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September 4, 2012

Ms. Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert Humphrey Building
200 Independence Avenue, S.W.
Room 445 - G
Washington, D.C. 20201

Re: Medicare Program: Payment Policies under the Physician Fee Schedule
and Other Revisions to Part B for CY 2013; Proposed Rule; 77 Fed Reg.
44,722 (July 30, 2012) CMS-1590-P

Dear Acting Administrator Tavenner:

The Massachusetts Medical Society (MMS), which represents over 24,000 physicians, medical students and physicians in training programs, submits the following comments in response to the Centers for Medicare and Medicaid Services (CMS) proposed physician fee schedule rule for calendar year 2013 and other revisions to Part B. The MMS supports the extensive comments and recommendations submitted by the American Medical Association (AMA) in response to the proposed rulemaking. The following document supplements comments submitted by the AMA.

Physician Value Based Payment Modifier

The MMS has been actively engaged in the development of quality measurement programs at the state level for numerous years. While we strongly support efforts to improve quality and cost efficiencies, the MMS, AMA and other medical societies strongly opposed the value based payment modifier as outlined in Section 3007. Significant progress is being made to define and implement quality and cost measurements. As written we do not believe the value based modifier will improve our ability to assess value and efficiency. To our knowledge, the methodology does not exist to implement the Value Based Payment Modifier as defined in this section, nor does the agency have the capacity to apply to VBM to every physician, in every practice, in every specialty in this country. The provision is impractical, unworkable and at worst, potentially harmful to patients and physicians. It should also be noted that the VBM is budget neutral. It does not incent more efficient care or cost savings but redirects Medicare dollars within Part B. We

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strongly oppose the agency's decision to implement the VBM based on 2013 data.

CMS needs to develop a rational and comprehensive approach to deal with all the quality and cost measurement protocols that are being developed. We strongly believe these measurement tools must be based on a valid, reliable, scientific methodology that can be used to teach physicians before using them as a basis for sweeping payment changes. The MMS agrees that physicians share a role in implementing cost efficiencies. We remain concerned that this section will implement dramatic changes in Medicare payment policy without adequate study and testing on the potentially negative impact on patients and physicians.

We recommend that CMS initially pilot test the Value Based Payment Modifier (VBM) measurements. We agree with the AMA that the current threshold of groups with 25 or more practitioners is too large. As our comments detail, we also strongly recommend the physician practices be given the opportunity to review and correct their data profile before it is used in any manner. Finally, given that the methodology does not currently exist, to accurately risk adjust for health and economic conditions, as well as geographic variations and their impact on cost, we strongly recommend the Agency work closely with the physician community and other researchers on a meaningful measurement tool.

In Massachusetts we are well aware of the unintended negative consequences of these programs on patients and physicians when they are ill designed. In 2008 the Group insurance Commission required health plans to tier physicians. Many physicians, who were ranked the highest tier by one program, were ranked adversely in another. Others were measured on patients who were not in their practice, procedures they did not perform, or a case mix that was too small to be relevant. This painful experience taught us that physicians must have the opportunity to review and appeal the information before it's made available to the public. In addition we learned that performance measurements and the public reporting of these measures must be evidence-based to improve outcomes; that measures should focus on results that are directly attributable to the physician's performance; that our analyses should focus on data that are appropriate to the questions being addressed and are effectively risk-adjusted; that public reports must be easily and accurately interpreted and that incentives should be aimed at rewarding physicians or hospitals based on important differences in clinical outcomes or the cost-effectiveness of care.

We oppose using this modifier now, as currently constructed, as the basis for financial penalties. Even a 1 percent penalty, which some of our Massachusetts physician practices have incurred from problems with the ERX program, is financially significant to a small practice. It has also been our experience that it is very difficult for CMS to implement these new programs without problems - e.g. practices that were wrongly penalized because of technical difficulties or other implementation problems. We strongly oppose CMS's decision to use 2013 data as the basis for the

financial penalties in 2015. The agencies determination to use data prior to the legally mandated start of this and other new programs, suggests less of an interest in educating physicians about these measures, and more of an expedited opportunity to impose penalties. The AMA, MMS will continue to vigorously oppose this approach.

The MMS appreciates that rising health care costs and further attention to the quality and cost of health care delivered nationally requires payers, employers, and health care providers to seek out new ways to measure costs and value. While many of the efforts under discussion to accomplish these goals are laudable, many are also experimental. We continue to believe that meticulous attention must be paid to the methodology, quality measures, reporting mechanisms to providers, roll out of the programs and public release of information before CMS institutes a national program. The potential for unintended consequences to the patient, the physician, the patient- physician relationship and the cost of care are significant if these steps are not thoroughly designed and tested before implementation. It would therefore be essential for any new programs to be extensively piloted in order to establish the most effective method of implementation.

As the following details, we believe it is essential that every physician be given the opportunity to review and correct their profile before it is used for any purpose. Our experience in Massachusetts, which is supported by the findings from Rand and other groups, demonstrates that current data bases are inaccurate and that aligning physicians to their patients is extremely difficult. This is particularly true with the Medicare patient who on average, has several chronic conditions and sees a variety of physicians.

To this end we offer several recommendations regarding the development of a value based system for physicians. It is important to underscore that we believe that the current methods of physician profiling are not yet mature enough to be applied to modifying reimbursements at the individual level and should only be piloted at the group level. Given the lack of reliable measurement tools, we oppose modifying payment based on these profiles. Rather we believe this information should be used initially to educate and inform physicians about their practice patterns.

Support the Patient/Provider Relationship: Quality and cost efficiency measurement programs should be directed at supporting and improving patient-physician relationships. They should not create obstacles for providers treating patients regardless of their health condition, ethnicity, economic circumstance, demographics, or treatment compliance pattern.

Support Sound Performance Measures: Quality, efficiency and cost performance measures should be evidence-based, valid, reliable, broadly accepted, and clinically meaningful. Measures should be consistent with those collected by national or regional organizations such as the AMA's Physician Performance Consortium, National Quality Foundation, JCAHO, Massachusetts Health Quality Partners (MHQP), and the Centers for

Medicare and Medicaid Services thus facilitating an alignment of measurement goals in the marketplace.

- Evidence-based quality and cost measures should be evaluated in relation to each other. Measures should result in no unintended harmful consequences.

Support Methodology/Data Transparency: Complete descriptions of all criteria, algorithms, methodologies and data sources used in such programs should be made readily available to patients and their physicians, as should all of the underlying individual physician quality, cost, efficiency and patient satisfaction data.

- There should be a statistically valid reason for judging any data used and arbitrary cut-offs must be avoided; physicians whose practices are too new, too small to measure, or different from their peers should be handled separately from others.

Support Data Accuracy: Measurements should be accurate and timely. Physicians should be given patient-level drilldowns for the efficiency and quality measure, as well as patient lists for these measures. There should be a formal feedback and correction mechanism so that errors uncovered by physicians, payers, and other analysts can contribute to improving the evaluation system.

- Data should be adjusted for such items as sample size and case-mix composition, outliers when appropriate, socio-economic differences when possible, appropriate use of preventive care and other under-utilized interventions; reasonable targets should be set for each measure; and adjusted to account for variations in the cost of delivering care which are outside the providers' control (e.g., variations in payer mix, area wage index, and state mandated requirements).
- Data must also be adjusted for geographic factors and variations. The issue of regional variations in spending, the reasons for the variations, and the impact of those variations, require further analysis. Even the respected authors of the Dartmouth Atlas, which has sparked much of this interest, noted that their data was not meant to serve as the basis for payment reform. Of equal importance, an emphasis on spending, which does not take into account rate of growth in areas and socioeconomic factors will do little to improve our national cost efficiencies. For example, while Boston is considered a high spending area, the rate of the growth in spending is lower than the national average.

The recent IOM report reinforces the importance of factoring in geographic variations in physicians payments. Massachusetts, for example, has some of the highest practice expense costs in the nation with some of the lowest reimbursements. Physicians have no control over these costs which include rent and prevailing wages. Any determination of value will need to accurately and precisely account for these uncontrollable variables, the cost of doing

business in one region vs. another. CMS continues to grapple with the best method to appropriately account for variations in costs across regions. How CMS calculates this formula will be critical to its ability to accurately assess a physician's cost margin compared to physicians in other regions.

Support Data Sharing at Individual Level only for Quality

Improvement: At this time, because of limitations to the current system and issues surrounding attribution and appropriate volume it is inappropriate to judge physician performance at a level finer than the large group level. It is, however, appropriate and desirable to provide data to medical groups and physicians that can be drilled down to the individual physician and individual patient for purposes of providing best care and improving the process of measurement.

Support Physician Involvement in the Process: Practicing physicians, hospitals, and their professional organizations should be involved in the design and ongoing modification of programs such as these that judge physicians. Results must be shared with physicians well in advance of any final judgments about their performance. Physicians should also be given an opportunity to correct errors in a timely and non-burdensome manner.

- Criteria used to judge physician's performance should be circulated well in advance of any final opinions about their performance. There should not be any introduction of unnecessary administrative complications to practices. Physicians should be provided with specific behaviors (action items) by which they can improve their results. A uniform approach to measurements should be adopted.

RAND has completed several comprehensive studies on the limitations of using claims data and the current methodologies for evaluation of physician performance. They found that cost profile scores do not meet common reliability thresholds and that about 22 percent of physicians would be assigned to a different cost category under current methodologies. The RAND report stated that their findings strongly suggest that current methods of physician cost profiling are not ready for prime time in some cases, physicians who were actually lower cost were categorized as not lower cost; in other cases, the opposite was true.

Physician Compare

The MMS strongly supports the AMA comments regarding the Physician Compare website. As our previous comments detail, our experience in Massachusetts shows that inaccurate information can mislead patients and malign physicians without improving the quality of care or reducing costs.

At the simplest of levels, it is extremely difficult to insure the data is being attributed to the correct physician and is accurately risk adjusted. In Massachusetts we have scores of physicians who were assigned to the wrong specialty or to the wrong patient. The MMS has detailed a number of specific recommendations that are crucial to making these reports useful. These

include: the data must be accurate on all levels, accurately risk adjusted, shared with physicians who are allowed to make corrections before the information is released to any source, based on specialty specific measurements and based on a statistically significant number of cases to make the analysis meaningful. Given the difficulty that individual states have had with this methodology it is difficult to believe that CMS will have the time and resources available to make this program work without errors.

We strongly recommend CMS adopt the alternative proposal to provide group practices with confidential data and the opportunity to review their data and make any necessary changes before moving to public reporting on Physician Compare. We also urge CMS to not list the names for groups for which CMS is not issue a report. CMS should clearly state that not all groups need to report on the site and why. We believe the inclusion of this information is essential to prevent any negative implications for these practices, albeit unintended.

Electronic Prescribing

The MMS strongly supports the AMA comments regarding Electronic prescribing (E-prescribing). Although many of our physician practices have been eprescribing for years, there were significant problems with the implementation of the Medicare's ERX program. Several physician practices who successfully eprescribed in their practices incurred the 1% penalty either because the G code was stripped out of the records, or in some cases they did not appropriately add in the G code. For physicians who were used to eprescribing the need to go back into an automatic transaction to add the G code was not only cumbersome, but defeated the point of the program. Our concern, which was brought to the agency's attention, is that these early adopters were in fact being penalized because of how CMS chose to implement the new program – not because they were noncompliant. The irony of the situation – that Congress passed this law to encourage physicians to eprescribe – was now being used to penalize the very physicians who had prescribed for years - was problematic. We are also very concerned about what this precedent means as we go forward with the EHR and other new technologies and programs. Other factors compounding the problem: CMS changed the rules about the G code, problems with clearinghouses, the inability to the "Quality Help Desk" to provide real assistance to physicians and the agency's decision to close any appeals after the end of the year. Even in cases where the problem was ultimately resolved, the Quality Help Desk could not state that was the case. In two instances, practices were told they were exempt, only to end up being penalized. We also learned at the deadline for filing for a hardship exemption for the ERX program that the program was not compatible with MACs. At issue is not that there were problems – that is to be expected with a program of this magnitude – but the agency's inadequate customer service. In this transition period for physician's practices, it will be imperative for CMS to work with the AMA, medical organization and physician practices to develop systems to help physicians move to the next phase. This also includes a glide path to allow physicians an opportunity to prove they were in fact in compliance.

We strongly support CMS's proposal to add another exemption category to protect physicians who have registered or attested for the meaningful use for EHR's from eprescribing penalties. As the AMA recommends, the categories should be broad enough to cover any physician who has registered or attested for meaning use in years 2011, 2012 or 2013. In that same approach, we believe the agency should establish an informal review/appeal process for the eprescribing programs for physicians regarding the 2012, 2013 and 2014 programs. If a physician can demonstrate they successfully eprescribed the requisite number of scripts, we believe the agency should reinstate the penalty that was inappropriately applied. We also support the AMA recommendation pushing back the deadline for exemptions and hardship categories. As noted earlier, we opposed the agency using physicians 2011 claims to implement the 2012 penalties. Nor do we believe this was Congressional intent. Our point is that physicians, who make a good faith effort and can document that good faith effort, should not be penalized. The goal of these programs is to help evolve physicians practices – not to impose financial penalties which can undermine the practice. We would suggest that CMS pursue a less punitive and more educational approach for those who can prove they make a good faith effort going forward.

As always, the Massachusetts Medical Society looks forward to working with you on these and other proposals to improve both the quality and cost efficiencies of our health care system

Sincerely yours,

Richard V. Aghababian, MD