specimens tend to degrade over time.

Instead of creating an unnecessary, redundant and burdensome new requirement for physician signature on requisitions, CMS should carefully review and resolve the inconsistencies and ambiguous language in its Medicare manuals. It is critically important that Medicare policy be clear to avoid disputes with Medicare contractors such as Recovery Audit Contractors. Also, we recommend that CMS provide further education and training to its contractors about the acceptable ways to document physician orders for clinical laboratory tests.

AVERAGE SALES PRICE (ASP) "INTENTIONAL OVERFILL" ISSUE

In the proposed rule, CMS describes situations where manufacturers include a small amount of "intentional overfill" in containers of drugs. Such "intentional overfill" is intended to compensate for loss of product when a dose is prepared and administered. CMS asserts that when a provider purchases a vial or container of product, the provider is purchasing an amount of drug defined by the product packaging or label and any excess, free product (that is, overfill) is provided without

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charge to the provider and, according to CMS, may not be billed. CMS notes that providers who bill Medicare for overfill harvested from containers could be subject to scrutiny and follow up action by CMS, its contractors, and the Office of the Inspector General because that overfill does not represent a cost to the provider. The agency proposes to update regulations to clearly state that Medicare ASP payment limits are based on the amount of product in the vial or container as reflected on the FDA-approved label and that payment for product in excess of the amount reflected on the FDA-approved label will not be made by the Medicare program. This reflects new Medicare policy. Nothing in CMS's regulations requires a provider (as opposed to a physician) to have incurred a cost in order to bill for an item or service including a drug. In addition, the provider in the situation CMS describes actually incurs the cost of the "overfill." **If CMS decides that this is to be the agency's policy in the future, we urge CMS to ensure that the rule is applied and enforced prospectively only. In addition, we ask CMS to state affirmatively that any new policy restricting the billing for use of overfill apply only in the physician office setting and not in hospitals or other provider settings for which CMS never has said the drug must be a cost in order to be billed, and there is no basis for such a policy.**

PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI)

We applaud CMS for its investment in establishing the PQRI program. The AHA is committed to partnering with all eligible professionals (EPs) and stakeholders to ensure that quality measures are harmonized across the continuum of care. It is in the spirit of harmonization that we note that there are several aspects of the PQRI program that are very different from those of the hospital quality reporting program (Reporting Hospital Quality Data for the Annual Payment Update, or RHQDAPU).

Transition Away from Claims-based Measures

CMS has clearly stated its intention to transition the PQRI program away from claims-based quality measures. In the CY 2011 Medicare PFS proposed rule, CMS states, "...we recognize that there continues to be a number of limitations associated with claims-based reporting since the claims processing system was developed for billing purposes and not for the submission of quality data." CMS further states, "...continuing to reduce our reliance on the claims-based reporting mechanism after 2011 would allow us and EPs to continue to devote available resources towards maximizing the potential of registries and electronic health records (EHRs) for quality measurement reporting."

While CMS is moving *away* from claims-based quality measures for eligible professionals, they are moving *toward* claims-based quality measures for hospitals. In the fiscal year (FY) 2011 inpatient PPS final rule, CMS finalized 10 new claims-based quality measures for the FY 2012 RHQDAPU program. Further, several other claims-based quality measures, including readmission, mortality and patient safety indicators, currently are used in the RHQDAPU program.

There is a wide array of peer-reviewed published articles¹ that conclude that the granular clinical data elements needed to populate quality measures are available only through medical records. The Joint Commission states that claims data are not an appropriate source for clinical data. CMS also drew the same conclusion for the PQRI program. We strongly encourage CMS to harmonize their programs and make this same conclusion for the RHQDAPU program.

Waiver of Reporting if Participating in a Demonstration

For the 2011 PQRI program, CMS proposes to deem eligible group practices participating in the Physician Group Practice (PGP), Medicare Care Management Performance and Electronic Health Record demonstrations to be participating in PQRI. As such, all eligible professionals participating in these demonstrations automatically will receive PQRI bonus payments. We support CMS' proposal and further commend the agency for taking positive steps to reduce the reporting burden for eligible professionals. We also request that CMS extend this same waiver to all types of providers who participate in demonstrations. The majority of participants in the PGP demonstration are hospitals and, like the PQRI program, many of the measures that hospitals report to the RHQDAPU program overlap with the measures required for participation in the demonstration.

Attribution

We support CMS' proposal to analyze the January 1 through October 31, 2011 National Claims History file to assign Medicare beneficiaries to each physician group practice using a patient assignment methodology modeled after the patient assignment methodology used in the PGP demonstration. This analysis will allow CMS to assess how well the PGP attribution methodology compares to the EP self-assigned methodology that the PQRI program uses. We strongly encourage CMS to compare both methodologies and make the results publicly available. Further, though we understand CMS' desire to focus on one attribution rule, we strongly encourage the agency to test many options to continue learning the best methodologies for attribution. In addition to playing a critical role in PQRI, attribution also will play a critical role in many other ACA provisions, including Accountable Care Organizations. Because attribution will continue to be a prominent methodological aspect of many major ACA programs, CMS should take advantage of the ability to carefully study several methodologies before selecting a single one.

DISCLOSURE REQUIREMENTS FOR IN-OFFICE ANCILLARY SERVICES (ACA SEC. 6003)

The ACA requires that for services furnished on or after January 1, 2010, physicians referring patients for radiology services under an in-office ancillary services exception to the physician self-referral ("Stark") law must inform patients in writing at the time of referral of any ownership interest in certain imaging services to which the physician refers the patient, and of the availability of other suppliers who may provide such services. They also must furnish a written list of suppliers who provide the services in the area where the patient resides. In the rule, CMS

¹ Accountability measures – using measurement to promote quality improvement. *New England Journal of Medicine*. June 23, 2010. Chassin et al.

proposes that hospitals and critical access hospitals (CAHs) do not qualify as “suppliers” of imaging services.

The agency states that a “supplier,” as defined in statute, is “a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.” Given that the list will not include “providers of service,” – which, according to statute, include hospitals and CAHs, among other facilities – CMS states that hospitals and CAHs are not to be included on the list. The AHA believes that including hospitals and CAHs on the written notice would benefit patients in choosing an alternative entity for imaging services. Hospitals often are the only provider of this service within the 25-mile radius of the physician’s office. Requiring physicians to include hospitals and CAHs would provide patients with more options. **We urge CMS to allow – and to actually require – that physicians include hospitals and CAHs in the written list of suppliers who provide imaging services in the area where the patient resides.**

ANNUAL WELLNESS VISIT AND PERSONALIZED PREVENTION PLAN (ACA SEC. 4103)

In addition to the one-time “Welcome to Medicare” comprehensive physical exam, the ACA provides Medicare beneficiaries with *annual* wellness visits, including “personalized prevention plan services,” with zero cost-sharing, effective January 1, 2011. CMS proposes to establish two new Healthcare Common Procedure Coding System (HCPCS) G-codes for reporting the first and subsequent wellness visits. The codes will be linked to Current Procedural Terminology (CPT) 99204 (Level 4 new patient office or other outpatient visit) and CPT 99214 (Level 4 established patient office or other outpatient visit), respectively.

In the rule, CMS proposes not to include a separate facility payment for these codes when a practitioner furnishes this service in the facility setting. CMS states this is “because only a single payment will be made under the PFS when this service is furnished.” We could not identify where in statute it requires only a single payment be made for the annual wellness visits. We are concerned that hospitals will not receive payment for the “technical component,” or facility fee, when these wellness visits are performed in hospital outpatient departments. Thus, hospitals would not receive payment for the facility space, receptionist and nursing staff, supplies, electricity and other direct and indirect expenses that are typical of most evaluation and management services. **The AHA requests that CMS provide clarity on whether and how hospitals should bill, and how they will receive payment, for annual wellness visits performed in hospital outpatient departments.**

PHYSICIAN FEEDBACK PROGRAM AND VALUE-BASED PAYMENT MODIFIER

Multi-Stakeholder Input

Measurement of resource use has a tendency to be a highly sensitive assessment of performance. Given the sensitive nature of this body of work, we strongly encourage CMS to engage in open

communication with stakeholders. One example of a successful ongoing effort is the Hospital Quality Alliance (HQA).

Established in December 2002, the HQA is a national, public-private collaboration that is committed to making meaningful, relevant and easily understood information about hospital performance accessible to the public, and to informing and encouraging efforts to improve quality. Among other important activities, the HQA has a long history of prioritizing and advocating for the nationwide implementation of quality measures, many of which are used in CMS public reporting programs for hospitals. Since the inception of CMS' hospital inpatient public reporting program, the HQA has been a leader in recommending and implementing measures and providing feedback on the feasibility and usability of the measures in the hospital setting. HQA members have the ability to speed implementation and effective use of performance measurement data. The AHA is committed to partnering with CMS to establish a similar network of stakeholders to provide leadership and direction on resource use measures.

We also note that the National Quality Forum (NQF) has a multi-stakeholder Steering Committee (SC) addressing resource use measurement. In addition to drafting a white paper to guide stakeholders on the various aspects of resource use, the SC will be assisting the NQF in the development for a call for resource use measures and will ultimately endorse the first standards (measures) for resource use. We strongly encourage CMS to align the principles of the Physician Feedback Program and the Value-based Payment Modifier to the principles that are being developed by the resource use SC. Further, the principles of these programs should also be aligned with the principles being developed under the National Quality Strategy that is mandated by the *Patient Protection and Affordable Care Act (ACA)*.

Per Capita Resource Use Measures

We do not support CMS' proposal to only report per capita (total Part A and Part B expenditures for a one-year period for a given beneficiary) resource use measures in Phase II of the Physician Feedback Program. Rather, we encourage CMS to report both per capita and episode of care measures in the confidential feedback reports. Though we agree that there are limitations to the commercially available episode grouper software packages, we do not think it is the right time to completely remove episode of care measurement from this program. Rather, CMS should continue to use the best means available for calculating episodes to continue learning the best methodologies for episode measurement. If, in the future, CMS determines that another episode methodology, such as a future "public domain" episode grouper, offers a superior methodology the agency should pursue an alternative approach at that future point in time. CMS should take advantage of the "low stakes" that confidential feedback reporting offers and test many methodologies. Once the stakes are higher (public reporting and payment) CMS should narrow the options for resource use measurement.

GEM Quality Measures

We do not support CMS' proposal to include only GEM measures in Phase II of the Physician Feedback Program. The GEM measures have several limitations, including being derived from old (2006 and 2007) claims data. Rather, we encourage CMS to report on PQRI data. PQRI is a national program that offers several advantages over GEM measures, including the ability for: (1) eligible professionals to self-select the measures that are most relevant to his/her patient panel; (2)

capturing more robust clinical information through CPT category II codes, registries and electronic health records; and (3) greater harmonization with other quality measures across the continuum of care. Though we recognize that the early years of the PQRI program had limited participation, we note that in more recent years many more eligible professionals have engaged in the program. We strongly encourage CMS to include the most recent PQRI data available in the confidential feedback reports.

Attribution

Though we understand CMS’ desire to focus on one attribution rule for purposes of consistency in a national program, we do not support relying on one attribution rule at this stage of the program. CMS should test many options to continue learning the best methodologies for attribution. CMS should take advantage of the “low stakes” that confidential feedback reporting offers and test many methodologies. Once the stakes are higher (public reporting and payment) CMS should narrow the options for attribution.

Researchers have successfully used many different attribution rules when working with patient and episode attribution. For example, in a 2009 study (<http://aspe.hhs.gov/health/reports/09/mcperform/index.shtml>) sponsored by the Department of Health and Human Services Assistant to the Secretary for Planning and Evaluation, the RAND Corporation successfully tested six attribution methodologies (included in the table below).

Table 16: Design Characteristics of Episode-Based Attribution Rules

Title of Rule	Signal for Responsibility	Single or Multiple Providers	Relevant cut-off
Episode Payments Plurality	Professional Payments	Single MD	At least 30% professional payments
Episode Payments Multiple Physicians	Professional Payments	Multiple MDs	All MD with >25% At least 30% E&M visits
Episode Visits Plurality	E&M Visits	Single MD	
Facility Payments Plurality	Facility Payments	Single Facility	At least 30% facility payments
Facility Payments Multiple Facilities	Facility Payments	Multiple Facilities	At least 25% facility payments
Episode Payments Plurality + Facility Payments Plurality	Professional Payments + Facility Payments	Single MD + Single Facility	Facility with at least 30% facility payments or MD with at least 30% professional payments

We strongly encourage CMS to test all six of these attribution methodologies in the Physician Feedback Program. Further, we note that in addition to playing a critical role in this program, attribution will play a critical role in many other ACA provisions, including Accountable Care Organizations. Because attribution will continue to be a prominent methodological aspect of many major ACA programs, CMS should take advantage of the ability to carefully study several methodologies before selecting a single methodology.

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Thank you for the opportunity to submit comments. If you have any questions regarding these comments, please do not hesitate to contact me or Ashley Thompson, AHA director for policy, at (202) 626-2688 or athompson@aha.org.

Sincerely,

Rick Pollack

Executive Vice President