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August 30, 2011

Donald Berwick, MD  
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 2012: Proposed Rule: 76 Fed Reg. 42,772 (July 19, 2011); CMS-1524-P

Dear Dr. Berwick:

The Massachusetts Medical Society (MMS), which represents over 23,000 physicians, students and residents, submits the following comments in response to the Centers for Medicare and Medicaid Services (CMS) proposed physician fee schedule rule for calendar year 2012 and other revisions to Part B. The MMS also supports the extensive comments and recommendations submitted by the American Medical Association (AMA) in response to the proposed rulemaking. This document elaborates on several issues of significant concern to our members.

## Main Recommendations

### Physician Quality Reporting System

- CMS should allow physicians to provide feedback on the format and content of interim feedback reports in the Physician Quality Reporting System (PQRS) once CMS has developed the prototype for these reports.
- The MMS urges CMS to immediately rectify the separate certification requirements for PQRS and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program.
- We urge CMS to identify measure clusters up-front and not leave physicians guessing as to the specific requirements for successful participation in the PQRS.
- We urge CMS to ensure that all measures in measures groups are also reportable as individual measures.

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- At least for the first year a measure is proposed, it should be reportable via claims-based reporting AND registry-based reporting. It is critical to offer the claims and registry option at least for the first year a measure is in the program, in case no registries adopt a certain measure.
- We urge CMS to ensure that there is an analytically sound method for reporting measures groups when denominators differ.

#### Electronic Prescribing

- In order to better align the e-prescribing incentive program with the e-prescribing penalty program, we urge CMS to only require the reporting of at least 10, rather than 25, G8553 codes for electronic prescriptions per year for the 2012 and 2013 e-prescribing incentive programs.
- We support CMS' decision to make a reporting option available for group practices, and allowing physicians a choice to submit e-prescribing data through Medicare Part B claims or a qualified registry or EHR product.
- We oppose CMS' proposal to require reporting one-prescribing activity the year before the penalty program begins. We previously have called on CMS to take such steps as establishing a new reporting period in 2012 and to refrain from applying the penalty until 2013. We also strongly urge CMS to establish an additional reporting period in 2013 to avoid 2013 penalties and in 2014 to avoid penalties in 2014.
- We strongly recommend that CMS add more exemption categories so that more physicians facing hardship will be eligible for an exemption from e-prescribing penalties in 2013 and 2014.
- We also recommend that CMS provide feedback reports to physicians and establish a process to allow physicians to appeal decisions.
- CMS should take appropriate measures to ensure the accuracy of the list of successful e-prescribers and eligible professionals (EPs) participating in the EHR incentive program and to provide the appropriate disclaimers for the Physician Compare website listing.

#### Confidential Feedback Reports

- If coming up with an attribution method that creates credible feedback reports for all physicians treating Medicare patients proves to be impossible, CMS should inform Congress that this is the case and recommend modifications in the Patient Protection and Affordable Care Act's (ACA) value-based modifier requirements.

- The MMS supports CMS' proposal to investigate the possibility of stratifying physicians by specialty and the conditions they treat, and we would like to work with CMS to develop an improved physician specialty and sub-specialty list that could be applied consistently across many Medicare programs, including the value-based payment modifier, Physician Compare, and the Medicare Provider Enrollment, Chain and Ownership System (PECOS).
- If ongoing efforts produce reliable Medicare-specific groupers for at least a limited set of conditions, CMS should adopt them in lieu of the per capita data.

#### Value-Based Payment Modifier

- The MMS strenuously opposes CMS' plan to truncate an already inadequate preparation period by basing the 2015 value-based payment adjustments on performance in calendar year 2013.
- The MMS continues to oppose the Value Based Payment Modifier and does not believe that methodologies exist to implement these requirements according to our standards for reporting on quality measurements. This issue is being studied currently by the IOM.

#### Medicare Economic Index

- The MMS is disappointed that CMS has not yet convened the MEI technical panel. We understand from CMS staff that the agency still intends to convene this technical panel, and we urge CMS to move forward quickly on this front.

#### Geographic Practice Cost Indices Proposals for 2012

- An impact table should be made available separately showing the impact of the different CMS proposed revisions to the geographic practice cost indices (GPCIs) for 2012.
- CMS' proposal to switch from one source of apartment rental data to another source of apartment rental data is a substitution of one office rent proxy for another, and a far better solution would be for the government to develop actual data on the cost of renting medical office space. The new data base must be verifiable, accurate and based on unit costs as opposed to self reported survey data on aggregate office expenses.

### Consolidating Reviews of Potentially Misvalued Codes

- We urge CMS to ensure rigorous agency review of public comments and supporting documentation when determining whether a publicly nominated code should be reviewed as a potentially misvalued code, especially when a code is nominated by only a few commenters's or even a single commenter.

### Multiple Procedure Payment Reduction

- CMS should withdraw its proposal to apply a 50 percent multiple procedure payment reduction to the professional component of some 119 imaging procedures and drop consideration of other even broader versions of this proposal.

### Codes with "23-Hour+" Stays

- The AMA urges CMS to accept the RUC-recommended values and physician time for all site-of-service anomaly codes, including codes relating to stays of 23+ hours (observation care services), which should be valued the same as an inpatient visit.
- We also urge CMS to accept the RUC recommendation and restore the time data for all services for which claims data indicate that the service is performed in the inpatient setting. At least three years of consecutive data should be available indicating a site-of-service anomaly before a review and adjustment is considered.

### Annual Wellness Visit

- The MMS urges CMS to ensure Medicare coverage for a physical exam as part of the Annual Wellness Visit (AWV).
- The MMS urges CMS to issue clear guidance to beneficiaries and their physicians on what is and is not covered in the "free" preventive service visit that is part of the AWV.

## **I. Physician Quality Reporting System**

### **Initial Feedback Reports**

The MMS applauds the MCS proposal to provide interim feedback reports to physicians and other electronic prescribers participating through the claims based reporting mechanism under the PQRS program for 2012 and beyond. Physicians participating in the electronic prescribing program have been extremely frustrated by the lack of the feedback from the agency. Many have thought they were successfully participating in the program only to learn they did not meet the basic requirements. The proposed interim reports will alert physicians to potential problems in their PQRS reporting and enable them to revise and correct their reporting practices, if necessary,

to be successful. We strongly support the AMA recommendation that physicians be allowed to provide feedback on the format and content of these interim feedback reports once CMS has developed the prototype.

## **II. Electronic Prescribing**

We once again strongly oppose CMS' proposal to impose financial penalties on physicians in 2012 for failure to eprescribe in 2013 and 2014. Congress' intent, as reflected in the statute, was to create incentives to encourage physicians to participate in the program and to give CMS time to implement this new program before inflicting penalties. This proposed change is particularly troubling given the agencies chronic delay in sharing feedback with physicians who are enrolled in the program. Greater than 60% of physicians working in Massachusetts are in one or two physician practices. Nationally, according to MGMA, this number is closer to 80%. We believe this abbreviated time frame will pose additional financial stress as well undermine the time necessary to educate physicians about meaningful IT implementation within their clinical framework.

Imposing penalties in 2012, based on 2011 usage, without any information and feedback about the program and without any evidence that the program is working is unreasonable, unwarranted and contrary to the authorizing law.

### **Exemptions**

CMS proposes several new exemption categories from the eprescribing penalty, including (1) EP/ group practices in rural areas without high speed internet access (2) EP/group practices in an area without sufficient available pharmacies for e-prescribing (3) inability to e-prescribe due to local, state or federal law or regulation and (4) EPs who have fewer than 100 prescriptions during the six month reporting period requirement. We support these exceptions and recommend that CMS include the following as well:

1. The exemption regarding compliance with state or federal law should include physicians who are unable to comply because their e-prescribing software is not yet compliant with the DEA and/or state requirements for this exemption.
2. Physicians who are currently eligible or who will be eligible for Social Security in 2014. We strongly believe that physicians who are eligible for Social Security by the year 2014 should be afforded the opportunity to be exempted from any of these requirements. The investment in money, education and time in modernizing their practices at the end stage of their careers is not justified. Moreover, we are concerned that more physicians will be compelled to retire earlier to avoid the financial penalties that will be imposed. At a time when society at large is experiencing huge financial problems, when Medicare has failed to cover even the

basic costs of medicine for over 10 years, we do not believe these physicians should be required to invest in new and costly technologies.

3. Physicians who are registered in the EHR program should be exempt from the 2013 and 2014 eprescribing penalties.
4. Allow physicians to apply for an exemption if they did e-prescribe at least 10 times but they were denied because of the failure to include the G8553 code or because of other administrative errors.

In addition, we support CMS examining exemptions on a case by case basis. For example, physicians who do a lot of pain management cannot electronically prescribe most of the medications used by their patients. They must do written scripts. This is the same for patients needing stimulant medication. It should also be noted that many patients request written scripts because they aren't sure what pharmacy they will go to or they have had trouble in the past with long delays for electronic scripts to "get to" the pharmacy. .

As we noted earlier, given the absence of feedback reports, physician practices, which thought they were complying with the program, were shocked to learn they did not qualify. CMS should examine these cases to determine whether the practice should be exempt from penalties given their good faith efforts to comply. We believe it will be extremely important that CMS provide interim feedback reports to physicians on their compliance and well as establish an appeals process for contested cases.

### **III. Confidential Feedback Reports and Value Based Payment Modifier**

The MMS has serious concerns about the implementation of the confidential feedback reports and the value based payment modifier. The MMS strenuously opposed the Value Based Modifier amendment during the Congressional debate over the Patient Protection and Affordable Care Act. We continue to believe that there is no scientifically verifiable or reliable methodology to accurately implement this provision for all physicians. Indeed this clause is currently the focus of an IOM study. The MMS strongly opposes using this information to profile and penalize individual physicians. Our experience in Massachusetts shows that inaccurate information can mislead patients and malign physicians without improving the quality of care or reducing costs.

The MMS has detailed a number of specific recommendations that are crucial to making any measurement program work. 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. In addition, we believe HHS's methodology for calculating the Value Modifier Index and other mandated programs must be transparent, available for public comment and pilot tested before implementation. Patient compliance with recommended treatment must be considered and factored into the formula. The agency also must establish an effective and timely appeals process which physicians can access easily before any information is disclosed. In addition physician should have regular and routine access to their data on an ongoing, timely fashion to correct any inaccuracies and routinely thereafter. 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.

We strongly urge CMS to advise Congress accordingly if the agency determines that is impossible to implement these requirements without meeting the above criteria. We strongly support the AMA's position to strenuously oppose any consideration of implementing 2015 payment adjustments based on the value based modifier in 2013. It is inconceivable, and unjustifiable, that the agency would proposed to alter payments to physicians based on their comparison to an unknown peer group using a set of cost and quality measures, risk adjusters and payment attribution methodologies - all of which have yet to be determined. Overall we continue to believe that the value based modifier language is fatally flawed and cannot be implemented reliably to all physicians. Not only does this approach run the risk of defaming physician practices and reputations, it undermines our efforts to move toward new payment and delivery system reform based on care coordination and coordinated payments.

#### **IV. Medicare Economic Index and Geographic Practice Cost Indices Proposals for 2012**

At the outset we want to thank CMS staff for their ongoing efforts to work with the MMS, California Medical Society, AMA and other state medical societies to develop the appropriate formula and input factors to calculate both the MEI and Geographic Practice Cost indices. As you know, we were extremely concerned about several proposals in last year's Notice of Proposed Rulemaking which the agency appropriately changed in the final rule. Of particular significance both the final rule and recommendations from IOM affirmed the importance of geographic practice costs in the Medicare physician payment schedule. These findings are consistent with AMA policy which states that "geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index based adjustments as needed to remedy demonstrable access problems in specific geographic areas."

The MMS is committed to working with CMS, the AMA, the IOM and other involved organizations to develop a Medicare physician payment formula which accurately

reflects the costs of medical practice for all physicians. We also believe that the Medicare physicians' payment formula has an impact on patient's access to care in underserved areas, both urban and rural, and support developing different values or variables to address these concerns.

Several issues which continue to be of concern in the 2012 proposed rule are outlined below.

Perhaps the most dramatic and controversial changes in the 2011 payment rule were the adjustments to the Geographic Practice Cost Indexes (GPCIs). Although modified, the current rulemaking again proposes to rebase the data sets to calculate the MEI and revises the underlying assumptions and weights given to each factor. We continue to oppose these changes absent verifiable justification for the changes.

#### **Reducing the impact of office expenses harms urban areas with higher rents:**

A significant change in the CMS rule is the proposal to reduce the weight of rent on physician office expenses from the overall Medicare payment. Physician office expenses currently represent 12.2% of the practice expense GPCI. Under the proposed rule, physician office expenses would represent only 10.2% of the practice expense GPCI. This is a fundamental shift of significant dollars in Medicare funding away from urban state physicians and patients to the rural states that is not justified by the data. Of particular concern, CMS does not provide an adequate explanation or justification for this change which, by definition, undermines the significance of rent in high cost areas. Due to the large disproportionate underserved populations dwelling in urban areas, this may result in even greater financial burdens for physicians committed to the mission of treating the urban impoverished.

Congress has already undervalued the cost of practicing medicine in urban areas by reducing the weight of rent and wages in the practice expense GPCI by 50%. In addition, the ACA gave billions of dollars to rural states, by permanently increasing the work floor to 1 for the frontier states, as well as other changes to the Practice Expense GPCI calculation. For the past several years, Congress has raised the work floor for all rural areas to the national average of one, even though the actual costs of medical practice in rural areas were below the national average. Congress believed these changes were important to help address physician shortages in rural areas. While we have never opposed those changes, the unavoidable reality is that high cost areas are being paid less than their fixed costs, while rural areas are receiving more than their fixed costs in an effort to reduce rural physician shortages. The unfortunate irony is that in the era of health care reform, urban areas, which include the entire state of Massachusetts, are experiencing significant shortages in physicians. According to the 2010 Massachusetts Physician Workforce Study, shortages were found in four out of the five Metropolitan Statistical Areas (MSA) in Massachusetts. With the exception of Boston, shortages were found in Worcester, Springfield,



New/Bedford/Barnstable, and Pittsfield/Western Massachusetts. Recent data has indicated that while the absolute number of physicians licensed in Massachusetts appears adequate, greater than 25% of these physicians either are not involved in direct clinical care or live in other states. Many of these physicians are academicians, researchers or physicians who practice part time. This rule, if finalized, will only exacerbate that problem.

It is also important to note that the small increases in physician income in Massachusetts have not kept pace with the increases in the professional liability insurance premium increases or the cost of maintaining a physician's practice. According to the Society's 2011 Physician Practice Environment Index report, in both Massachusetts and the U.S., increases in the median income of physicians have been cut in half while increases in the cost of maintaining a physicians' practice have held steady over the past ten years. Massachusetts has experienced the additional burden of professional liability insurance premium rate increases. During the period 2005-2010, Massachusetts professional liability premium rates increased 2.4% compared to 0.5% for the U.S. as a whole,

The Society's Index report also examines class B office space by square feet. According, to the Grubb & Ellis Research Department, a commercial real estate service and investment company, rental rates for the Boston Metropolitan area decreased by -2.5% from 2009 to 2010. Although a decrease, this number is significantly less than the 5% decrease in rent which is average for MA according to CMS estimated. As for employee office wages, an increase of 3.3% was seen for registered nurses, accounting specialists, and secretaries combined, according to the Bureau of Labor Statistics data.

In the proposed physician fee schedule rule for calendar year 2011, CMS announced its intention to convene a technical panel in late 2010 to review all aspects of the MEI, including the inputs, input weights, price measurement proxies, and productivity adjustment. The AMA has long requested that CMS address the problem that the "market basket" of inputs whose prices are measured in the MEI is outdated, and we are disappointed that this technical panel has not yet been convened to review the MEI. **We understand from CMS staff that the agency still intends to convene this technical panel, and we urge CMS to move forward quickly on this front because the MEI has not kept pace with increases in the cost of medical practice.**

### Creating an Office Rent Index from ACS Data

The CMS proposal to switch from the HUD apartment rental data to the ASC apartment rental data is a substitution of one office rent proxy for another. **A far better solution would be for the government to develop actual data on the cost of renting medical office space.** The current Medicare physician payment schedule has been in place for 20 years, yet CMS is still relying on

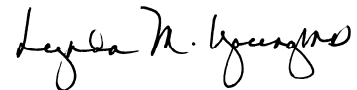
apartment data as a proxy for medical office rent. A plan for replacing this proxy with actual data is long overdue.

All existing sources of relative rents are imperfect for the Practice Expense (PE) GPCI. The CMS should adopt the Institute of Medicine's recommendation to identify a new source of information to obtain data on commercial office rent per square foot. The new data source must be scientifically valid, verified and assess costs on a per unit basis. We do not believe data sources which are self reported and based on aggregated costs are reliable. We are also very sensitive to any new survey requirements which would impose an additional burden on physician offices.

The current proposal to move from HUD apartment rental data to the ACS apartment rental data will impact the state of Massachusetts as a whole. Although the overall rate of change for Massachusetts' GAF is estimated at -0.8% specific counties such as Nantucket, Plymouth, Essex, and Dukes will experience a loss in their office rent index value of -7.3%, -11%, -12.6% and -29.3% respectively when ACS data are used. This compares with the average rate of change for the U.S. for rent decreased -5.1. We are very concerned that the ACSA data is not consistent with that seen in Massachusetts and may be inaccurate. For example the change for Nantucket and Dukes counties are dramatically different, yet the two counties experience similar economic trends and demographics. We are very concerned that these changes could worsen patient's access to care in these counties in which significant physician shortages exist. We strongly encourage the agency to review the ACS data and to consider the undue impact of proposed changes on underserved and physician shortage areas.

The Massachusetts Medical Society appreciates the opportunity to comment on these proposed rules and looks forward to working with you and the agency in the future.

Sincerely,

A handwritten signature in black ink, appearing to read "Lynda M. Young". The signature is fluid and cursive, with the first name "Lynda" being more prominent.

Lynda M. Young, M.D., FAAP